

PSYCHOSOCIAL EVALUATION

THE FOLLOWING AREAS NEED TO BE LOOKED INTO:

1. Knowledge about illness - Both the patient's and relatives' knowledge about the disorder, its manifestations and treatment should be inquired into.
2. Attitudes towards illness - Attitudes towards the illness as well as perceptions of the persons involved need to be explored. Special emphasis should be placed on cultural beliefs and attributions e.g. diet or supernatural causes.
3. Family background / social support - A more detailed assessment of the family is required at this stage. Primary carers of the patient need to be identified. The social network and supports available for the family are to be assessed.
4. Physical factors - Factors such as accommodation, sources of income and financial situation, access to medical facilities, opportunities for leisure etc., are expected to have important bearing on subsequent treatment efforts. A clear idea of these is thus essential for planning any family based intervention.
5. Family burden - Various areas that need to be looked into are those of financial burden, disruption of routine family activities, disruption of family leisure, effect of patient's illness on physical and mental health of carers, and subjective burden. A list of symptoms or behaviours that the relatives find particularly burdensome can be made. An attempt should be made to differentiate those behaviours which the carers feel are due to the illness from those which they feel to be a part of the patient's 'personality.'
6. Coping - Coping strategies, resources, previous efforts, and coping in different situations by both the patient and the family as a whole should be evaluated.
7. Involvement with / satisfaction from treatment agencies - Families may have been to several doctors, hospitals, and traditional healers before seeking treatment at a psychiatric facility. This involvement with various treatment agencies reveals a lot about the family, their beliefs about the illness, their expectation from treatment etc. Their level of satisfaction with the current treatment also needs to be examined. Family's expectations from treatment should be assessed.
8. Family interactions - At each session with family members it would be useful to observe the pattern of family interactions. Although a structured assessment of EE might not be possible, it is important nevertheless, to ascertain whether the elements of hostility, criticism and over-involvement are a part of the interactions between the family and the patient.
9. Occupation - If the patient is employed the status of his/her occupational functioning, including housework, need to be evaluated. After obtaining permission from the patient and family, a visit to the work place (distance permitting) can be planned. If the patient is unemployed his suitability for work and opportunities available might be explored.
10. Other assessments - Specialised assessments such as behaviour analysis, evaluation of risks such as risk for suicide or violence etc. will need to be carried out as required.

ANTIPSYCHOTIC TREATMENT

DOSE

The dose of the antipsychotic needs to be individualized. A balance has to be struck between the need to reduce side effects and the need to prevent relapse.

Stable patients who do not have positive symptoms may be candidates for reduction in doses. Doses need to be reduced gradually at the rate of about 20% every 6 months till a minimum effective dose is reached. Minimum doses would be in the range of 2.5 mg of oral haloperidol, or 6.25 -12.5 mg

of fluphenazine decanoate, or 50 mg of haloperidol decanoate, or their equivalents (APA, 1997; 2004; NICE, 2002).

Targeted or intermittent dosage maintenance strategies should not be used routinely. This strategy is only recommended for patients who refuse continuous medication and might comply with an intermittent regimen if properly educated (APA, 1997; 2004; NICE, 2002).

Reduction of dose/ withdrawal of antipsychotic medication should be undertaken gradually whilst regularly monitoring signs and symptoms for evidence of potential relapse. Following withdrawal from antipsychotic medication, monitoring for signs and symptoms of potential relapse should continue for at least 2 years after the last acute episode (APA, 1997; 2004; NICE, 2002). Any re-emergence of symptoms should be immediately treated.

DEPOT PREPARATIONS

Depots are helpful in ensuring compliance and should be used in all situations where non-compliance is a problem. They should also be used if patients/relatives indicate a preference for this kind of treatment. Since SGAMs are not widely available in long-acting forms, first generation preparations need to be used in patients requiring treatment with depot injections. For optimum effectiveness in preventing relapse, depot preparations should be prescribed within the standard recommended dosage and interval range. Test doses should normally be administered at the start of treatment. People receiving depots should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen (NICE, 2002).

DURATION OF TREATMENT

Duration of treatment depends on a number of factors and will need to be individualized. The suggested guidelines are as follows:

- first-episode patients should receive 1-2 years of maintenance treatment
- patients with several episodes or exacerbations should receive maintenance treatment for 5 years or longer
- patients with history of aggression or suicide attempts should receive treatment for an indefinite period, even lifelong.

PSYCHOSOCIAL INTERVENTION

INTERVENTIONS WITH THE FAMILY

Standardised treatment packages which have been tested under controlled conditions in India, are not available. However, modules for use in outpatient and community settings have been described (Shankar & Menon, 1993). The following guidelines are partly based on these.

GENERAL PRINCIPLES

The focus of any psychosocial treatment is expected to include both the patient and the family. It might not always be possible either to meet all the family members, or include all of them in each and every session. So, it would be worthwhile to identify and focus on 'key members' while involving the others as often as possible.

One of the principal tasks of any family based intervention is to form a supportive and trusting relationship with the patient as well as the family. This allows gathering of important information about them and lays the foundations on which treatment can be implemented. Often a substantial portion of the initial sessions is needed to foster a trusting relationship.

It is essential to consider the family members as allies, not as targets of treatment. Otherwise it might be difficult to get them to cooperate fully. It is also important to tell the relatives at the very outset that they are not to blame for the patient's condition. Relatives often fear this and feel guilty.

Allaying their anxieties in this regard might make them more willing to cooperate with any treatment plan.

The patient may be seen individually or with the family depending on the circumstances. It is advisable to hold some sessions jointly, and some separately with the patient. Natal as well as marital families may need to be involved in this process.

As with the family, a member of the treating team can be designated as a 'key-worker' or as a sort of a 'case manager'. The patient and his family should have ready access to this person. In addition the key-worker should be in a position to coordinate treatment efforts by different team members, so that they provide maximum benefit to the patient and the family.

In most instances the locus of treatment will either be the inpatient ward, the outpatient clinic, or rarely the patient's home.

The frequency of sessions will vary, but a minimum of once monthly is recommended. Contact should be maintained for as long as possible, preferably for a year.

Involvement of nurses, social workers, psychologists, occupational therapists, rehabilitation professionals and other paramedical professionals is highly desirable. Every effort should be made to solicit their help.

Treating teams would often have to be flexible and innovative in their approach. They need not rigidly adhere to Western models of psychosocial interventions with the family. Approaches can be simple and goal oriented as long as they are acceptable to the family and feasible in the context of limited treatment resources that are usually available.

PHASES AND TASKS

1. Engagement

This is the phase when therapists introduce themselves. They explain the nature of treatment and what it will entail.

2. Intervention phase proper

This can be held in the form of monthly sessions of 45-60 minutes each. The location could be the outpatient clinic or the patient's home if this is possible. This phase is expected to last anywhere between 6-9 months.

CONTENT OF SESSIONS WILL INCLUDE:

INFORMING ABOUT DIAGNOSIS

Both the patient and relatives need to be told about the diagnosis. If the patient is acutely ill informing him about the diagnosis may be postponed till he is in a receptive frame of mind. A realistic picture of the illness should be presented, emphasizing positive aspects such as treatments available, but without detracting from the implications of the condition. The patient and the family need to be assured that more detailed information would be provided subsequently, and that they should feel free to clarify any doubts they may have.

EDUCATION

Information booklets about schizophrenia can be distributed to those who can read. After the booklet has been read, various aspects of the illness such as aetiology, symptoms, treatment and prognosis should be discussed. The information imparted should cover the disorder in general, but should be made relevant by focusing on areas concerning the individual patient. The explanations should be in simple terms, professional jargon should be avoided. The patient's and relative's level of education and understanding need to be considered while trying to educate them about the illness. Questions should be encouraged and doubts clarified. The ability to understand might vary among the

different family members. The patient's understanding might be particularly affected by the illness. Relatives will need time to absorb the facts. Thus, education needs to be an ongoing process. It is not necessary or possible to cover all aspects of the illness in the initial few sessions; some areas e.g. early recognition of relapses could be discussed later. For an educational programme to be successful it is imperative to justify the need for education and stress the advantages of learning skills to have more control over treatment. Expectations of the family may be different from the treating team. Setting common educational objectives at the very outset, is thus, very helpful. Imparting of information should never be one sided, the family and the patient (wherever possible) need to be actively involved in the process. One or more sessions should be set aside to discuss issues that the family wants to bring up. The carers commonly want to discuss issues such as marriage, work, care of children and other relevant issues. These must be, therefore, given due importance.

THE AREAS COVERED COULD INCLUDE

- aetiology
- symptoms
- prognosis
- treatment methods
- common myths and beliefs

While discussing aetiology of schizophrenia, it is important to emphasise both the biological and psychosocial aspects of the disorder. Stating that schizophrenia is a brain disorder worsened by stress of any kind is perhaps a good way to start this part of the discussion. Both positive and negative symptoms need to be discussed. The differentiation of symptoms from 'personality traits' needs to be emphasized.

Variations in prognosis and risks of relapse need to be highlighted.

Different treatment methods and the rationale for their use should be mentioned

Belief in supernatural causation of mental illnesses is commonly prevalent in our country. The relatives need to be told that there is no scientific evidence for this. Similarly, the myths about the effect of certain diets in influencing the patient's mental state need to be dispelled. Some families hold that marriage has a curative role in mental illnesses. Such families frequently want to get the patients married and seek advice regarding this. Although, what is to be told will differ depending on the individual patient's circumstances, some aspects will be applicable to all. It needs to be stressed that marriage can be stressful for a patient hence it should not be planned till the patient has been stable for a considerable period of time. Informing the prospective husbands/ brides and in-laws that the patient suffers from a mental illness and is undergoing treatment is necessary, though it makes the task of finding a suitable partner more difficult. The risk of offspring's developing the illness also needs to be addressed at some point.

At the end of the initial sessions a feedback needs to be obtained. Areas in which information has not been retained may need to be covered again.

TREATMENT ADHERENCE

Enhancing compliance with the treatment regimen is one of the main objectives of any educational programme. Long-term treatment is required for most patients. However, missing appointments, not taking medicines as prescribed, or not reporting essential information is far too common. Frequent causes of non-compliance are denial of illness, cultural beliefs, failing to appreciate the need for medication in a relatively asymptomatic state, and expectation of, or actually experiencing distressing side effects (Kuruvilla, 1996; Kulhara et al., 1999; 2000). The following areas thus need to be addressed:

- information about available treatment modalities.

- an explanation of treatment for acute as well as more stable phases of the illness; the need to continue treatment even when relatively free of symptoms to reduce risks of relapse should be stressed.
- information about medication actually being administered, the role of each drug, doses, frequency of administration; written material can supplement verbal instructions if felt appropriate.
- explanation of therapeutic effects e.g. how long is the drug expected to take to act, which symptoms will respond and which might not respond so well, what if one drug fails.
- information about side effects; patient and relatives should be encouraged to report side effects rather than stopping treatment.
- enquiry about whether they can actually afford the drug being prescribed; exploring alternatives whenever this is not possible.
- re-emphasizing the risks of discontinuing treatment.
- discussion of the pros- and cons of traditional methods of treatment since they form a common part of the belief system.
- certain treatment modalities such as ECT or clozapine may need more detailed explanations.

As far as possible the patient should be persuaded to take medications by self. In addition, it is often helpful to nominate a family member to supervise the patient's drug intake. However, care should be taken to ensure that this does not become a source of conflict between the patient and family members. The aim is to create an atmosphere in which the patient feels free to discuss his negative feelings about a particular drug or treatment. Attempts should always be made to modify the treatment plan (whenever possible), according to the patient's and family's needs and preferences.

REDUCING FAMILY DISTRESS

After confirming the diagnosis the family members should be allowed every opportunity to express how they feel about being told that one of them has schizophrenia. Help can also be sought from the primary care physician in this regard. It must be ensured that they do not blame themselves or the patient in any way for what has occurred. More often than not, the relatives have high expectations of the affected individual. That the illness severely compromises the person's capabilities must thus be explained. The family should be helped to tone down their expectations and have a realistic appreciation of what the patient can achieve now that the person has developed the illness. During the course of the illness families also need continued advice and information on such matters as dealing with problem behaviours, managing medication, avoiding exposure to stressful situations etc. These should be readily discussed, and if possible, the relatives need assistance to arrive at some sort of solutions to these common problems.

ENHANCING COPING

Individuals and families use a number of different strategies to cope with the effects of the illness. Broadly coping mechanisms can be divided into problem solving and emotion focussed ones. Problem solving techniques aim at reducing stressful life situations. Emotion focussed strategies are meant for dealing with emotional turmoil. It is important to remember all these aspects while trying to improve the individual's or family's coping skills. Some of the ways in which the family is already coping with the illness may be quite appropriate and effective. These need to be reinforced rather than suggesting alternative strategies, which they might find alien and unhelpful. Families often seek advice on how to cope with distressing symptoms e.g. suspiciousness, aggressive behaviour, suicidal threats or refusal to take medications, disinhibited sexual behaviours. So particular attention needs to be paid to these problems. Patients might need help in dealing with persistent positive symptoms like delusions and hallucinations. Practical measures such as using distraction or masking techniques can be suggested.

Cognitive techniques can also be tried.

REDUCING BURDEN / INCREASING SUPPORT

All measures that the family can adopt to reduce the burden of care and increase the amount of social support available to them have to be considered. It would be useful to remember the various functions of social support including emotional support, instrumental support, motivational support and social companionship (Champion & Goodall, 1994). Instrumental support includes all those measures, which provide practical, tangible and material help. Therefore, some of the measures that can be taken in this regard are enlisting help of voluntary and corporate organisations to fund the costs of treatment if needed; rail or bus passes can be arranged to reduce the costs of transportation. Assistance should be offered in getting disability benefits under the Persons with Disability Act. Sharing of certain principal tasks in the family e.g. looking after the children could be suggested. Making use of community resources such as neighbours, local clubs, religious groups or family doctors can be encouraged. Informational support i.e. the provision of information, education and guidance has already been considered. Emotional support consists of providing reassurance, attempting to boost self-esteem etc. Support that consistently helps to maintain hope in chronically difficult circumstances is referred to as motivational support. It does not need to be reiterated that providing emotional and motivational support are the key aspects of working with patients and their families.

IMPROVING FAMILY FUNCTIONING

Both during the initial assessments and subsequent sessions it would be possible to form an idea of the family functioning in terms of specific problems, interactions, assets and resources etc. This information needs to be used now in an attempt to enhance communication and improve problem-solving skills. Enhancing communication would entail teaching family members to listen to, and consider each other's views on a particular issue. Positive feelings need to be expressed and positive communications acknowledged. Requests can be made in a non-confrontational manner and as calmly as possible. Similarly, negative feelings can be expressed in constructive ways. Teaching the family a problem-solving approach is another major objective. They should be able to discuss a problem objectively, generate alternatives to deal with it, choose a reasonable alternative and try and implement it. For both the above learning tasks it is best to apply them to issues or problems that arise during the sessions. This makes the concepts more relevant and understandable for the family members. Homework assignments are essential. Some families might need more structured and extended treatment based on the same principles.

3. MAINTENANCE PHASE

During this phase, contacts can be made once every 2-3 months and more frequently in times of crises, or if desired by the family. Feedback needs to be taken from the family. Any new issues that arise are discussed. Some of the previous points may need reemphasis.

OTHER FORMS OF INTERVENTION

IMPARTING SOCIAL SKILLS

It might not always be possible to implement a structured social skills training programme. Nevertheless, every attempt should be made to teach the patient skills of daily living e.g. self care, managing medications, looking after money matters, shopping or cooking, using public transport and interacting with others in social situations. Encouraging the patient to use these skills in real life settings, offering praise for any successes will all be important components of this effort.

INDIVIDUAL TREATMENT

Apart from providing education, support and guidance to the patient certain situations might need more structured approaches e.g. behaviour therapy for negative symptoms or treatment for social

anxiety. Simple measures such as time structuring, or attempting to increase social contacts are also of help to the patient.

VOCATIONAL REHABILITATION

Facilities for vocational rehabilitation are scarce. However, if the patient is already working efforts can be made to help out in any problems at the work place, which could be due to the effects of the illness. If the patient is unemployed, his suitability for work needs to be assessed. If he is ready for work, he should be encouraged to seek appropriate jobs.

RE-EVALUATING / MODIFYING THE TREATMENT PLAN

As time elapses the nature of the illness, problems faced by the relatives, needs of the patient and the family and previously determined targets are all expected to change. Regular contact, awareness and monitoring are needed to detect these changes. Ongoing assessment is thus essential. It allows those modifications to be made in the treatment plan, which are required to accommodate any new problems or demands that may have arisen.

EARLY INTERVENTION FOR RELAPSES

The treatment programme should be organised to respond as quickly as possible to any relapses in the patient's condition. Patients and relatives need to be educated to recognise prodromal symptoms of a relapse. They should be told about the need for early intervention in impending cases of relapse. They should have easy access to treatment facilities such as emergency services or inpatient settings, which will cater to the needs of a patient on the verge of a relapse. Contact should be increased during the prodromal phase. Crisis intervention measures such as brief admissions or frequent home visits need to be adopted, whenever feasible. All these are important steps in efficient detection and treatment of relapses.

OTHER INTERVENTIONS

Based on the available evidence it would be reasonable to expect that other psychosocial treatments e.g. cognitive behavioural therapy could also be effective. However, there are no studies on the usefulness of such interventions under Indian conditions. It is, therefore, unclear how such treatments should be implemented.

ASPECTS OF TREATMENT DURING THE STABLE PHASE

- **Determining goals**
- **Assessments**
 1. For drug treatment
 2. Psychosocial evaluation
- **Regular monitoring**
 1. Mental state
 2. Drug side effects
- **Antipsychotic treatment**
 1. Dose
 2. Duration of treatment
 3. Use of depot preparations
- **Psychosocial interventions**
 1. Interventions with the family
 2. Other interventions