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# Rehabilitation in psychiatry: A review

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Rehabilitation occupies an important place in the world of psychiatry. Persons suffering from various mental disorders need proper rehabilitation to help them overcome there problems and to adjust as well as adapt to the needs of society. This becomes an important part of patient's management and improving their quality of life. In the present paper we discuss in detail types of rehabilitation and its role in different psychiatric disorders.

Keywords: rehabilitation, psychiatric disorders, models

Rehabilitation has now become one of the most important terms related to psychiatry. Mental illness, with their chronic nature or frequent episodes adversely affects patients' socio-occupation functioning and causes disability in almost all aspects of patient's life. When it begins in younger age, consequences are more severe. Rehabilitation is an attempt to regain what has been lost and to teach new adaptive skills.

## *Concepts of rehabilitation in psychiatry*

The role played by rehabilitation in psychiatric illnesses may be conceptualized on the basis of the bio-psycho-social models of disease and the stress-vulnerability theory of schizophrenia.

According to the bio-psycho-social model, human behaviour can be understood as a hierarchically organized system, where disturbances at any level may influence any other level in the hierarchy (Engel, 1980). Unlike other biomedical or reductionistic models, here, information is not discounted from any level and hence, effect of any biological or environmental intervention on multiple levels of human functioning may be studied. Accordingly, bio-psychosocial rehabilitation refers to a spectrum of services offered to an individual with a disability.

In the vulnerability stress model (Nuechterlein & Dawson, 1984), it is presumed that socio-environmental stressors, superimposed on an underlying and enduring biological vulnerability, lead to abnormalities in central nervous system function, especially when protective factors are inadequate. The later includes antipsychotic medication, social competence, and a supportive social network. The therapist may try to build rehabilitation team via social support, skill building, transitional work and housing programs, and case management (Kopelowicz, 1997).

## *Assessment of function in rehabilitation*

The success of the rehabilitation process depends as much on the reliability and validity of the assessment instruments as on the efficiency of the available treatment methods. The importance of assessment lies in:

Pinpointing the incompetent coping responses which need to be treated and in

Evaluating the success of the process both for individuals and for programmes.

There are a number of skills to assess disability, adjustment etc. which can assist in rehabilitation.

However, one of them is wholly adequate for assessing functional living skills. Also general they are for multidimensional assessment, but rehabilitation efforts proceed from individualized evaluation and goals using more focal target behaviours.

## *Types of rehabilitation in psychiatry*

Rehabilitation in psychiatry has been classified to be of the following types.

- Depending on the areas of concern, rehabilitation may be-
  - Medical- involving restoration of function
  - Vocational- involving restoration of the capacity to earn a livelihood
  - Social- involving restoration of family and social relationships.
  - Psychosocial- involving restoration of personal dignity and confidence.
  - Cognitive- involving restoration of cognitive functions like attention and memory.
- Depending on the setting of activity rehabilitation may be (Gopinath & Rao, 1994)
  - Inpatient- focusing on pharmacotherapy and psychoeducation.
  - Outpatient focusing on individual - pharmaco- and psychotherapy, functional assessment, skills development and family-psychoeducation and family therapy
  - Community- including community care, day care centers, sheltered workshops etc.
- One may also talk about two parallel rehabilitation 'ladders' (Dyer, 1993).
  - Domestic- where the traditional path originates in the hospital and progress through 'hostel wards', 'hospital hostels', 'halfway houses', and group homes, to own tenancy.
  - Occupational- which is akin to vocational rehabilitation, aiming at patients' reentry into employment including occupational therapy and sheltered workshops.

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However, it is clear that there are no watertight compartments and many overlap and intermingling occurs aiming the different above-mentioned aspects of rehabilitation.

For the purpose of convenience, detailed description will be given of the following:

- Psychosocial rehabilitationincludes social skills training, partial hospitalization, halfway houses, home care services, and therapeutic social clubs

### *Social skills training*

In chronic mental illness, social skills deficits are assumed to reflect the combined influences of

- Symptoms intruding on skills,
- Inadequate learning before onset of illness,
- Lack of environmental situation, and
- Loss of skills due to prolonged disease (Liberman et al, 1989).

Hence, social skills training is an essential component of psychiatric rehabilitation, and is of the most widely used social interventions. It is done through systematized programs that employ specific behavioural techniques like role-playing, modeling, feedback, coaching, didactic instructions, attention focusing procedures positive reinforcement, and problem solving techniques. Complex behaviours are broken down into discrete behavioural elements each of which are focused on by the trainers.

### *Cognitive rehabilitation*

Patients with mental illness particularly schizophrenia suffer from a wide range of cognitive disorders in the areas of attention, information processing, social perception, problem solving ability, and social interaction. These disorders increase the likelihood of stressful interaction and social isolation.

Thus cognitive rehabilitation becomes an essential part of the rehabilitation of the patient. It aims at

- Improving the impaired cognitive mechanism directly.
- Developing some compensatory mechanism, and
- Changing environment so that the cognitive deficit has less effect.

It is hypothesized that severe attentional limitations prevent some patients from being bale to benefit from psychosocial therapy. Also, the demands of such therapy may be stressful for them.

Two general areas of cognitive rehabilitation have been defined

- Focus on the person's psychosis like hallucinations and delusions, which remain even after antipsychotic treatment: Using CBT (Kupiers et al. 1997) self instructions and self reinforcement and behavioural modification techniques.
- Focus on patients' particular cognitive deficits like attention, cognitive flexibility and vigilance. It includes:
  - Computer assisted behavioural training
  - Vocational approach to cognitive training
  - Integrated Psychological Therapy (IPT)

### *Community based rehabilitation (CBR)*

This aims to rehabilitate individuals by integrating them into their communities. Thus, here the disabled person, the family, the community and the health professionals collaborate to provide the needed services in a non-institutional setting.

## Models of psychiatric rehabilitation

Since the 1950s, when the first psychosocial services began, a gradual expansion and diversification of rehabilitation services have occurred. There have been five main approaches with specific philosophical orientations and program elements, namely:

### *Clubhouse model*

Clubhouse emphasizes a supportive environment that serves as a surrogate family provides a full continuum of services. Persons are considered to be members, rather patients or clients; they are free to choose the frequency and intensity of contact with the clubhouse, staff and other members. The basic programme elements include.

- An accepting climate
- Assistance in job related skills development
- Provision of normalized housing
- A stimulating milieu that encourages meaningful participation.

Studies have demonstrated the clubhouse model to be effective in reducing hospitalizations. The model has also shown greater member satisfaction and development of stronger social networks, though it did not result in betterment of employment, leisure activities or symptom reduction (Dincin, 1982).

### *High-expectancy model*

This is composed of structured and time-limited modules in which the patients are expected to show progress. The patients and staff set the goals and expected skill achievements at the beginning and necessary modifications are made as the program progresses; finally the patients are expected to graduate to independent living, working and social progresses; finally the patients are expected to graduate to independent living, working and social activities.

However, the patients may perceive such expectations as stressors and withdraw from the program or even decompensate. Thus it is necessary but the staff may be flexible, tolerate slow and unsteady progress, and modify plans where needed (Dincin, 1975).

### *Intensive case management*

Since the 1980s, case management has emerged as a widely applied and publicly supported mechanism for coordination of the fragmented delivery system serving chronically ill psychiatric patients. It has five core functions, namely assessing, planning, linking, monitoring and advocacy (Hargraves, 1984). The two main goals are (1) to prevent decompensation and hospitalisation, and (2) to promote rehabilitation, enabling patient's functioning in their best capacity.

Case management may be delivered in either the patient's environment or in an office.

The major criticisms of case management are that

- it frequently lacks a multidisciplinary approach
- it is highly dependent on community resources which are unavailable or insufficient, and
- It relies on individual case managers to fix an uncoordinated and fragmented system.

The models of case management in current practice include the Broker or generalist model, Personal strengths or developmental acquisition model, Clinical case management, and Assertive community treatment (ACT).

*Expanded broker or generalist model:* This is closely akin to traditional social work. The case manager here assists in linking and brokening of services on behalf of the patient. The service is centered in the case manager's office. Caseloads are higher and hence the managers may respond more to only those patients who are more demanding or in a crisis (Solomon and Meyerson, 1997).

*Personal Strengths Model:* This emphasizes the identification of the patient's strengths and development of personal opportunities and environmental situations which can enhance these strengths. Individuals with severe mental disorders may need assistance in acquiring necessary support and resources essential for functioning in domains of work, housing, education, medical care and personal growth. The community is thought to be the network of available sources and patients are taught resource acquisition skills.

*Clinical Model:* This model goes beyond provision of support, skills training and accessing environmental resources by involving the provision of psychotherapy (Kanter, 1989). It focuses on growth of patient's psychological capacities for adaptation as well as functional skills acquisition.

Interventions utilized may belong to 3 classes

- Environmental acquisition of and linkages between services consultation with families and other caregivers, collaboration with psychiatrists, and maintenance of social networks.
- Patient related individual psychotherapy skills training psycho-education
- Combined e.g. crisis intervention.

*Assertive Community Treatment Model:* This has historical roots in the 'Training in Community Living' model or 'Program of Assertive Community Treatment' (PACT) developed in Wisconsin (Stein, 1980). It attempted to bridge the gap between inpatient and outpatient services via a community based, multi disciplinary team. The function of the team is to address (in a timely manner) the patient's needs including medications; long term one-to-one clinical relationships, 24-hour crisis availability; employment rehabilitation services and assistance with ADL and housing.

Originally developed as an alternative to psychiatric hospitalization.

## *Consumer-sponsored programmes*

These programmes are run, guided and / or sponsored by the patients themselves. There is emphasis on a group approach to problem solving and focuses on empowerment of patients. Initially, professional staff may be involved, but once the patients are in the community, only the consumer-patient does the governing. The basic philosophy is that only someone with a disability would be sensitive to the needs of similarly disabled persons. The Fair-weather Lodge is one of the best-known examples of this type of programmes, where long-term patients are trained and discharged into the community as a group.

This model has been found to be effective in reducing time spent in hospitals, and impressive employment outcomes as long as patients remain in it.

## *Boston university rehabilitation approach (or BU Model)*

This is supposed to consist of three phases- the diagnostic, planning and intervention phases. Two commonly used rehabilitation procedures in this model are social skills development and resource development. The former has been elaborated before. Resources development involves resource coordination and resource modification (Anthony, 1982).

*Rehabilitation in specific psychiatric disorders:* The psychiatric population in which rehabilitation has been most studied is among schizophrenia, and almost each of the methods described above are applicable here. Certain issues specific to other mental illnesses may be considered now.

*Affective disorders:* They are often precipitated and maintained by social stress, and thus it is often necessary to consider what stress the patient is being exposed to, what support he is getting from the environment and how much personal resources or specific skills he has, to cope with the stress. The problems are concentrated more in interpersonal and domestic roles and this needs to be reflected in the rehabilitation plan (Watts & Bennet, 1983).

In depression, focus is on the patients' adjustment in social roles with subjective sense of impairment being frequently greater than the objective reduction in performance.

- Specific impairments like difficulty in concentration may be managed by practicing sustaining attention, and paraphrasing work instructions; while, retardation of performance may be managed by cognitive methods.
- Teaching depressed person the social skills needed or achieving satisfaction in the lives by creating alternatives.
- Involvement of the family and developing social network is needed.

In manic patients, preventive social measure need to be taken e.g. to monitor patients carefully, intervene to remove car keys and cheque books, and to admit to hospital early to prevent the patient from damaging his future prospects much (Benet, 1982).

*Phobia and obsessions:* In these patients social adjustment may be secondarily affected by the symptoms, and the rehabilitation team needs to assess individually how much spontaneous improvements may occur due to direct alleviation of symptoms. Where necessary, additional measures for social adjustment are needed. In a 4 years follow up study of patients with anxiety disorders, work and leisure areas have been shown to have spontaneous improvement following behavioral treatment. However sexual, family and other relationships do not improve, and hence need specific remedial efforts (Marks, 1971).

In general patients wit agoraphobia are unable to travel to a suitable job and may be confined to the limited range of jobs available around their homes. Patients with social phobia may have anxieties about interaction with their co-workers especially while starting a new job or meeting a new set of people. Leisure activities maybe interfered with by phobic avoidance behaviour; specific focus on marital adjustment is also necessary in these persons, as studies have shown marital relationship to influence behavior in agoraphobia (Hafner, 1977).

Persons with obsessive traits or OCD, commonly present a challenge to rehabilitation. They have difficulty in maintaining social roles, especially in jobs while responding to unexpected events. Here also, treatment is found to improve work and leisure functioning rather than personal and family adjustments (Marks, wt al. 1975). Beech and Vaughn (1978) have discussed the ways in which OCD patients may need help following treatments: e.g., removal of compulsive rituals leaves considerable time that can be filled with recreational or other social activities, and rehabilitation workers may help them find alternative pursuits to present recurrence. Patients need to acquire flexible skills in bringing up their children; occupational rehabilitation and guidance may be needed focusing on their over meticulous approach and obsessional slowness.

*Conduct disorders:* In present with deviant social behaviour, specific areas need to be focused those with family roles (care of children, marital and sexual conduct), regarding antisocial

behaviour (contact with the law, abuse of drugs and alcohol), and with violence (to people or property). Rehabilitation in these people is less a matter of teaching skills than of modifying attitudes. During planning, focus is necessary to identify areas of functioning where some gain will be possible with maximum impact on self-esteem. Development of satisfactory relationships with colleagues and supervisors, and the responsibilities and support of marriage is found to help sometimes (Watts and Bennet, 1983).

*Substance abuse:* Two basic processes are involved in the rehabilitation of persons with problem drinking and drug abuse. First is to enable them utilize personal resources and modify attitudes skills to achieve a stable and fulfilling way of life with minimal or no substance related problems. The second is to provide the environmental supports so that they get established in roles in community, which are more fulfilling than their previous ones. A non-medical multidisciplinary approach involving social network, occupational therapy and behavioral therapy is necessary in these cases. Certain fundamental services that exist include drug clinic services, residential rehabilitation projects, therapeutic communities and self-help groups like alcoholic anonymous.

### *Role of psychiatric social worker*

The psychiatric social worker has a very important role to play in this regard in organizing the rehabilitation activities, cooperating between the different team members, and utilizing available resources to the maximum. He also has a personal role to play with the patients as per the 'case work' relationship. He thus needs to be a 'friend', philosopher and guide' to the patient and not be restricted to his professional activities alone.

## Conclusion

Rehabilitation was previously considered to be just a process for helping patients with chronic mental illness compensate for immutable deficits. However, recent advances suggest that rehabilitation is not just palliative, but may contribute in important ways to the recovery process. It may lead to reintegration of the mentally ill patient, in helping them get themselves 'together' again, in regaining their 'sense of identify' and in improving their quality of life. Mental health authorities all over the world are taking important steps, but a lot more needs to be done for rehabilitation to attain its full potential. It is the duty of every persons associated with the mental health from psychiatrists, social workers, and psychologists to caregivers and health planners to take up the challenge.

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