Occupational therapy in India: focus on functional recovery and need for empowerment

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ABSTRACT

While there have been significant advances in treatments for mental disorders over the past century, cure for many mental disorders remains elusive. The complex problems of mental illness require a multi-sectoral, multi-disciplinary and multi-dimensional approach to care. The need for focus on biopsychosocial model rather than on biomedical practise, client-centred rather than physician-oriented care, personal rather than clinical recovery, are often preached but rarely practiced. The lack of emphasis on functioning and the limited workforce and evidence base complicate issues related to the care of people with chronic mental illness in India. The role of occupational therapy in bridging the gap between symptomatic improvement and functional recovery is discussed.

Key words: Functional recovery, India, mental illness, occupational therapy

INTRODUCTION

The early success of psychotropic medication in reducing symptoms of psychosis and ameliorating anxiety and depression led to optimism among psychiatrists that people with these conditions will recover from their mental illness and lead normal lives. Six decades later, mental health professionals accept that a significant proportion of people with mental disorders continue to have persistent and disabling symptoms and are unable to get back to their previous occupations and social roles.

The promise of psychotropic medication, of curing mental illness, failed to materialize. Many people with significant residual deficits seem to live in our communities but are not in the mainstream of life. Many are unable to “get their life back on track.” The persistent clinical symptoms, disabling medication adverse effects, inability to hold secure employment, and significant livelihood issues complicate the outcomes. Stigma, discrimination, and social exclusion blight the lives of people with mental illness.

Residual symptoms and poor clinical outcomes in a significant proportion of people treated with psychotropic medication limit biological explanations and generalizations. Many argue that biological arguments are reductionistic and that biological abnormalities may not explain all behavior.

BIOPSychosocial and Recovery Models

The biopsychosocial model proposed by Engel almost four decades ago was considered revolutionary.[1] This was especially true in mental illness where the importance of mind as well as body, subjective as well as external points of view, and a dialogic rather than a paternalistic approach needed to be legitimized. It also accepted the position suggested by “complexity science,” which views morbidity as the result of the interaction between...

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How to cite this article: Samuel R, Jacob KS. Occupational therapy in India: focus on functional recovery and need for empowerment. Indian J Psychiatry 2017;59:242-6.
various open systems without necessarily having a direct cause-and-effect relationship. It is currently accepted that complex interactions between systems, rather than linear, unidirectional relationships, help to better understand the experience of having an illness, which is a product of multiple and diverse interconnected elements that produce unique and complex patterns.

Nevertheless, the biopsychosocial model operates within the paternalistic medical culture, where psychiatrists decide the diagnostic formulation and choose management solutions. Despite its attempts at “patient-centered” medicine, psychiatry continues to be undergirded by the “doctor-centered” biomedical model.[2] Social and cultural issues are often on the back burner. In fact, many issues related to patient beliefs about causation, impact, treatment, and outcome expectations are never systematically elicited as they are not essential to diagnosis and classification. This results in a neglect of large swathes of information about the patient’s background, concepts, culture, and local reality.

The difficulty in integrating the diverse and contradictory strands (disease with personal, emotional, family, community, culture, and spirituality dimensions) has resulted in superficial and idiosyncratic approaches.[3] While eliciting psychological and social causes is possible, managing them is outside the usual range of expertise and the comfort zones of most psychiatrists. As a result, the biopsychosocial model is often praised, but it is the biomedical model, which is practiced.

Nevertheless, for many people with mental illness, the concept of recovery is about staying in control of their life rather than the elusive state of return to premorbid level of functioning. Such an approach which does not focus on full symptom resolution but emphasizes resilience and control over problems and life has been called the recovery model.[4-7] The approach argues against just treating or managing symptoms but focusing on building the resilience of people with mental illness and supporting those in emotional distress.

While there is no single definition of the concept of recovery for people with mental health problems, there are guiding principles which emphasize hope and a strong belief that it is possible for people with mental illness to regain a meaningful life despite persistent symptoms. Recovery is often referred to as a process, an outlook, a vision, and a conceptual framework. There is a clear consensus around the belief that good-quality care should be made available to service users to promote recovery both as inpatients and in the community.[5]

**IMPLICATION FOR MENTAL HEALTH**

These paradigm shifts initiated the change in focus of mental health care delivery from symptom removal/reduction to functional recovery. This change was characterised by emphasis on a multi disciplinary approach to care delivery, provision of community care for mentally ill, use of non pharmacological methods in therapy, advocacy for laws protecting human rights of patients, provision of government certifications and benefits, etc. The term “psychosocial rehabilitation” became an oft-used phrase when the World Health Organization in 1995 defined it “as a comprehensive process that offers the opportunity for individuals who are impaired, disabled, or handicapped by a mental disorder to reach their optimal level of independent functioning in the community.”[8] This concept gained more importance with the realization of the medical community that pharmacology alone failed to provide all the answers for the rehabilitation needs of the mentally ill.

**OCCUPATIONAL THERAPY**

Occupational therapy, as a profession which has always asserted the need for therapeutic use of occupation to enable people to participate in their various individual, social, vocational, and societal roles, has a large part to play in psychosocial rehabilitation.[9] It is a popular misconception that “rehabilitation” is needed only for people with chronic mental illnesses but not for people having mental disorders arising from difficulties in adjustment or personality factors. For the former, whose dysfunction is compounded by the negative symptoms and cognitive deficits, the age-old principles of habit training in self-care, life skills, social skills, and vocational skills still hold true. However, for the latter, the fact that they can function if they wanted to does not preclude the fact that they are not able to function, irrespective of the reasons behind it. Rehabilitation measures for people with adjustment and personality difficulties would include interventions help them change patterns of maladaptive behavior brought about by dysfunctional thoughts, beliefs, or environmental adaptation. Ultimately, occupational therapy focuses on optimizing the fit between an individual’s abilities and the environmental demands, which is the core theme of the recovery and biopsychosocial models.

While pharmacological management might alleviate symptoms, this does not always translate to improved functioning unless each person’s unique personal, familial, societal and contextual factors are examined and modified to enable maximum possible level of recovery. For example, in patients with schizophrenia, medications are more effective in reducing positive symptoms than cognitive or negative symptoms, which are predictive of functional recovery.[10-14] Nevertheless, the improvement in cognitive function does not automatically translate into real-world functioning. There are many personal factors such as social and work skills and motivation and environmental factors such as support and stigma, which mediate and influence the translation of skills into performance.[15,16] Therefore, it is imperative
that rehabilitative strategies include a detailed assessment of all these variables followed by a comprehensive package of cognitive retraining (restorative or adaptive), social and work skills training, and group therapy to suit each person’s needs. The Social Functioning Questionnaire,[17] Rathus Assertiveness Schedule,[18] Lawton Instrumental Activities of Daily Living Scale,[19] Assessment of Communication and Interaction Skills,[20] Life Skills Inventory,[21] and the Vellore Occupational Therapy Evaluation Scale[22] are some of the scales used by occupational therapists in addition to various job assessments and vocational evaluations to assess functioning and focus on achieving functional recovery.

FRAMEWORK AND MODELS

The theoretical frameworks in occupational therapy consist mostly of approaches based on the ecological and sociological models, focusing on the complex interaction between humans and their environment. There exist many system models where concepts of occupational behavior, occupational performance, and likewise have been defined and the approaches to achieve these outlined.[23] There are also developmental models which define the normal sequence of achieving various adaptive skills and the interventions to promote the same in case of dysfunction.[24] Occupational therapy in mental health has also modified principles from behavior therapy, cognitive behavior therapy, and psychoanalytical, humanistic, and existential schools of thought to suit the requirements of functional improvement. This integration is essential while practicing in a multidisciplinary context where consistency and clear communication between team members are of paramount importance.

INDICATIONS AND TECHNIQUES

A variety of techniques for a diversity of issues have been employed in mental health occupational therapy. These include as follows:

- Behavior therapy approaches, which employ the principles elucidated by Skinner and Thorndike,[25] use behavioral analysis, positive and negative differential reinforcements, and graded exercises to manage deficient or maladaptive task and social and occupational skills. They can also be used to ameliorate the impact of persistent and medically unexplained symptoms and health anxiety
- Humanistic and client-centered therapies, advocated by Maslow[26] and Rogers,[27] attempt to improve and enhance self-esteem through graded tasks, improved goal setting, and problem-solving and decision-making skills
- Cognitive therapy, suggested by Beck et al.[28] consists of cognitive analysis, identification of cognitive distortions, behavior activation, graded assignments on functional tasks, and diverisional activities to improve functioning. Cognitive retraining suggested by Allen[29] is also useful. Vicarious reinforcement, self-produced consequences, imitative- and goal-centered learning, based on Bandura’s cognitive behavioral approach,[30] can be used to treat maladaptive or deficient task and social and occupational behavior. Focus on decision-making skills is also helpful in improving functioning
- Rehabilitative and recovery model by Deegan[31] focuses on socio-occupational dysfunction and employs prevocational evaluation, vocational training, and life skills training. Socio-occupational dysfunction can be also managed through social skills training and activity-oriented therapy
- Motivational enhancement therapy[32] can be employed for people with substance use problems through cue identification and management: assertiveness training, improving drink refusal skills, enhancing coping skills, and through lifestyle modification
- Group therapy as an approach using a variety of principles and theoretical models can also be used to enhance and improve outcomes. The principles employed by Yalom and Leszcz[33] using “here and now” emphasis are useful. Similarly, social skills training, anxiety management, assertiveness training, etc., can be done within a group therapy context.

These approaches can be employed in sequence and combination across psychiatric diagnoses and categories as an eclectic mix to target impairments in functioning.

ABSENCE OF EMPHASIS

Despite the role of occupational therapy in managing psychiatric disorders and the felt needs of patients with mental illness and their families related to vocational training, vocational rehabilitation and psychosocial rehabilitation are largely unmet in India. While symptom checklists and symptom control seem to be priorities of the biomedical model, people with mental illnesses are more concerned with being productive in the society even within the constraints of their illness. Patient and family empowerment using occupational therapy and rehabilitation is crucial to helping people reintegrate into society. Without such a focus on recovery and reintegration into society, people with mental illness will continue to remain on the margins and will be unable to get back into mainstream life. The management of negative symptoms, cognitive deficits, social anxiety, occupational problems, and livelihoods issues is more often praised rather than actually practiced within the biomedical model. There is a need to foreground such deficits to manage them using rehabilitative services.

LIMITED WORKFORCE

The lack of emphasis on rehabilitation is coupled with a limited number of mental health professionals practicing
in the country. The World Health Organization’s Mental Health Atlas 2014 estimates the mental health workforce in countries such as India to be around 4.8/100,000 population with the breakdown being psychiatrists (0.4), other doctors (0.6), nurses (2.6), psychologists (0.1), social workers (0.1), occupational therapists (0.1), and other mental health workers (1.5). The comparative estimate of occupational therapists in other regions is European (2.1) and American (0.3), with a global average rate of 0.2. Considering the relative importance of nonpharmacological measures in the treatment of mentally ill, these numbers point to the inability of India’s workforce to comprehensively address rehabilitative needs of patients. The limited opportunities for training and the reduced number of positions in the workforce make it difficult to focus on rehabilitation needs of people with mental illness in the country.

While it is claimed that various biological, psychological, and social factors interact together to form a unique experience of each person’s illness, mental health care delivery packages fail to reflect this in actual practice. The psychiatrist’s own attribution toward the cause of illness has a powerful influence on the patient and their families. When psychiatrists focus only on providing the pharmacological care, they indirectly communicate that only medicines are sufficient for recovery. Change in the attitudes among psychiatrists toward nonpharmacological therapy is required so that people with mental illness receive eclectic therapy from multidisciplinary teams.

**SCANTY RESEARCH**

While the need for rehabilitation and long-term community support has been documented in the West, there is a dearth of articles on the psychosocial management and rehabilitation of mentally ill. This is particularly true in India where there is a need to demonstrate the usefulness of locally tailored approaches to fit the regional environment and culture. There should be focus on treatment strategies and approaches that are tailored to suit the Indian milieu and provision of evidence base for their usefulness.

**THE WAY FORWARD**

Complex problems rarely have single or simple solutions. While it can be argued that the Indian government should modify legislation, open more tertiary care hospitals, grant more educational institutions to train personnel, and modify legislation, open more tertiary care hospitals, there is a need to demonstrate the usefulness of locally tailored approaches to fit the regional environment and culture. There should be focus on treatment strategies and approaches that are tailored to suit the Indian milieu and provision of evidence base for their usefulness.

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