WORK PERFORMANCE OF SCHIZOPHRENIC DAY BOARDERS IN AN OCCUPATIONAL THERAPY CENTRE

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SUMMARY

Performance of 129 schizophrenics attending the Occupational Therapy Centre at NIMHANS, Bangalore as day boarders has been assessed on a 5 point scale, and by Griffiths Work behaviour assessment scale and correlated with various demographic and clinical characteristics.

Those unemployed earlier had significantly (P < .005) poorer work performance. Poor social support (P < .05) and presence of residual symptoms (P < .001) were also significantly related to poor work performance. Other demographic characteristics, sub-type of schizophrenia, duration of illness and age of onset of illness did not influence work performance significantly. The implication of these findings in rehabilitation of schizophrenics are discussed.

Introduction

Work performance and vocational functioning of a mentally disabled person have been a focus of interest as regards rehabilitation. Work performance has been studied in relation to duration of stay (Morgan and Gopalaswamy 1983), psychiatric symptoms (Green et al 1968, Lorei 1967, Strauss and Carpenter 1972, 1974) and demographic characteristics (Anthony and Jansen 1984). The need for additional research concerning the efficacy of occupational therapy in treating psychiatric disorders is acknowledged by leaders of the profession (Yerxa and Gilfoyle 1976, Fidler 1983, King 1978). Affleck and Mcguire (1984) have emphasised that the aim of rehabilitative services should be to obtain the best level of functioning of which the patient is capable inspite of his impairments. These should take into account, besides self care and domestic responsibilities, money management and occupational outputs also (Affleck and Mcguire 1984). Watts and Bennet (1977) had examined the bearing of previous work performance on employability after rehabilitation. Work performance scores were found to be predictive of future employability by Morgan and Gopalaswamy (1983). But there are very few day care centres in our country and the role of occupational therapy is hardly ever systematically examined. This study examines the work performance of schizophrenic patients attending the occupational therapy centre and its correlation with various demographic and clinical characteristics.

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Material and Methods

The study was conducted by retrospective chart review of all schizophrenic patients who were admitted to the day care centre during the period of five years. In order to get adequate, consistent and uniform information, the details were recorded on a semi-structured proforma. Only cases, who had a definite diagnosis of schizophrenia as per ICD-9 (WHO 1978), had attended day care at least for a period of 6 months and had adequate information of all the variables were included. The proforma recorded demographic variables as age, sex, marital status, education and previous occupations; clinical variables as age of onset of illness, duration, course, medications and the sub-type of illness. Work performance was assessed using Griffiths (1973) scale. The ratings on Griffiths scale were carried out every month by the occupational therapists, nursing staff and the section instructors by mutual concurrence. For this study average of 3 months trainings were taken, which included one month prior to, and 2 months after starting the study. The data was analysed and relationship of work performance with demographic and clinical variables was computed by chi-square analysis. Work performance was rated on 5 point scale depending upon observation by instructor and occupational therapist, as well as average scores on Griffiths scale (Less than 30: very poor; 31-60: below average; 61-90: average; 90-110 slightly good; 111-125 very Good).

Results

One hundred and fifty charts were reviewed of which 21 were found to be incomplete and did not have sufficient information, hence these were excluded. The sample consisted of 88 males, 41 females; 55 between 15-29 years age, 52 between 30-44 years and 22 above 45 years. Majority of patients (107) were unmarried. Forty seven were illiterate or had education up to middle school, 39 were matriculates and 42 above matric; whereas 30 had previous employment experience, 62 did not have so, and 37 did household activities or were students. Social support, rated as good, adequate or poor depending upon help and motivation from family members, relatives, friends, or other agencies, was found to be good in 24 cases, adequate in 51, whereas 53 had either no social support or had poor social support. No scale was used for measurement of social support. Majority of patients (92) had residual schizophrenia, 21 had paranoid schizophrenia. The age of onset was above 25 years in only 48 cases, in others it was before 24 years. Most patients (97) had duration of illness longer than 5 years. In patients with episodic course total duration of illness is considered from the age of onset and does not reflect duration of each episode. The number of attacks were not taken into consideration.

On examining the relationship between work performance and socio-demographic variables (Table 1) no significant difference was noticed. Though more married patients (46%) had above average performance, this difference was not significant. Similarly clinical characteristics as sub-type of schizophrenia, age of onset and duration of illness did not significantly influence work performance (Table 2). However, those with poor social support performed poorly, nearly half the cases with poor social support had below average performances (P < .05). Previous employment experience was related to better work performance (P < .005) in comparison with those unemployed earlier (Table 3, 4). Regarding clinical course (Table 5) 47% of cases with mild residual symptoms had below average
Table 1
Work Performance and Socio-demographic Aspects

|                | Very Poor (27) | Below Average (19) | Average (37) | Slightly Good (22) | Very Good (24) |
|----------------|----------------|--------------------|--------------|--------------------|----------------|
| **Sex**        |                |                    |              |                    |                |
| Male           | 22             | 13                 | 20           | 13                 | 20             |
| Female         | 5              | 6                  | 17           | 9                  | 4              |
| **Age**        |                |                    |              |                    |                |
| Under 30 years | 12             | 8                  | 17           | 9                  | 9              |
| Above 30 years | 15             | 11                 | 20           | 13                 | 15             |
| **Marital Status** |            |                    |              |                    |                |
| Single         | 23             | 15                 | 33           | 19                 | 17             |
| Married        | 4              | 4                  | 4            | 3                  | 7              |
| **Education**  |                |                    |              |                    |                |
| Below Matric   | 10             | 7                  | 14           | 9                  | 7              |
| Matric         | 9              | 4                  | 11           | 8                  | 7              |
| Above Matric   | 8              | 8                  | 12           | 5                  | 10             |

(Chi-Square analysis reveals no significant differences)

Table 2
Work Performance and Clinical Aspects

|                  | Very Poor (27) | Below Average (19) | Average (37) | Slightly Good (22) | Very Good (24) |
|------------------|----------------|--------------------|--------------|--------------------|----------------|
| **Sub-type**     |                |                    |              |                    |                |
| Paranoid         | 5              | 1                  | 6            | 3                  | 6              |
| Residual         | 17             | 15                 | 30           | 14                 | 16             |
| Others           | 5              | 3                  | 1            | 5                  | 2              |
| **Age of Onset** |                |                    |              |                    |                |
| 15 - 19 years    | 5              | 8                  | 8            | 6                  | 6              |
| 20 - 24 years    | 11             | 7                  | 15           | 9                  | 6              |
| Above 25 years   | 11             | 4                  | 14           | 7                  | 12             |
| **Duration of Illness** |         |                    |              |                    |                |
| Less than 5 years| 8              | 1                  | 11           | 5                  | 7              |
| 5 - 10 years     | 9              | 8                  | 12           | 7                  | 5              |
| More than 10 years| 10             | 10                 | 14           | 10                 | 12             |

(Chi-Square analysis reveals no differences)

Performance as compared to only 12% of patients with episodic course (P < .001). Thus continuing clinical symptoms also influence work performance. Whereas residual schizophrenia (Table 2) refers to the sub-type, mild residual symptoms (Table 5) refer to clinical course irrespective of the sub-type of schizophrenia.

Discussion

This evaluation has identified patients likely to have poor work performance. The three factors identified namely, persistence of residual symptoms, poor social support and previous unemployment, could partly be inter-related. It is understandable how these could interfere with vocational train-
Table 3
Relationship of Work Performance with Social Support

|                      | Very Poor (26) | Below Average (19) | Average (37) | Slightly Good (22) | Very Good (24) |
|----------------------|----------------|--------------------|--------------|--------------------|----------------|
|                      | n (%)          | n (%)              | n (%)        | n (%)              | n (%)          |
| Good (24)            | 3 (12.5)       | 2 (8.3)            | 7 (29.2)     | 3 (12.5)           | 9 (37.5)       |
| Adequate (51)        | 8 (15.7)       | 6 (11.8)           | 19 (37.2)    | 10 (19.6)          | 8 (15.7)       |
| Nil or Poor (53)     | 15 (28.3)      | 11 (20.8)          | 11 (20.8)    | 9 (16.9)           | 7 (13.2)       |

(Not Known-1)  P<.05

(X² Test was applied after lumping those rated very poor and below average together).

Table 4
Work Performance and Previous Occupation Status

|                      | Very Poor (27) | Below Average (19) | Average (37) | Slightly Good (22) | Very Good (24) |
|----------------------|----------------|--------------------|--------------|--------------------|----------------|
|                      | n (%)          | n (%)              | n (%)        | n (%)              | n (%)          |
| Employed (30)        | 3 (10)         | 3 (10)             | 7 (23.3)     | 6 (20)             | 11 (36.7)      |
| Unemployed (62)      | 20 (32.3)      | 12 (19.4)          | 20 (32.3)    | 5 (8.0)            | 5 (8.0)        |
| Housewife/Students (37) | 4 (10.8)      | 4 (10.8)           | 10 (27.0)    | 11 (29.8)          | 8 (21.6)       |

P < .005

Table 5
Work Performance and Clinical Course

| Clinical Course                          | n | Below Average | Average | Above Average |
|------------------------------------------|---|---------------|---------|---------------|
| Mild residual symptoms                   | (75) | 35            | 13      | 27            |
| Static but moderately symptomatic        | (21) | 3             | 8       | 10            |
| Episodic Course                          | (24) | 3             | 14      | 7             |

(Please Note: 5 cases who had complete recovery and 4 who had chronic deterioration have not been included in this table)

Importance of previous work history in predicting future employability depending on work performance has also been noted earlier (Watts and Bennett 1977, Morgan and Gopalaswamy 1983). Watts (1978) and Morgan and Gopalaswamy (1983) had also recorded that patients who had successful work performance had significantly longer stay and had better relationship with other people. These aspects were not directly examined in this study. There are only few reports on the impact of occupational therapy on psychiatric conditions of the patients from Indian setting (Behere and Varma 1983, Behere et al 1981), but these did not examine work performance.
Anthony and Jansen (1984) have summarised major findings with respect to the predictability of the vocational functioning of the severely psychiatrically disabled. Though a number of studies illustrate the lack of relationship between psychiatric symptomatology and future work performance (Ellsworth et al 1978, Green et al 1968, Lorei 1967, Strauss and Carpenter 1972, 1974), our results indicate that continued psychiatric symptoms (Table 5) influence work performance, though specific symptoms were not investigated separately. But since most patients had chiefly negative symptoms, it is likely that these resulted in poorer performance. Anthony and Jansen (1984) also emphasised the best demographic predictor of future work performance is the person's prior employment history. Our results also support this observation. In many of our patients, the work section is selected on the basis of previous employment experience. The observations could be useful in planning rehabilitation services for chronic schizophrenic patients. It is expected that more research on this area will be performed since, as Herz (1982) pointed out that not everyone is convinced by the face value validity of partial hospitalisation. To be definitive, future research efforts will have to be prospective, with better designs and long follow up studies.

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