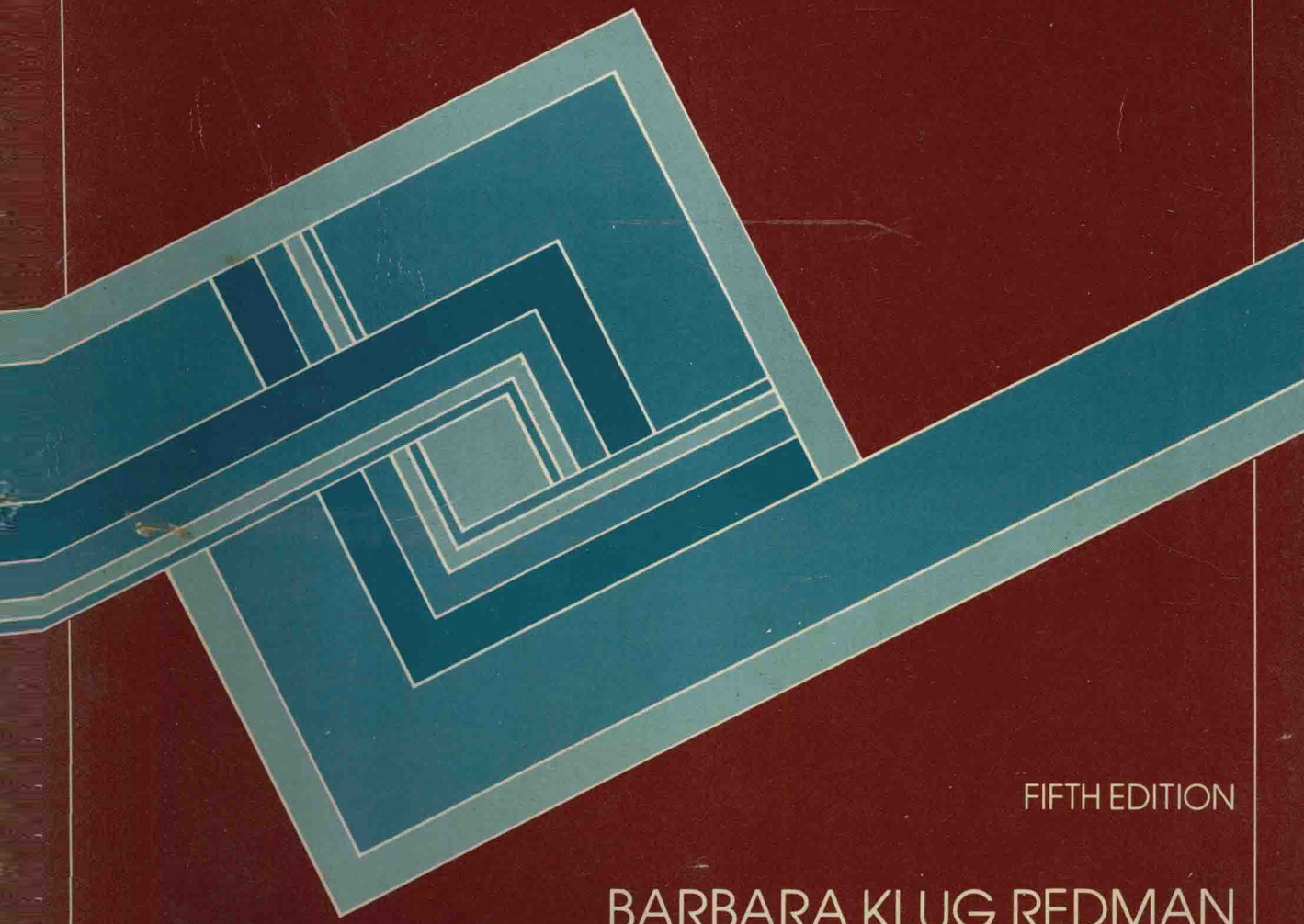
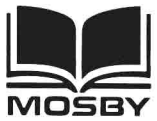
The Process of Patient Education



FIFTH EDITION

BARBARA KLUG REDMAN



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To

Darlien and Harlan Klug

In grateful appreciation
for years of sustenance of various kinds.

Preface

This book is written for all health care providers who want to know more about how to teach patients and families. Since the book began as a text in nursing, and since nursing has such a rich philosophic and conceptual heritage in patient education, much of the background is still drawn from that field. Students should be ready to use the book when they recognize the need for learning in their patients and when they are sufficiently knowledgeable in the subject matter to be taught and competent in their interactions with patients.

The impetus to write the book began with students, by way of their interest in the excitement of directing learning in their patients. It came also from frustration on the part of student and teacher alike over the lack of materials specific to the patient-teaching process in nursing.

After a beginning statement about the relevance of patient education in health care, the chapters are organized around elements of the teaching-learning process and delivery systems for patient education. Examples given are not meant to be exhaustive; they are only illustrative of the process. It will be advantageous if the student already has a basic understanding of the psychology of learning, because this complex subject must be abbreviated in a book of this size.

Barbara Klug Redman

THE PROCESS OF
Patient education

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Contents

CHAPTER 1

The place of patient education in health care

■ Almost everyone will agree that health care providers ought to explain many things to the patient. This statement leads to these questions: Does the patient want to learn? How important is it that the patient learn? What should he or she know? What is the best way to teach? Does the nonphysician provider need the physician's permission to teach? How does the provider know whether or not the patient has learned? Also of importance is an understanding of how teaching came to be a tool of health care, of what it is expected to accomplish, and of the ways in which providers now function as teachers. Such a perspective helps to delineate what the role of patient education can be. The present chapter develops this perspective in preparation for the following chapters, which focus on the process of teaching-learning.

HISTORIC, PHILOSOPHIC, AND LEGAL BACKGROUND

Nursing background

Early English leaders in nursing in the middle and late nineteenth century saw the importance of teaching families about sanitation, cleanliness, and care of the sick. Since much of the care of the sick at that time was done by the family, the efforts of nurses to teach represented a way of extending their services. This same reason no doubt motivated the early visiting nurses in the United States, who fought together with other workers against disease and poverty among immigrants. Also basic to these health education efforts was the realization that health could not be legislated or mandated successfully. These tenets remain important today.

Statements by the National League of Nursing Education reflect the concern during this century with preparing nurses for their teaching tasks. The following comment shows such a concern as early as 1918:

> Another limitation of the ordinary training is that it deals only or mainly with disease, neglecting almost entirely the preventive and educational factors which are such an essential element in the many new branches of public health work, such as school and visiting nursing, infant welfare, industrial welfare, and hospital social service.*

The 1937 curriculum guide commented, "The nurse is essentially a teacher and an agent of health in whatever field she may be working."[37] In 1950 some of the areas common to all nursing curricula were identified as "teaching, contributing subject matter, psychology (especially principles of learning) . . . knowledge of principles of learning and teaching . . . [and] teaching skills."[38] Note the extension of the place of teaching in nursing and the increasing interest in knowledge of the scientific bases of the teaching-learning process, which are characteristic of each of these statements of nursing thought at different times in this century. These recommendations represent the thinking of the nursing leaders; actual translation of these thoughts into schools of nursing and then into nursing practice seems to have occurred much more slowly.

The centrality of patient teaching varies with formal philosophies of nursing. Kreuter identified teaching of self-care and counseling on health matters as nursing operations needed to provide care.[28] Sister Olivia viewed teaching as one of the tools of the nurse with the objective of promoting spiritual, mental, and physical health.[40] Some authors

*National League of Nursing Education: Standard curriculum for schools of nursing, Baltimore, 1918, The Waverly Press, p. 6.

imply that nursing involves teaching. So it is with Henderson, who says that nursing assists the sick or well to do health activities they would do unaided if they possessed the necessary strength, will, or knowledge, with a goal of increasing independence.[19] Other authors view the teaching-learning process as more central to nursing. Lambertsen characterized nursing as an "educative process,"[29] and Peplau described nursing as a maturing force, an educative instrument.[44] Hall viewed some of the tenets of teaching as central to her philosophy of nurse-patient interaction—the nurse facilitating patients' verbal expressions by reflecting them so that patients will hear what they are saying. Hall believed that through this process patients come to grips with themselves and will learn to be well.[17] Travelbee indicated that both the patient and the nurse learn as a result of the interactive process and that if changes do not occur in either or both of the participants, a relationship has not been established.[54]

King sees usable health information at a time when they require it and are able to use it, as one of three fundamental health needs of human beings. This definition of need follows from her definition of health as the dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment, through optimal use of one's resources to achieve maximum potential for daily living.[23] Johnson describes the Behavioral System Model for nursing, with its goal of fostering efficient and effective functioning in the patient to prevent illness, during and following illness, and sees teaching, role modeling, and counseling as ways to help people find new or better ways of behaving, contributing to an enlargement of choices. Larger behavioral repertoires characterize more adaptable individuals.[21]

The Nursing Development Conference Group describes a theoretical and philosophic approach in which self-care agency is a key concept, referring both to a characteristic of individual human beings and to an element of a nursing system in which self-care agency and therapeutic self-care demand are interactive with nursing agency. Self-care agency is the power of an individual to engage in the operations essential for self-care; it is an action repertoire that includes both an estimative capability (investigation of internal and external conditions, their meaning, and their possible regulation) and a productive capability (preparation for and performance of self-care operations, monitoring for evidence of effects). This agency will have degrees of development, operability, and adequacy in relation to a known self-care demand.[39] Clearly, the caregiver's role in this conceptual system involves not only providing care that patients need but cannot provide for themselves, but also assistance with development of self-care agency.

Major changes in conception of the teaching function in nursing seems to have been occurring. Peplau sees a shift in emphasis from traditional mother-surrogate activities to more educative-nurturing ones.[45] Kinlein's description of her practice, based on Orem's theory, provides a view of a truly nursing focus for patient education. Kinlein proposes a health care system in which people are the primary givers of care to themselves—by virtue of choosing the health professional who the person thinks would be most helpful at the time.[24] Nursing is assisting people in self-care practices with regard to their state of health. Instead of a practice focused on support of medical goals, the nursing focus in practice involves the use of nursing knowledge to help achieve the patient's health goals.[25] Indeed, the patient's knowledge, skills, and problem-solving ability form a self-care asset worth developing in and of itself.

Many of these expressions of philosophy emphasize the similarity of teaching and nursing; each involves a helping relationship that has as its objective development of independence in the subject. Teaching is seen as one means toward the goal of nursing, with both the nurse and the patient assuming responsibility for movement toward that goal.

Of the three major types of conceptual frame-

works for nursing, the developmental framework focuses on the forward movement of the personality and skills for meeting needs, the systems framework on necessary learning to coordinate and function within one's systems and to negotiate with external systems, and the interactionist framework on the symbolic meaning and values in all interactions.

General background

A number of factors have converged to bring health teaching into prominence. In general the greater effort in this century to maintain health rather than just treat disease has enlarged the sphere of knowledge a person needs and has demanded a change in attitudes about health. World War II emphasized the need for teaching in rehabilitation, perhaps because of the return of so many servicemen in need of this service. Shortened hospital stays with early ambulation require preparation for the convalescence the patient will undergo at home. There has been an increase in long-term illnesses and disabilities, and both the patient and family should possess a high degree of understanding of the illness and its treatment. The consumer movement and the general movement of society toward social leveling also played a part.

Recent additions to social thought on patient education reflect more strident themes, such as control and patients' rights. Some see that medicine has become a major institution of social control by making the labels "healthy" and "ill" relevant to an ever-increasing part of human existence. The new definitions of these terms appear to be that anything shown to have a negative effect on the workings of the body in some way and to a lesser extent the mind can be labeled an "illness" and jurisdictionally a "medical problem." Further, the patient's moral character is not demonstrated in having the disease but in what the patient does about it.[58] It follows from this point of view that patient education would be one means of effecting control.

In elucidating the character of the professional functioning in medicine, Freidson concluded that "professional" is a way of organizing work rather than an orientation toward work or a body of knowledge. In contrast to the general notion that patient welfare is protected by professionals, one finds no generally accepted notion of due process for the client in professional work, including medicine.[13] In the same vein, Myra Levine has charged that, in fact, a large percentage of what is called "teaching" is actually communication of the rules of behavior dictated by the rituals that the nurse has been taught to value. The intransigent patient is one who either rejects or fails to understand the rules in the same way that the nurse understands them.[31]

Significant changes have been occurring in medical ethics basic to patient education. In July 1980, the American Medical Association's House of Delegates approved a new version of Principles of Medical Ethics, which indicates that a physician shall make relevant information available to patients and the public.[3] In commentary on this revision, Veatch underlines the basic shift of position from Hippocratic ethics that this document represents. Traditionally, the physician has considered honesty with patients to be secondary to a more fundamental commitment to protect the patient from harm. The new statement implicitly recognizes rights of patients and recognizes the role of the lay person in determining what is ethically appropriate in the professional role. Clearly, the traditional paternalism of the profession is in conflict with society.[56]

This analysis is consistent with the view of Pellegrino that so fundamental is the right of self-determination in a democratic society, that to limit it, even in ordinary medical transactions, is to propagate an injustice. The usual objections of fear of inducing anxiety in the patient, inability of the patient to participate in decisions, the technical nature of medical knowledge, and the possibility of litigation, do not justify concealment except in special circumstances. Disclosure permits the physician to serve as technical expert and adviser; the most im-

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portant revision is to allow consideration of the patient's personal values. The definition of health is highly personal. The professional can make a valid claim for technical authority but no longer for moral authority. In a pluralistic society, patients have the right to their own moral agency if they wish to exercise it.[43] It has been noted that because medicine is not an accomplished science, physicians who assume complete autonomy for medical decision making are putting themselves in a very difficult ethical position.[6] Most of a physician's daily decisions do not involve situations that have been tested in double-blind randomized clinical trials. Indeed, it has been estimated that in about 90% of medical conditions, either there is no specific remedy or the effectiveness of treatment is unknown.[46] So, given the arbitrary nature of many clinical decisions, unilaterally ordering a patient to comply with a decision without considering the person's values and preferences seemed unjustifiable to Brody.[6]

Collegial and contractual models of medical care have been added to older ones. Indeed, the consumerist perspective in which the physician and patient bargain over the terms of the relationship, neither automatically in charge, is at variance with the traditional sociologic concept of the sick role as the basis for the relationship, in which the physician is in charge and the patient obligated to cooperate with the regimen. A recent study of members of the public and physicians showed substantial minorities expressing beliefs and reporting actions congruent with the consumerist perspective. Information control with a wide competence gap between patient and provider formed the traditional pattern of relationship; the consumerist concept turns on a narrowed competence gap.[18]

Holistic health care embodies a number of the precepts of the consumerist ethic: (1) comprehensive programs that address physical, psychologic, and spiritual needs of those who come for help, (2) programs that meet unique needs of each individual, (3) therapeutic approaches that mobilize the individual's capacity for self-healing and independence rather than remedies that promote further dependence, (4) emphasis on education and self-care rather than on treatment or dependence, and (5) the view that the setting where health care takes place is a place for education, volunteer work, and socializing as well as for care in health and illness. The holistic health care movement is part of a broad movement to create humane, democratic alternatives to large, impersonal, unresponsive services and institutions, beginning with the commitment to participatory democracy that animated the civil rights, youth, and women's movements of the 1960s.[15]

The legal base for medicine has long included the patient education area of practice. As early as 1898, giving proper instructions to a diabetic patient in relation to care of an injured limb was found to be a duty, and failure to supply these instructions was abandonment. Today, other duties include explicit instruction in the use of prescribed medication, follow-up care, and informing the patient he or she has a condition requiring continual treatment.[22]

In regard to disclosure, in the *Canterbury v Spence* case and others following it, the trend is to disregard the local community or national standards of disclosure and to substitute in their place the needs of a reasonably prudent patient. Such a rule is likely to lead to either greater disclosure or greater liability. It is permissible to withhold information if the disclosure will cause physiologic or psychologic harm to the extent that the effectiveness of the procedure will be impaired, but it is not permissible to withhold information merely to negate the possibility that the patient will refuse treatment or make a "wrong" decision.[26]

The Patient's Bill of Rights, developed and approved by the American Hospital Association, appears on pp. 6 and 7. A modified version of this bill became state law in Minnesota. It has been suggested that once a hospital adopts the Bill of Rights as policy, the provisions can be the basis for legal action in the same manner as the hospital's

bylaws and rules of nursing practice.[41] Courts may use the bill as a higher standard of hospital conduct than was previously the case. The position of nursing regarding the compliance of physicians with the Patient's Bill of Rights is not yet clear[20] but may well include involvement in upholding the hospital's policy.

The case of *Darling v Charleston Community Hospital* established liability of a hospital that failed to perform treatment consistent with its own standard of care. If a patient education program is available to all patients admitted to a hospital, is known by the community to be offered, and is part of the standards of care drafted by the medical staff of the hospital, liability is likely if the standard of care is breached and that breach is the proximate cause of injury to the patient. It is the responsibility of the hospital that establishes such a program to monitor the professional care in patient education. A hospital can be held liable under the doctrine of respondeat superior, for negligent actions of its employees.[33]

Finally, revision of some nurse practice acts has made explicit the inclusion of patient education, in addition to increasing the independence of the nurse. No body of legal opinion regarding standards of practice in this area appears to exist, although several professional associations have issued statements regarding the nurse's practice in patient education.

GENERAL GOALS OF HEALTH TEACHING

What health teaching can accomplish is a key question. In general, health education is concerned with learning to live life in the healthiest way possible.[52] Alternative approaches to change in health behavior, such as legislation and environmental controls, ultimately depend on education for acceptance by people. In addition, many actions seen as important for improved health and welfare, such as family planning and seeking early diagnosis, are privately controlled and are not completely open to other approaches to effect behavioral change.[49] It is possible to prevent, to promote, to maintain, or to modify a number of health-related behaviors by means of teaching.

Several global objectives have been suggested. "An objective when dealing with illness is for the patient to fully participate in and integrate the illness in his life experience in order to prevent regression or dissociation of the event."[44] Closely related is the view that instruction should help the individual to find meaning in illness as well as in measures he or she must take to conserve health and control symptoms of illness.[54] Teaching plays a part in the general goal of nursing to help patients strengthen themselves through strengthening role performance. This includes support during role change initiated by growth and development, movement into a new geographic or social environment, or transition between health, sick, and handicapped roles. To this end, the nurse in the outpatient department helps the diabetic patient reconcile the sick role with that of worker, and a public health nurse gives prenatal counseling to parents.[55]

Other more specific goals fit within the general framework of carrying out one's role as a patient. Included are follow-through on treatment and rehabilitation, self-direction, including participation in decision making, and self-care. Closely related to carrying out one's role as a patient is the objective of relieving the tensions of illness by means of learning. It is believed that a patient is reassured when someone trusted provides authentic information when it is needed.[16]

It has been said that a general characteristic of psychosocial treatment, of which patient teaching is a part, is that the goals are usually short-term and palliative rather than curative. For example, the nurse may discuss a patient's fears with him or her preoperatively with the intention of decreasing the probability of postoperative complications, but the goal does not involve altering the patient's psychologic reaction to operations in general. To the extent that this statement is true, it demands reflection on the value of such goals, on our ability to attain them, and on ways in which accomplish-

A PATIENT'S BILL OF RIGHTS*

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.

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ment of numerous short-term goals affects attainment of the long-term goals.

These views about objectives are the basis of the comment that every person who receives health care has some need to learn, at least with regard to orientation to the environment and to the diagnosis; perhaps the person may also need an interpretation of how to be sick or well. This information allows one to assess his or her rights as a patient. For the families of these individuals there is need to learn how to support the sick and how to maintain and promote good health for the family unit.

Major objectives of teaching are often classified by phases of health care. Providers teach about health care facilities, growth and development, nutrition and hygiene, safety, first aid, preparation for childbearing, and other such topics so that people will maintain health and prevent disease. During the phase of diagnosis and treatment, the patient and family learn about the disease, the need for care and treatment, and hospital or clinic environment. During the follow-through phase there is

A PATIENT'S BILL OF RIGHTS—cont'd

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.
11. The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

need for an understanding of care at home, including medications and diet, activity, continuing rehabilitation, and prevention of recurrence or complications. Providers in public health, schools, and industry center their teaching activities in the phases of promotion of health, prevention of illness, and follow-through. Examples include classes about parenthood and health, counseling in day centers for the elderly, and prenatal counseling. Those working in hospitals deal primarily with teaching during the diagnosis and treatment phases and the beginning of the follow-through phase. The nurse in the outpatient clinic or nursing home may have the opportunity to teach during all phases.

A number of strong forces in the health care field, including widespread and growing dissatisfaction with the results of enormous expenditures on therapeutic medicine and the consumer movement, have thrust health education forward into a position of higher priority than it has held before. These forces have brought with them goals for patient behavior change. One area for such change

is in people's individual responsibility for their own health, which is seen by some as a moral obligation. This means doing things that require special effort: exercising regularly, improving nutrition, going to the dentist, practicing contraception, ensuring harmonious family life, submitting to screening examinations. The individual then has the "right" to expect help with information, accessible services of good quality, and minimal financial barriers.[27] Such responsibility is seen as essential to financial savings from reduction of demand for health care. Although the elements that will be effective in reducing this demand are often not known with certainty, to change consumer expectations and behavior is one such strategy.

The self-care movement, if properly managed, is seen as supporting the goal of people's individual responsibility for their own health and goals of cost containment. There is a strong "antiestablishment" thrust within the self-care movement. It began outside the traditional, or formal, medical delivery system. Its goals include helping the public protect itself against the abuses of medical services provided by institutions, determining one's own risk mix, and assisting toward restoring a more appropriate control over professional and technologic domination. Estimates show that perhaps 85% of all health care may now be self-provided; purposeful self-care is necessary as a part of the health care system to avoid the flooding of certain services.[30] Educational support is obviously a necessary part of the self-care movement. The model promotes an organizational approach and philosophy that nurture self-reliance, responsibility, and initiative, rather than ones that decrease utilization by creating barriers, for example, by allowing extended waiting times.

CURRENT PRACTICE IN PATIENT EDUCATION

Definitions of teaching

The definition of teaching as "activities by which the teacher helps the student to learn" is broad yet useful, for it emphasizes active learning by the student as the primary goal. Equally broad is the view of teaching as any interpersonal influence aimed at changing the way in which other persons can or will behave. The centrality of control is evident in these two definitions of education. Activities are used in which the learning of one or more persons is being deliberately controlled by others, and there is a controlled introduction of discontinuities in the form of new objects, events, or information into the learner's environment.[42]

Teaching is a special form of communication and so encompasses what is known about that subject. Again very broadly, teaching has been seen as communication specially structured and sequenced to produce learning. Some authors view teaching as limited to activities designed to change behavior in the learner; they feel that other interaction is outside the realm of teaching. Although it is true that a change of behavior often is intended, it is not always easy to obtain evidence of the change immediately. Therefore, teaching is seen by many as involving the intention to produce learning and not necessarily success in doing so. This is consistent with the fact that we do not know exactly how and to what extent teaching contributes to or causes learning.

Perhaps it is most useful to health practitioners to view all interaction with patients as contributing to the broad process and objectives of teaching-learning. For example, each time nurses are with patients, they are assessing patient needs, some of which can be met by providing patients with information, clarifying their thinking, reflecting their feelings, or teaching them a skill. Nurses also communicate nonverbally and by example about such topics as health and good hygiene practices.

Differentiation from related interpersonal skills

Other functions such as counseling, guidance, and support are related to teaching, as are skills used in crisis intervention and psychiatric care. Counseling may be regarded as emotional, intellectual, and psychologic support.[48] One author views the teacher role in nursing situations as a combination of roles including counselor,[44] imply-

ing that teaching is the more general of the two. Thus these definitions are confusing at present. Teaching, guidance, counseling, and support all have the common goal of development of the individual or group, although support may not involve active development on the part of the patient. Guidance, counseling, and support focus on development of attitudes and feelings, whereas the most traditional focus of teaching has been intellectual growth, and training has been thought of as concerned with psychomotor growth; however, these distinctions are by no means clear-cut.

The boundary between education and psychotherapy has been variously defined. It is believed that significant learning is facilitated by psychotherapy, aimed at such goals as accepting oneself and one's feelings and those of others, becoming self-confident and self-directing, and adopting realistic goals for oneself.[50] The function of psychiatric nursing, as defined by Travelbee, is to create a therapeutic milieu in which the ill person can develop as a human being, to assist the person in respecting self and others, and to help the patient derive enjoyment and pleasure from socializing and becoming a part of the human community. The nurse helps the ill person cope with present problems, conceptualize problems realistically, perceive participation in an experience, face emerging problems, envisage alternatives, and test new patterns of behavior, as well as communicate, socialize, and find meaning in illness.[54]

These goals seem to overlap with those of patient teaching. There are those who argue that much that is regarded as intrapsychic dynamics can fruitfully be seen from a skills-ability perspective. Rehabilitation programs with mental health patients need to pay attention to information, skills, and abilities that an individual needs to adapt satisfactorily to community life. Indeed, problems of living, on which community mental health is based, may not be part of the same continuum as chronic psychoses.[34]

Education is seen as the use of techniques directed toward the healthier conscious and near-conscious aspects of the individual personality to effect change.[32] Its limitations in the attaining of important goals have been pointed out in the area of parent education. Educational programs are generally of little help to parents whose anxiety pervades all aspects of their functioning or whose anxiety is so intense in the area of their parent-child relationships that it paralyzes them. For these parents, treatment services are indicated. For people without such a degree of difficulty, the following question remains: What content is teachable through the use of educational methods alone? It has been suggested that the assumption that much of parents' behavior toward their children is under conscious and volitional control is erroneous and that as parents become aware of a "better" method that they cannot pursue, their guilt may increase.[32] There has been no adequate resolution of this issue, but it is clear that education is but one of several kinds of activities necessary to help parents achieve full effectiveness in their parental roles.

A therapy in which teaching skills are a component is crisis intervention, which is carried out during the time when the person in crisis is establishing a coping pattern. Crisis intervention is seen by Aguilera and Messick as being on a continuum with psychoanalysis, psychoanalytic psychotherapy, and brief psychotherapy. Crisis intervention does not require the practitioner to have mastery of knowledge of the intrapsychic and interpersonal processes of an individual in crisis. This therapy includes direct encouragement of adaptive behavior, general support, environmental manipulation, and anticipatory guidance, but the nature of intervention technique is highly dependent on the preexisting skills, creativity, and flexibility of the therapist.

More specifically, helping individuals to gain an intellectual understanding of their crises, helping them bring into the open their present feelings to which they may not have access, exploring coping mechanisms, and reopening the social world can be part of crisis intervention.[1] Stated in another but complementary way, part of the therapist's procedure is to state the problem in terms that the patient can assimilate in the available time, to help

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