Teaching Patients Self Care: A Critical Aspect of Psychiatric Discharge Planning

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ABSTRACT

This article addresses techniques that can be incorporated into both inpatient and outpatient programs in psychiatric-mental health nursing to decrease chances of rehospitalization. The authors write from their clinical experience in these settings and from research by the first author that has examined discharge planning techniques and outcome measures.

INTRODUCTION

The key to helping patients successfully manage after psychiatric discharge is self care — the art and science of helping patients to understand their illness, cope with the medical regimen, and prevent relapse by recognizing symptoms if and when they reoccur. The most successful kind of teaching in psychiatric-mental health nursing is that which allows patients to take charge of their illness and become partners in the treatment process.

The dimensions of self care perhaps have been defined best by Dorothea Orem (1971) as “The practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health, and well-being.” Teaching and anticipatory guidance are important aspects of self-care assistance that are emphasized in this article. The theoretical implications of self care have been substantiated in research conducted by the first author (Buckwalter, 1980), which demonstrated that inclusion of the patient’s family in a predischarge planning program (Figure) positively influenced social and community adjustment variables, satisfaction and stress levels, and compliance with medication regimens and aftercare appointments.

Recidivism rates are indicative of the ultimate failure of self-care teaching. Although deinstitutionalization has brought about an impressive decline in the number of psychiatric patients, this has been countered by the fact that there also has been an increasing readmission rate to state and county mental hospitals every year from the 1950s to the 1970s. Moon and Patton (1965) reported that readmission rates for 1960 to 1963 increased 12% over 1948 to 1955 rates. Friedman, Von Mering, and Hinks (1966) noted that high discharge rates and modern treatment methods were accompanied by readmission rates of up to 64%. While some episodes of relapse cannot be prevented, many can be handled on an outpatient basis if effective patient teaching has taken place. Readmission to the hospital often is unnecessary and most often is precipitated by the inability of patients and family members to cope with a crisis in an outpatient setting.

Relapse statistics are related to several factors. If treatment is initiated as soon as signs and symptoms worsen, outpatient management rather than rehos-
Hospitalization is more likely. This form of treatment is successful only if patients are knowledgeable about their illnesses, and have support groups that understand their conditions. The family's knowledge of the illness and their support for medical treatment is an essential aspect of outpatient management. It is often much easier for families to return the patient to the hospital than to cope with the illness, but ultimately the patient suffers because of renewed stigma associated with rehospitalization and the development of a "failure identity" (Glasser, 1972).

Knowing how to handle the crisis of recurrent illness is essential to managing the relapse, and the manner in which family and patient handle stress is indicative of the methods they will use to cope with recurrent illness. Finally, medication compliance is an important factor in determining length of community tenure. This entails not only patient knowledge of medications, their proper dosage, and potential therapeutic and adverse side effects, but also awareness and support on the part of family and significant others in the patient's home setting.

This article addresses techniques that can be incorporated into both inpatient and outpatient programs in psychiatric-mental health nursing to decrease chances of rehospitalization. The authors write from their clinical experience in these settings and from research by Buckwalter (1980) that has examined discharge planning techniques and outcome measures.

UNDERSTANDING THE DIAGNOSIS

Psychiatric nomenclature is confusing to patients and sometimes is considered nothing more than just a label. However, if patients can understand what their diagnosis means and how to cope with their particular symptoms, the chances of adaptive living in the community are enhanced. One of the primary aims of discharge teaching, therefore, is a full explanation of the psychiatric diagnosis that includes both understanding of the symptoms and the implications of the psychosocial and biochemical aspects.

Many nurses, because they do not understand fully the neurophysiological and biochemical basis of psychiatric disorders, are unable to explain the physiological components of the diagnosis to patients. We have found that patients' compliance with the treatment regimen is enhanced if they can see the illness in more concrete physiological terms. We explain to them the basic concepts of neurotransmitters and how a psychiatric illness such as...
depression or mania can change the way these neurotransmitters function. We use a diagram to illustrate the way in which neurotransmitters work between synapses and use pictures of neurons available in the drug and medical literature. We also explain how the patient's particular drug is thought to act on the synapse and how medication therapy can cause changes in symptomatology.

We find it useful to compare psychiatric illness with a physical illness. Many patients have some knowledge of a common disease such as diabetes and easily can relate the biochemical imbalances of a psychiatric illness to the blood sugar imbalances of diabetes. Using the analogy of medication and insulin, patients can understand that psychiatric medication can restore some of their former functioning through biochemical means. Therefore, the patient does not view medications as merely tranquilizers but sees them as altering neurotransmitter function. If patients understand the biochemical basis for their symptoms, they often feel less stigmatized and are more accepting of a psychiatric diagnosis.

Another aspect of understanding one's illness is an appreciation of the fact that psychiatric illness is not static. Rather, it can be cyclical and possibly can reoccur. For example, when dealing with someone experiencing a depression, we try to determine the natural history of the disorder. Some patients will note seasonal variations and only become depressed in the fall or spring. If such a pattern can be established, then preventive measures can be instituted more effectively. With other patients, depression tends to reoccur in a cycle of several months or years, or in response to specific stressors such as the loss of significant others through divorce, separation, or death. Many patients believe that if they have one episode of depression they will have no more. If a relapse occurs, they feel defeated and believe they have done something "wrong" to precipitate the reoccurrence. It is helpful for patients to understand that in some people depressions occur in self-limiting cycles, and it is therefore best to prepare them for the possibility of a reoccurrence so they might accept it with fewer feelings of failure. We find that patients who feel good about themselves and their postdischarge progress, and believe they have some measure of control over their illness, are more likely to return for treatment with the onset of the first signs and symptoms of relapse.

Our experience suggests that certain patients benefit from conceptualizing their illness in terms of "coping" rather than "curing." Patients get discouraged when they cannot, in spite of concerted efforts, become totally symptom free. Psychiatry is not at the point where it can promise cures for every diagnosis. The outcome measure then becomes not the absence of symptoms, but how well patients cope with symptoms when they reoccur. Since nurses cannot promise patients that they will remain symptom free after discharge, it is helpful to teach patients the techniques of anticipatory guidance to help them cope with the initial signs of recurrent illness.

We feel it is essential to work with the families of psychiatric patients. This may sound trite, but one of the most significant aspects determining the success or failure of teaching psychiatric patients is the awareness, support, and knowledge of the family members. Our definition of "family" in this context includes significant others such as roommates, friends, or any other person with whom the patient has any type of enduring relationship.

Families commonly feel a great deal of guilt and responsibility when one of their members becomes psychiatrically ill. A discussion of guilt and concerns is imperative in order to work effectively with the family. This enables the family to work with the patient in a more realistic manner. It has been useful to point out to patients that the family often spots trouble before they do. We help the patient understand that in so doing the family is not being overly suspicious, placing less faith in them, or criticizing them unduly. When a family member suspects that symptoms are becoming worse, we encourage the patient and the family to schedule an outpatient appointment immediately, so that a nurse-therapist can make a decision regarding imminent relapse and begin appropriate interventions if necessary. We conceptualize the family and patient acting as a team, with the therapist functioning in a "coaching" role to help patients and their family members to function within this framework.

Bibliotherapy can be an effective patient teaching strategy. There are books on the market now for lay people that do a good job of explaining affective disorders. We also use articles from popular periodicals, news magazines, and pharmaceutical pamphlets that explain medications and illnesses in a relatively simple and yet accurate manner. Another advantage of using lay literature is that it effectively explains psychiatric illness in understandable terms and thus helps lessen the stigma. These articles usually have a positive focus and emphasize the commonality of the problem. Local mental health associations supply many excellent pamphlets as well.

Another effective technique is the assignment of homework that requires both the patient and family to read instructive material between appointments. The following appointment then is used to clarify any misconceptions they may have. We incorporate techniques of learning such as return demonstration and explanation into our patient teaching and encourage feedback so that we can evaluate if learning has taken place. If the patient is unable to read because of emotional problems, illiteracy, or blurry vision secondary to medication, we record...
pertinent information on tape. If this is not appropriate, we devote therapy time to explaining written material.

Yet another approach is to note that famous people have had similar psychiatric problems and have been able to cope with their mental illnesses. For example, when explaining depression, we point out that Abraham Lincoln and Winston Churchill suffered depressive episodes and considered suicide, or give examples of people in show business who have handled depression or mania successfully. When patients understand that many productive and admired individuals have coped with similar problems, they often feel more confident in handling their own situation.

**STRESSORS**

The prehospitalization phase often is accompanied by a series of stressors. The nature of these stressors can be discovered by taking a thorough history of events leading up to the crisis. One problem with this approach is that patients tend to look for external causes of illness when in fact there may be none. However, for many patients, there is a clear history of stressors such as childbirth, a new job, or a change in marital status, that can precede a relapse for certain individuals.

When a clear history of stressors has been elicited, the therapist can continue to teach prevention of future relapses and techniques to lessen the severity of reoccurrence within an anticipatory guidance framework. Patients are taught to be “tuned into” potential stressors in their lives. If they have a great deal of unavoidable stress in one area, they are instructed to try and relieve stress in other areas. Changes in signs and symptoms may be used as a barometer of the phase of the illness to indicate how well or how poorly they are handling stress. Patients are instructed to check with their nurse-therapist for possible medication changes and crisis counseling whenever they are placed in an unusually stressful situation. They are taught to view stress not as an insurmountable problem, but rather as an opportunity to test coping skills. Stress is presented as a challenge to be dealt with rather than something to be feared.

**SIGNS AND SYMPTOMS**

In order to cope effectively with any psychiatric illness, patients need to know what signs and symptoms are characteristic of their problem and the particular meaning these symptoms have for them. Every patient has a unique pattern of symptoms. Patients need to understand thoroughly that symptoms should not be thought of negatively, but rather seen as indicators for dealing with illness. The patient’s individual symptom pattern best can be identified from interviews with the family and patient. For example, the first sign of recurrent depression for some patients is loss of energy. If the family knows this is one of the symptoms to watch for, they will be concerned if the patient becomes inactive at night, falls asleep, and loses interest in outside activities. The patient may interpret this as simple fatigue, but it could signal the beginning of a relapse to family members. If a mental health professional is called in at this point to make a judgment, a further deterioration of the patient’s condition may be averted. On the other hand, the family can be reassured that the patient is simply, as he states, over-tired.

The most important point related to changes in signs and symptoms is the consequent initiation of either psychotherapy, medication therapy, or both to abort an impending relapse. In this way, patients develop a real sense of being in charge of their illness and can learn to view symptoms as potentially-helpful, early-warning signs and to seek immediate intervention when appropriate.

**RESOCIALIZATION ISSUES**

One of the most critical problems patients face when re-entering the community is that of explaining their hospitalization to co-workers and acquaintances. In therapy sessions, we often discuss this issue with patients and encourage them to formulate answers for awkward situations with which they may be confronted after discharge. Role playing can be especially effective with the therapist portraying the role of employer or friend. Patients are asked to relate how they would respond to various situations. Initially, patients may be very uncomfortable with role playing but after several sessions and encouragement to try out many different situations, they usually are able to determine which behavioral and verbal responses are most effective for them.

After discharge, patients may delay rejoining social groups and activities that are important aspects of positive reintegration into the community. There is a fine line between joining too early only to fail and procrastinating so long that the patient becomes phobic of social situations. If patients can explain confidently their absence, they usually are more willing to re-enter social groups at an earlier date.

Following discharge, patients also should be encouraged to continue some of the recreational activities that they participated in while hospitalized as effective ways of managing leisure time and constructively discharging tension.

**COMMUNITY SUPPORT**

Patients need to learn to call upon community resources they used prior to hospitalization. For example, if a member of the clergy was a mainstay in the patient’s life, he/she should be contacted during hospitalization so that appointments can be set up at the time of discharge. One of the roles the minister
can play is to help reintegrate the patient into the social and religious life of the church and thus help to rebuild self confidence. If patients cannot identify any community support groups, the nurse can guide them to such groups. Most communities have self-help organizations such as Recovery, Inc., which consist of former mental patients who provide support and care to people in similar circumstances. Many mental health centers have socialization groups for discharged patients that offer an opportunity for interpersonal contact, support in the community, and an outlet for discussions of problems related to community living. Public health nursing is an excellent source of postdischarge support, and referrals to public health agencies should be a standard part of discharge planning. In order to maintain some patients in the community, services such as Meals on Wheels, a friendly telephone service, and volunteer visitors also may be considered.

MEDICATION COMPLIANCE

Eighty to 90% of all discharged mental patients are placed on medications. Research related to medication compliance in the aftercare period is somewhat contradictory. Franklin, Kittridge, and Thrasher (1975) found that use of medications, length of time on medication, or dosages after discharge did not relate to readmission, whereas research by Zolik, Levin, and Hubeck (1970) and Davis, Dinitz, and Pasamanick (1972) showed hospital returnees had significantly more medication problems than nonreturnees. Segal and St. Clair (1977) found that only 16 of 86 rehospitalized patients mentioned any medication problems, but research conducted by Sanders, Smith, and Weinman (1967) suggests patients may underestimate medication problems in the aftercare period.

Psychotropic medications provide professionally acceptable reasons for increased staff attention and optimism. The biochemical aspects of psychiatric disorders in many ways have come to be viewed as the key to the solution. However, psychological therapy and retraining are important in helping patients match their behavior to new-found biochemical normalities after hospitalization.

Psychosocial interventions together with medication teaching will ensure optimum treatment. The introduction of psychotrophic medications has not “preempted the necessity for developing more effective psychosocial interventions” (Erickson, 1975).

As noted previously, the biochemical aspects of drug treatment are understood poorly by many nurses. Much information about the neurological basis of drug treatment has been available in the past five to ten years but has not been emphasized in the nursing literature. Therefore, many nurses see drug treatment as adjunctive rather than primary treatment. With the explosion of information about the biochemical components of mental disorders and knowledge about neurotransmitters, we have come to understand that drug treatment is, in many cases, of primary importance in the treatment of psychiatric disorders. Medication compliance can be increased if the nurse understands how medications work, knows when to recommend changes in medications, and knows how to teach patients to recognize a need to regulate their own medications after consultation with a professional.

For some patients, it is difficult to remember to take several medications on different time schedules. It is imperative that the nurse examine the scheduling of medications and consult with the physician regarding the most reasonable timetable for administration. Many antidepressant medications can be given at one time in a nightly dose that is more effective than several doses given throughout the day. Patients are more likely to remember to take a single daily dose than multiple doses. Other medication, because it is metabolized in a different manner, will not be amenable to this type of scheduling. It is effective for the patient to learn to pair medication taking with a routine event. For example, patients can remember to take the morning medication if they associate it with a daily morning task such as brushing their teeth. Similarly, if patients have lunch at approximately the same time every day, they can pair medication taking with lunch. If they skip lunch, then medication must be coupled with another routine event. Alternate plans should be made for weekends or periods without an established routine.

It is sometimes difficult for patients to remember if they have taken their medication and an individualized system needs to be developed to ensure that patients will not retake their pills. Pharmacies have many types of plastic drug dispensers available in disc or rectangular form with sections where each day’s medication can be placed. Patients are encouraged to purchase these dispensers and carry them in their pockets or purses so that they can see if the medication has been taken by looking at the dispenser. Patients and/or family members also can establish a nightly routine of setting out souffle cups containing the next day’s medication. Xeroxed check list forms that the patient can attach to the refrigerator or other conspicuous place detailing the dosage of medication and the time taken are another way of determining if medication has been taken properly.

For the patient who is unreliable and/or suicidal, frequent outpatient appointments are essential, and the patient should be given only enough medication to last for a few days with no refills. Patients never should be given more medication at any one time than their body can handle in case of an overdose. Each dosage of medication may be poured into a paper packet or plastic dispenser and three or four days’ worth of medication can be given to the patient.
Patients are instructed to return old packets to the nurse, at which time a new series of medications is provided. If the patient should bring in an unused packet, the nurse must avoid accusations that may result in guilt or a sense of failure on the part of the patient. If this happens, the patient will learn to hide mistakes and the nurse will not get an accurate idea of the patient's compliance. Home visits by the nurse-therapist or public health nurse can be enlisted to help with medication compliance by setting up a program in the patient's home. This is most appropriate if it is difficult for a patient to come back to the outpatient treatment center on a frequent basis. This also provides the opportunity to make a home assessment and to uncover any problems that might escape the outpatient nurse-therapist.

In our experience, most patients are compliant with medication regimens when exposed to this kind of teaching. They understand that there is a physiological and biochemical basis for drug usage and that medications are not solely for tranquilization. We thoroughly discuss any side effects that may be expected and teach them how to cope with these. For example, if an employed patient becomes sleepy after a noon dosage and this interferes with job functioning, we discuss with the psychiatrist either lowering or eliminating the noon medication or administering it later in the day. We fully explain to patients that they might feel sleepy for a period of time when on medication therapy, but this will soon abate. If patients know what to expect and realize that side effects are not permanent, they usually are more agreeable to medication therapy.

SUMMARY
This article has dealt with selected issues in patient education that involves teaching patients self care in the mental health delivery system. It has presented several predischARGE teaching techniques that have been used in a research study by the first author and other strategies that have been found to be effective in both authors' clinical practice. There are many other areas in need of systematic investigation related to self-care skills. The first author's study is one of very few conducted by psychiatric nurses to document effective self-care treatment techniques (Figure). We hope that other clinicians and researchers will become interested in this area and add to the knowledge base of self care in the field of psychiatric-mental health nursing.

REFERENCES
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