



Schizophrenia Research
Foundation

TOWARDS RECOVERY. . .

From the desk of the Editor

Dear Readers,

Season's Greetings!

We are delighted to bring out the third edition of "Towards Recovery...", a Rehab newsletter from the Department of Psychosocial Rehabilitation.

With continuing enthusiasm, we strive hard to deliver on our agenda of information dissemination on Rehabilitation of persons with serious mental illnesses. This edition of the newsletter highlights Vocational Rehabilitation as an important agenda for psychosocial rehabilitation. This edition features departmental activities, case reports, an academic piece and other interesting topics. Random thoughts by Dr Sarada Menon, stresses the need for early intervention and good follow up programs that must be continued into Rehab Intensive interventions. A note on the personal journey of one of the staff highlights the challenges of field work outside the realms of data collection for research. A practising psychiatrist's point of view on vocational rehabilitation adds flavour to a challenging area of intervention. You will also read all about recent programs and upcoming events.

We eagerly look forward to the thoughts of our readers over time. All thinkers, writers, cartoonists, do connect with us at rehabtowardsrecovery@gmail.com. We are open to comments and suggestions and welcome contributions.

Current editor: R Padmavati

Random thoughts for the News Letter

Dr. M. Sarada Menon

Anyone interested in reading, writing or working in the field of schizophrenia, wonders why despite there being so many guidelines which were found to "work" in the management of schizophrenia, there are still wide gaps in the continuity of care, resulting poor outcome. Acute cases receive attention.... but before they come to the notice of experts, there is the challenge of the duration of untreated illness. When the severity of the acute illness subsides the patient, while still needing supervision, medication, stepping up of (psychosocial) interventions as necessary is moved to a "less-noticed" category, to make way for the next acute case. So in a busy center which has the responsibility of managing so many patients, the management of "post-acute" group spirals downwards and further towards disability. How does the psychiatric expert cope with this problem in the present scenario, with under-staffing (overworked personnel moving on or burning out) poor funding, less environment support, and possibly therapeutic nihilism?

Upcoming events

Vocational Rehabilitation Workshop has been scheduled for the 4th November, 2017 at SCARF (See Page 8 for details)

Group therapy programs will commence this month (See Page 8)

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The early intervention and good follow up programs must be continued into Rehab Intensive interventions. While occupational therapy leading to vocational training, employment, financial independence and social inclusions are the goals of rehabilitation, many centers stop with vocational training and attempt self-employment. Recently, however, more emphasis is being given to open employment, and the much needed followup.

In order to make the good outcome of rehab efforts permanent, it may be necessary to have a group of workers who will exclusively work only in the outpatient department and the community, to follow up on medication and sustain the improvements in all aspects. Discontinuation and fragmentation of services are in no small way responsible for the defeat

of the good come. If funding is going to be a problem can we involve volunteers?

On another note, assessing quality of life (QOL) is an essential exercise while working on rehab of a patient with mental illness. Subjective quality of life (SQOL) – self-report of how satisfied a patient is with his life situation, gives a better understanding of how the illness affects the patient at a personal level and how far the management of the illness and deficits have been useful. The patient's statements have to be assessed against the background of his mood. SQOL is an essential factor in treatment adherence and long term prognoses. SQOL assessments have demonstrated reliability and validity in patients with severe mental illness.

SUPPORTIVE COUNSELLING - A CASE VIGNETTE

Hepsiba Omega Julliet, Psychiatric Social worker



Supportive counselling is a person-centered therapy. We the therapists, give support, listen to people and help them talk about their problems and support them to find ways to deal with the problem. Some therapists combine supportive counselling with other methods of psychological treatment such

as cognitive behaviour therapy, cognitive re mediation therapy, interpersonal psychotherapy and psychodynamic psychotherapy.

The main aim of supportive counselling is enabling the client to return to normal functioning or to a level where the person is socially accepted in the environment. It is more of demonstration of support and acceptance towards client; Sympathetic Listening combined with empathy; encouragement, reassurance and guidance; emphasis on working together with client to achieve results; communication of a hopeful attitude that the goals will be achieved; respect of the clients' defences' and to focus on the patients strengths and acknowledgement of the growing ability of the patient to accomplish results without the therapists help.

Supportive counselling is required for almost all clients referred for rehabilitation.

Case vignette:

A 46 year old, well-educated man was referred to me for PSR. He was admitted to our residential care program. He had been diagnosed paranoid schizophrenia, and was ill for about 17 years. He was symptomatic initially, but responded satisfactorily to medications. Evaluation for PSR indicated poor insight about illness, (and therefore poor medication compliance); poor interpersonal relationship with family members (prior to admission, he used to live alone in an apartment, his wife had returned to her parents place); cognitive deficit- (problems with sustained attention) poor self esteem; amotivated to take up job and poor physical activity.

I prioritised low self-esteem as the first target for intervention- the focus being on building rapport with the client, listening to what he says and allowing him to ventilate. After three sessions, I raised the issue of other problems that were there, and the needs that we had identified together- he refused to discuss any of these! I continued with supportive counselling, trying to get him to talk about his strengths and how he could use these in his daily life. Over the 5 sessions (I would meet with him 3 days in the week, in the residential

facility), actively listening and adding perspective. We discussed his problems and how he had been coping - gently suggesting options. He was encouraged to participate in activities in the daycare - helping him to become aware of his abilities, his gradually improving functioning. We then revisited the needs identified, and a plan was developed, making sure that Mr. S actively contributed to the plan - to encourage him to take ownership of them - to increase his motivation. The goals were improving adherence to medication, interpersonal relationship and increase support network, scheduling pleasurable activities focusing on positive self for improving self esteem.

After about three months of interventions, of which supportive counselling formed the most critical part, he was ready to go home. His insight about the illness improved. He was encouraged to follow an

activity checklist at the facility which included self care activity, attending the vocational training centre (where he learnt some aspects of screen printing), yoga, breathing exercises, walking and cognitive tasks such as letter cancellation.

The family was involved in intervention plan - they visited the facility regularly and were encouraged to participate in the counselling sessions, at least once in two weeks. Gradually, the interpersonal communication with the mother improved. I was however, unable to reach the wife - the plan had been to get her involved in therapy as well. The mother was encouraged to look for a suitable accommodation - so that she could live with her son after his discharge.

In this case example, what became very evident to me was the role of support therapies as a foundation for the implementation of any plan.

It's Disorder not a Sin.....

Ramakrishnan, Psychiatric Social Worker

This is story of a family in a village in the outskirts of the town of Chengalpattu in Tamilnadu - a family steeped in cultural beliefs of causation of abnormal behaviors,

I am a Research Assistant at SCARF and my job primarily is field work to identify, screen and recruit subjects for a genetics study.

On one occasion, on a visit to a village near Chengalpattu, I had failed to recruit any subject for the study and was feeling tired and frustrated. As I was contemplating on what to do next, I spotted a man talking and laughing to himself. He appeared disheveled, clad in clothes which were dirty and torn. He was sitting a little distance away from a small tea shop, with. Exactly the subject that I could potentially recruit for the study! As I stood, a young lad from the teashop, carried a cup of tea to this man. I approached the tea stall and sipping a cup of tea, started a conversation about the man. An awkward silence! After all, who would want to talk about a "mad man"? I persisted, introduced myself as a psychiatric social worker and rapidly shot out a few questions. The person who manned the tea stall, narrated the story of my subject, "V was about 30 years old and had been a popular tailor in the village till about 3-4 years ago. He was known to tailor clothes for the young and old, men, women and children. He

was generally a cheerful person. One day he fell ill - fever of the 'head' - the village doctor could not help him. So his parents took him to the district hospital. His fever became better, but he had changed. He did not open his store - people whose clothes he had taken started asking questions - he reacted angrily and would abuse them. His family returned the unstitched clothes. Since then, I have only seen him to become gradually worse - he is always roaming about, never bathes, shouts at people you will find him lying down anywhere." I asked if the family had ever sought treatment from a doctor - he said he did not know. Taking directions to reach the home of my subject, I found his parents at home. Though very cordial, they were reluctant to talk about their son's "mental illness", they strongly believed that it was because of the black magic and possession by evil spirits. All discussions on myths and misconceptions were in vain. Even though I was raised some logical questions against their belief, I did not succeed. I changed my tactics...instead of confronting their belief, I turned the conversation to the benefits of medication. Careful not to break confidentiality, I narrated the example of another patient in an adjoining village and proceeded to make a telephone call - the patient and his family talked to the parents about the benefits of medication

and how the patient had functionally improved. Finally, half-heartedly the parents agreed to treat their son with medicines. I left their home after sharing my contact details, encouraging them to call whenever they required help. I kept in touch telephonically for a while, and was happy to note that the patient was getting treatment from Chengalpattu Government Hospital. A few months later, I had an opportunity

to visit the same village. It was heartening to see the patient now more functional than before... He had started to help in agriculture-related activities. The parents too acknowledged that treatment worked!

There is always a way to win – to convince patients and families that mental illness is a *Disorder and not a sin*

SUSTAINING SUPPORTED EMPLOYMENT – a practicing psychiatrist's perspective

Vamsi Srinivasan, Psychiatrist

Rehabilitation is one very important aspect, something not given its due attention by private psychiatrists. Until I joined SCARF, and like most other private practitioners, I largely focused on pharmacotherapy. Within a few months of joining SCARF, I became aware of the role of PSR and realised that it was imperative for us as a team to not only reduce the primary symptoms but also to enhance the patient's functioning. Work being an important aspect of one's life, it was critical to improve an individual's work and social skills as a prelude to effective reintegration them into the community and improve their quality of life overall.

I am learning that as a young psychiatrist, I should make sure I never miss a chance to have a discussion with my patients (once they are stabilized), regarding their ideas about involving them back in some work as most of them wish to return to some kind of productive work.

At SCARF, we are trying our level best to get the patients involved in some kind of supported employment. At the Job Fair which was recently conducted, however, I came in contact with few patients who have discontinued their work just few days after getting involved in them. What were the reasons for this? One patient reported that he had discontinued the work as his work timings were exhaustive and his pay was very minimal compared to it. The other factors contributing may be excessive work demand, interpersonal problems in work place, reduced motivation, impaired social skills affecting functioning at work place, family factors and the list goes on.

So what can be done to reduce the dropout of patients from work who has got a chance with supported employment? Here are a few of my suggestions:

Feedback can be given to the patients by the vocational

therapist after one to one discussion of the therapist with the employer / supervisor regarding the patients performance.

Periodic assessment by the vocational therapist, using scales such as Work Behaviour Inventory can be used not just for assessment, but also for training. Work Behaviour Inventory is a standardized work performance assessment instrument which assess work habits, work quality, social skills, cooperativeness and personal presentation.

Periodic group meetings can be conducted for the patients who are currently employed – a strategy that can allow for feedback from the Vocational therapist and inputs from other patients personal experience at the work place – an opportunity for sharing and work behavior feedback. These meetings can be held fortnightly or monthly. Involving employers in these meetings could add to the feedback value. By group interactions the patients can learn from each other's experience. The sessions can help to modify behavior of patients at work place, sustain motivation, enhance self-confidence and remain in the work force for longer periods.

Briefly on Work Behavior Inventory¹:

The scale measures vocational functioning. It involves observational measures which include employer interview and on site behavioral observation in real life work setting of the patient. The employer should be aware about the patients psychiatric condition. It would take around 15 minutes to apply and is a 36 item scale. It comprises of Work Habits, Work Quality, Personal Presentation, Cooperativeness and Social Skills which is useful for vocational rehabilitation specialists.

1. Bryson G, Bell MD, Lysaker P et al. The Work Behavior Inventory: A scale for the assessment of work behavior for people with severe mental illness. *Psychiatric Rehabilitation Journal* 1997; 20: 47-55.

Involving family helps in a successful discharge!

Kalaveena, *Psychologist Bhavishya Bhavan*

SD, a 41 years old, graduate, married woman had a severe form of Schizophrenia for over 17 year. Delusions, hallucinations, difficult behaviours, poor compliance with treatment were the predominant features of her illness, through the years.

Her illness started after the birth of her first child – at that time she became highly suspicious about her husband and other family members, would, refuse to take care of her child, there was marked irritability. There were several consultations with psychiatrists, admissions to psychiatric facilities, treatments with medications and ECTS over time –were in vain – SD would refuse to comply!

I came in contact with her when she was admitted to SCARF's facility at Bavishya Bhavan in Thiruverkadu. She was brought to SCARF in January, 2017 with a history of poor sleep, aggressive behaviour, frequently walking out of the house, talking to self and accusing the family (especially her spouse) of doing black magic on her! The family – her husband and her two sons – were very distressed and found it extremely difficult to manage her.

The first few weeks at the centre was tough. She was very poor in grooming and very slow in activities, had to be persuaded to take medications, kept on complaining about drowsiness and wanted to sleep all the day time also. It took nearly 45 days for her to settle down and engage in the routines of the facility. Counseling sessions focussed on motivating her to learn tasks in the Activity centre – she showed some interest in jewel making work. An list of activities of daily living (ADL) was planned with her --- to be monitored by other staff at the centre. Daily interaction with her paid off - within 3 weeks, she started bathing regularly. However, she wanted no sign of being married – “I am a widow – that that is how

I will remain. My husband will die soon”, she would say. She would actually talk about killing her husband by mixing some poison in the food, when she would return home! Another challenge was her constant complaints about medication side –effects.

Her ADL included her participation in Group therapy sessions for Medication compliance, anger management and self care. Gradual changes were noticed in the areas of care and compliance, in about 2 months. In the meantime, we felt that it was important to involve her family in her management, even though she was admitted. I spoke with the grown up sons and they agreed to visit the facility frequently be a part of rehab. They were involved in overseeing whatever activities were scheduled for her at the time of the day they visited and were encouraged to document in her chart. They were present in the counselling sessions that I had with her. Occasionally, they were present during the group sessions. Gradually, I encouraged them to talk to her about the husband and how she needed to get back home to live in the family. They also convinced her to be patient with her husband. After about 3 such sessions, she agreed to stay with her husband but stated clearly that she wouldn't talk to him. She agreed to do the household chores and take medications.

She was discharged in May 2017. Periodic telephonic follow up was done, to ensure that she followed up in the Out-patient services at Anna Nagar.

Currently, three months after discharge, she comes for follow up, with her sons. She takes medicines under supervision, does all the house hold chores and there are no disturbances from her side. She still has no intentions Still she doesn't like her husband and will not talk to him!

Meta-cognitive therapy

Subhashini Gopal *Psychologist*

Schizophrenia is the most disabling illness and it affects 1% of the world's population. Current treatment focuses not only on symptom reduction but also on improving functioning and hence reducing the level of disability. Pharmacological treatment

when combined with non-pharmacological treatment methods were found to have more effect. Amongst various non-pharmacological methods Cognitive Behavior Therapy (CBT) has been studied widely and it was found to be effective in reducing positive

symptoms in Schizophrenia. The effect size of CBT was found to be between .49 to .99 (pairwise comparison) and literature suggests that it is an effective adjunct treatment for persons affected with psychosis.

Recently a new approach called Metacognitive training (MCT) to treat positive symptoms of schizophrenia especially delusions and hallucinations was developed by Stephen Moritz and Woodward. Metacognition is the high-level cognitive function that can be defined as any knowledge or cognitive process that refers to, monitors, or controls any aspect of cognition. Patients with schizophrenia experience significant difficulties in the way they think and process information. These deficits are collectively grouped in to a domain called as Social Cognition. More recently, social cognition has been identified as a likely contributor to functional outcome. Problems in this area can impact peer, romantic, family relationships as well as behaviour at work/school. In addition, social cognition may impact the functional outcome of Independent Living Skills because of failure to assess to social cues from the environment. Recent studies indicate that patients with schizophrenia jump to conclusions, show attribution biases, share a bias against disconfirmatory evidence, are overconfident in errors, and display problems with theory of mind. Cognitive biases, that is,

distortions in the collection, appraisal and processing of certain information (e.g. jumping to conclusions (JTC), overconfidence in errors) has been linked to positive schizophrenia symptoms. Based on this research, Moritz and his colleagues have developed this new group treatment program. MCT is viewed as an effective treatment subjectively by patients with psychosis². Keeping this in mind this paper aimed to review the available literature on metacognitive training in psychosis.

How different is MCT from CBT:

Meta cognitive training is a variant of CBT targeting the cognitive biases in persons with psychosis. Unlike CBT it uses a backdoor approach to address these biases. The approach of using real world scenarios to raise awareness about cognitive biases among participants is an important feature of MCT. Instead of directly confronting about their delusions, normalizing cognitive errors through examples that everybody experience in their real life is one of the factor contributing to the wide acceptance of MCT by the participants. Through multiple examples and sharing their personal experiences the participants tend to gain insight about their delusions. The ultimate aim of MCT is make the participants aware of their cognitive biases and at the same time instil hope in them.

WORK READINESS- Concept, Assessment and Interventions

Sonia Sims, Psychiatric Social Worker

Work Readiness can be defined as an individual's ability to work. A "work ready" individual possesses the foundational skills needed to be minimally qualified for a specific occupation as determined through a job analysis or occupational profile. The skills needed for work readiness depends on one's personal history, socio-economic and cultural factors.

For a large number of individuals with mental illness, it has been a challenge to succeed in finding and keeping a job and the ability to work in the recent years is a treatment target for some individuals with mental illness.

Often the barriers to employment include interrupted schooling, Lack of qualification, limited work experience, Lack of workplace accommodations (flexible hours), Reduced income, Internalized stigma where they feel that they won't be able to be hired

because of their illness or feel incapable to work due to their current mental health status. In some cases Negative attitudes of MH staff and employers in an individual's ability to cope with work and make good employees is also another reason for unemployment.

It is therefore important for individuals to be assessed for work ability in order to counter these above mentioned hindrances.

But how do you assess if an individual is "work ready"? Some ways to assess work ability is to independently evaluate an individual's educational status, employment status or Functional status however these could be hindered for patients with serious mental illness.

To counter this The Work Readiness Questionnaire was created with psychometric properties for use in a clinical trial for patients with a broad range of symptom

severity. The questionnaire has been validated for (A) content validity, (B) reliability, and (C) construct validity. It is used to assess and rate patient's ability to engage in socially useful activity that could merit pay.

The questionnaire is composed of 7 items which are graded as follows: "strongly agree," "agree," "disagree," or "strongly disagree" that is based on a patient's ability to conduct daily activities, interact with others and adhere to treatment, and based on others' perceptions of patient appearance, behavior, and impulse control.

These 7 items are not totaled but are used to aid in reaching the dichotomous work readiness judgment

that helps the therapist to focus specifically in areas that need improvement, if any; in order to bring in specific approaches that would improve employment levels such as

1. supported education that are congruent with one's goals,
2. Vocational training- providing work skills, social skills to the point of work readiness.
3. Supported employment
4. Sheltered employment.

Employment is found to reduce symptoms of illness, increase self-esteem, social contact and improve the overall wellbeing of an individual with mental illness.

Job Fair 2017

Kiruthika Nandakumar



Gainful employment, play a big role in helping people with mental illnesses regain their roles and lives in the community. For the past several years, SCARF

had been able to find jobs for patients through the network of families, employers and personal contacts ...this was not sufficient ---- and the idea of a Job Fair was born early in 2017.

SCARF's first ever Job Fair was held on the 23rd of May - The World Schizophrenia Day. Several employers were invited to interview potential candidates from amongst our patients for placement in their companies. Planning for this event involved putting together a list of employers who were willing to take on persons with mental disability into their fold and a list of persons with mental health problems - who had sufficiently recovered to hold a job!!

The day dawned hot and humid - this did not deter our participants. Employers were from the industrial area were quite enthusiastic- they had made a serious attempt at getting to know about the illness and about the patients. Patients and families were quite

enthusiastic - an opportunity had come up to get a job in a friendly environment! Motivating talks by Dr Sarada Menon - who has always held that employment was the key to re-integrating patients back into the community and other senior consultants was a huge value addition for the employers, the patients, the families and the clinical team! Over all, 11 employers had participated. Of the 35 patients who had applied, 11 were placed.

We took this opportunity to acknowledge several employers who had stood by us in the past - they had been regularly providing our patients placements. Best employer's award was given Er.Krishnakumar, Mr.Sundaresan, Mr.Balaji.S.HR.

While the numbers may seem small - this is the beginning - a journey to which we are committed to ensure employment opportunities to our patients!



Continuing Professional Development

We strive to remain abreast of recent developments in the field of rehabilitation

1. Journals club : New research articles are discussed every second and third Fridays of the month
2. CRT supervision with Dr. Frances Dark, Australia last Friday of the month
3. Cognitive Behaviour therapy and Compassion – focused therapy for psychosis supervision is done with Dr. Charles Hamblet, UK, twice a month

Other activities

The domestic chores activity and caregiver education programs are some of our activities that continue with great enthusiasm.

What was new this season

Prior to Navarathri, old Golu toys, donated by a friend of SCARF were re-painted, an activity that some of our patients thoroughly enjoyed.



New products made by our patients



Upcoming events

• With the objective of orienting professionals involved in the care of persons with serious mental illnesses, in delivering vocational rehabilitation in various parts of Tamilnadu a one day workshop on vocational rehabilitation is being organized at SCARF Anna Nagar on 4th November 2017. The workshop will introduce the participants to concepts in vocational rehabilitation, the different models of delivering services, and practice in methods of assessment for vocational rehabilitation. This workshop is being organized by SCARF and the M.S. Chellamuthu Trust, Madurai and is being co-sponsored by the World Association of Psychosocial Rehabilitation (India Chapter). Experts in vocational

rehabilitation from different organisations will talk at the workshop. A panel discussion will provide opportunities to participants to ask questions and seek suggestion on the topic. The target delegates will be anyone working with patients with serious mental illnesses in a professional capacity with an interest to provide vocational rehabilitation, from the entire state of Tamilnadu.

• Group therapy sessions for social skills training and training in activities of daily living are to be initiated later this month