Understanding the Interplay of Social Adaptive Functioning and Self-Esteem in Chronic Schizophrenia for Vocational Rehabilitation Success

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Abstract- Background: - A variety of different approaches to vocational rehabilitation have been developed and evaluated over the past several decades, including social adaptive training methods, related self esteem, (Bond et al., 2008).Previous research also suggests that vocational rehabilitation for patients with chronic schizophrenia may yield clinical benefits, including a reduction in psychiatric symptoms negative schizophrenia as the term indicates is the loss in normal functions and is characterized by anhedonia (loss of interest in pleasurable activity), avolition (loss of ability to will), asociality (loss of ability to interact socially), apathy (loss of feeling of feeling), alogia (poverty of speech) and attentional impairment (Andreasen 1982). Positive symptoms such as hallucination and delusion which create reality distortionare associated with poor work performance in patients with chronic schizophrenia (McGurk & Mueser, 2004). Need for the study Vocational rehabilitation shows a significant improvement in social adaptability, enhanced self esteem, and quality of life (Mueser et al., 1997; Bio & Gattaz, 2011). Therefore the present study focuses in improving social adaptability and self esteem in patients with chronic schizophrenia using vocational rehabilitation. Method: - Based on purposive sampling method a group of fifteen male chronic schizophrenic patients between the age ranges of 35 to 65 years were taken from Manovikas Center, Gwalior. The diagnosis done according to the DCR, ICD – 10. Findings: - The present study confirms the essential role of vocational rehabilitation in social adaptability and self esteem patients with chronic schizophrenia. Non functional domains such as adaptive functioning, self esteem showed improvement and good indicators for vocational rehabilitation.

Key words*:-Schizophrenic, social adaptation ,self esteem, vocational rehabilitation*

INTRODUCTION

A variety of different approaches to vocational rehabilitation have been developed and evaluated over the past several decades, including social adaptive training methods, self esteem, transitional employment, and supported employment (Bond et al., 2008).Previous research suggests that vocational rehabilitation for patients with chronic schizophrenia may yield clinical benefits, including a reduction in psychiatric symptoms (Mueser & McGurk, 2004). Negative schizophrenia as the term indicates is the loss in normal functions and is characterized by anhedonia (loss of interest in pleasurable activity), avolition (loss of ability to will), asociality (loss of ability to interact socially), apathy (loss of feeling of feeling), alogia (poverty of speech) and attentional impairment (Andreasen 1982). Positive symptoms such as hallucination and delusion which create reality distortionare associated with poor work performance in patients with chronic schizophrenia (McGurk & Mueser, 2004).

Vocational rehabilitation shows a significant improvement in social adaptability, self esteem and quality of life (Mueser et al., 1997; Bio & Gattaz, 2011). It is generally accepted that work is therapeutic and is important part of life, filling much of an individual's time, provides social contacts and support, gives a sense of self worth, life satisfaction, skill acquisition, supplying a stable source of income, providing a source of identity, and contributing to the physiological and psychological wellbeing to societies (Drake et al., 1994; Chan et al., 1997; Priebe et al.,1998). While work serves an important

function in life of a person, vocational disability is considered to be a central feature of people with severe mental illness (Carone et al., 1991). Work is widely viewed as an important goal in the treatment and rehabilitation of patients with schizophrenia. It is also viewed both as a therapeutic modality, generating a social adaptability and self esteem and allowing a person to achieve personal independence and reducing the economic burden on society. Vocational rehabilitation services for psychiatric patients have therefore become a focus of concern among mental health professional. Bond (1992) pointed out; vocational rehabilitation for persons with severe mental illness was not considered important by rehabilitation centres, even as late as 1980s. From then onwards, there has been a growing interest in vocational rehabilitation for psychiatric patients.

Vocational Rehabilitation

The high rate of unemployment among people with schizophrenia has driven a number of different attempts to improve their job skills social adaptability . The majority of the techniques used involved skills outside of the workplace and then tries to place them in job settings. In general, the results of these efforts have been disappointing (Cook & Razzano, 2000; Wallace et al., 2000).

Lysaker & Bell (1995) studied 61 men and 7 women with diagnosis of schizophrenia enrolled in a 26 week work rehabilitation study. The result indicated that the ability to get along with others in the work place is a significant predictor of successful vocational functioning and improved social functioning has been associated with a variety of clinical improvements including decreased likelihood of relapse and improved self esteem.

In this study by Drake et al. (1999) examined 152 participants and were randomly assigned to IPS or EVR program. Individual Placement and Support (IPS) (n=76, schizophrenia n=54) and Enhanced Vocational Rehabilitation (EVR) (n=76, schizophrenia n=48) and were assessed at baseline and at 6, 12 and18 months using the measures The Expanded Brief Psychiatric Rating Scale, The Rosenberg Self Esteem Scale, Quality Of Life Interview. The result showed IPS participants were more satisfied that their vocational program was helping them to achieve their goals, and reported higher quality of life. However both groups improved over time on global functioning, general quality of life and self esteem with post hoc comparisons consistently revealing that improvement occurred during the first 6 months of the study and then remained stable. In Brief psychiatric rating scale the total scores increased significantly, but these increases were clearly in the subclinical range, with no average symptoms scores above 2 and no increases on subscales. During the 18 months study, participants in the IPS program were more likely to become competitively employed and to work at least 20 hours per week in a competitive job, whereas EVR participants had a higher rate of participant in sheltered employment. Total earnings, job satisfaction and non vocational outcomes were similarly improved for both groups. Overall the study concluded the IPS model of supported employment is more effective than standard, stepwise EVR approaches for achieving competitive employment, even for inner-city patients with poor work histories and multiple problems.

Further, Tsang et al. (2000) examined 46 participant (24 males, 22 females), majority were diagnosed schizophrenia (n=36) and were enrolled in occupational therapy program for 3 months and after the discharge the participant were divided into 2 group, the first group the employed participants were trained in sheltered environment (n=12) and the second group were unemployed participant (n=34), all the participant were assessed at baseline and at 3 months using the measures workshop behaviour checklist, vocational social skills scale. The result showed individuals with better psychosocial support and higher social competence especially in vocational context have more favourable employment outcome, in a supported or sheltered environment.

Social Rehabilitation

The impetus of the psychiatric rehabilitation centers movement was social; as mentioned earlier, most agencies have their origins in social clubs started by volunteers, and the concept of developing social relationships is intrinsic to all centers. Social skills can be learned both didactically and experientially, and programs in this area vary widely between agencies. At Thresholds social rehabilitation is considered vitally important-more important perhaps than any other aspect of our program. Therefore, considerable time and effort is spent in this area.

Many programs fall under this rubric, but in general social rehabilitation approaches can be divided into three categories outlined below (Dincin, 1975).

Self esteem

Cooley (1902) developed the idea of the "looking glass self", which stressed the importance of other people's reactions in shaping self-esteem. Similarly, Mead (1934) elaborated the notion that self-esteem derives largely from the reflected appraisals of others.

Rosenberg (1965) conducted the first major empirical study on the subject. He explored the effect of various social factors, including social class, ethnic group, religion, order of birth, and parental concern, on self-esteem in a large number of adolescents. Researchers have identified that a lack of social participation and inability to fulfill social roles is a significant contributor to low self-esteem for schizophrenic population (Petryshen et al., 2001; Bracke et al., 2008).Further, several researchers found better self-esteem to be correlated with better psychosocial treatment adherence (Fung et al., 2008) and medication compliance (Tsang et al., 2009). Many patients with schizophrenia experience alterations in self experience, assessed as a matter of self-esteem (Vauth et al., 2007) and personal narrative (Lysaker et al., 2008) and therefore many with this condition come to have a possible difficulty and unique struggle with issues of self-concepts. Self-esteem develops through the critical evaluation that a human being has of his or her response to demanding life events, which is then internalised as a personal characteristic (Bednar & Peterson, 1995).

Differences in self-esteem between employed and unemployed young people were due to a larger increase in those obtaining jobs rather than a reduction in those who did not. Interestingly, unemployment seems to give rise to an increase in negative self-appraisal rather than a decrease in positive self-appraisal (Warr & Jackson, 1983) a point that should be borne in mind when selecting an instrument of measurement.

Aim

To examine the effect of vocational rehabilitation on the social adaptability and self esteem of chronic schizophrenia.

Objectives

- To find out the effect of rehabilitation on socio-adaptive function of the patient.
- To find out the effect of rehabilitation on self esteem of the patient.

Hypotheses

- There will be no significant difference on socio-adaptive function between pre and post treatment assessment
- There will be no significant difference on self esteem between pre and post treatment assessment.

MATERIAL AND METHODS

Venue

The study was conducted at the Manovikas Center Rehabilitation Centre Gwalior. The sample consists of 15 patients with chronic schizophrenia, diagnosed as per ICD-10 DCR (WHO, 1992).

- Age range 35 to 65 years
- Schizophrenia with duration of 2 or more years (working definition for the purpose of study)
- Stable treatment with antipsychotic drugs during the last 6 months.
- Ability to understand and follow instructions

Exclusion criteria for the patients:

- Dependence on psychoactive substance and alcohol, except nicotine and caffeine
- History of seizures
- Mental retardation
- Auditory and visual impairment

Tools for Assessment

- Socio- Demographic and Clinical Data Sheet.
- Social Adaptive Functioning Evaluation (SAFE) scale (Harvey et al., 1997)
- Self – Esteem Scale (Rosenberg, 1965)

Socio Demographic and Clinical Data Sheet: A specially designed proforma which included various socio demographic (age, sex, religion, education level, marital status) and clinical variables (physical diagnosis, treatment history, family history) was taken.

Social Adaptive Functioning Evaluation (SAFE) Scale (Harvey et al., 1997) The social adaptive functioning evaluation (SAFE) developed by Harvey et al, 1997 is a structured 17 item observer rated scale that is used to generate the ratings of the severity of impairment in crucial social adaptive functioning domains. It was designed to be rateable through observation and care-giver interviews, as well as interaction with the patients. As a result, it can rate patients with severe positive or negative symptoms regardless of co-operativeness or even responsibility. The SAFE scale contains 17 items assessing self care, social competence and adjustment and miscellaneous skills including impulse control and co-operativeness. Each item is rated on a 5 point scale (0=no impairment, 1= mild impairment, 2= moderate impairment, 3= severe impairment and 4= extreme impairment) higher score reflects more severe impairment in social adaptive functioning. The superiority of the SAFE scale over other rating scales for social adaptive functioning in schizophrenia are: 1) it assess the additional complications and social-adaptive changes associated with aging, whereas the same have not been considered in previous scales for the assessment of social – adaptive functioning in schizophrenia, 2) its adequate internal consistency, internal reliability that is, interclass correlations of the ratings for the individual items of the scale, ranged from a low of 0.87 to 0.98.

Self–Esteem Scale (Rosenberg, 1965) This test was devised by Rosenberg (1965) according to author, a low score means that the individual lacks respect for himself, considers himself unworthy, inadequate or otherwise, seriously deficient as a person. A high score indicates that the individual feels himself or herself to be a person of worth, but not necessarily superior to others. The scale compares ten questions each answered on a 4 point array, which is subsequently collapsed in a dichotomy when scoring, these questions are said to constitute a Guttmann scale which has satisfactory reproducibility and scalability. Positive and negative items were presented alternatively in order to reduce the effect of respondent set. Here all the positive scores are summed which indicate low self-esteem of the subjects and that is his score on that questionnaire.

Statistical Analysis:-The statistical package for social sciences (SPSS) 22.0 for windows was used for statistical analysis. Descriptive statistics calculated for variables. Calculation checked the data for normality and applied paired‘t’ test to see the efficacy of intervention. Pearson correlation coefficient calculated for percentage change in scores of work behavior social adaptability and self esteem.

RESULT

Table -1.Shows Socio Demographic Characteristics of the patient group (N=15)

Variable		Mean ± SD/ n(n%)	Range
Age (years)		52.13±8.67	39-63
Education (years)		10.80±2.43	6-17
Duration of Illness (years)		22.53±7.11	10-32
Age of Onset (years)		28.27±4.76	20-40
Age at first hospitalization (years)		31.00±5.52	19-42
Duration of continuous stay in hospital (years)		19.73±7.15	9-30
Marital status	Married	4 (26.7)	
	Unmarried	11 (73.3)	
Religion	Hindu	15 (100)	
Diagnosis	Residual Schizophrenia	15 (100)	

Table 1: shows descriptive statistics of socio demographic and clinical variables. Mean age of the patient group was found to be52.13±8.67 years. It was seen that mean years of education was 10.80±2.43 years, duration of illness was 22.53±7.11 years, age of onset was 28.27±4.76 years, age at first hospitalization was 31.00±5.52 years and duration of continuous stay in hospital was 19.73±7.15 years.

Table:-2.Comparison of pre and post scores of Social Adaptive Functioning Evaluation Scale (SAFE) in schizophrenia patient group (N=15)

	Pre-Intervention	Post-Intervention	t	df	p
	Mean ± SD	Mean ± SD			
SAFE	28.20±6.11	20.47±3.22	7.99	14	.000***

***p<.001

Table 2: shows comparison of pre and post scores of SAFE in schizophrenia patient group using paired samples t test. Post scores of SAFE were significantly lower (p<.001) than the pre scores.

Table:-3.Comparison of pre and post scores of Self Esteem in schizophrenia patient group (N=15)

	Pre-Intervention	Post-Intervention	t	df	p
	Mean ± SD	Mean ± SD			
Self Esteem	22.13±1.73	24.13±1.55	9.16	14	.000***

***p<.001

Table 3: shows comparison of pre and post scores of self esteem in schizophrenia patient group using paired samples t test. Post scores of self esteem were significantly higher (p<.001) than the pre scores.

RESULTS

- The present study found that vocational rehabilitation significantly improved patient‘s work behavior.
- The present study found that Vocational Rehabilitation significantly improved patient‘s socio adaptive functioning.
- The present study found that vocational rehabilitation significantly improved patient‘s self esteem.
- The present study found that vocational rehabilitation significantly improved patient‘s quality of life
- The present study didn’t find any significant relationship between work behavior and self esteem.
- The present study didn’t find any significant relationship between work behavior and quality of life.
- The present study didn’t find any significant relationship between work behavior and social adaptive functioning

CONCLUSION

The present study confirms the essential role of vocational rehabilitation in social adaptability and self esteem patients with chronic schizophrenia. Non functional domains such as adaptive functioning, self esteem, quality of life, subjective well being and socio also showed improvement. However, it is generally accepted that work is therapeutic and is important part of the social adaptability and self esteem.

Limitations

- The sample did not represent female participants.
- Only Rehab/half way home patients were taken.
- The sample was not randomly selected.
- The sample was not matched with controls.
- Self stigma and its effect in vocational rehabilitation were not assessed.

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