INVITED ARTICLE

REHABILITATION IN PSYCHIATRY: AN OVERVIEW

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INTRODUCTION

The relationship between rehabilitation and psychiatry has been referred to as an "uneasy alliance" (Bachrach, 1992). Terms like psychiatric rehabilitation and psychosocial rehabilitation have been used interchangeably. While there is no commonly endorsed definition of rehabilitation in psychiatry, there appear to be several common concepts and values shared across 'models' or approaches. This shared philosophy is succinctly summarized by Bachrach (1992). She defines psychosocial rehabilitation as "a therapeutic approach to the care of mentally ill individuals that encourages capacities through learning procedures and environmental supports".

HISTORICAL CONTEXT

The origins of rehabilitation in psychiatry in the West, can be traced to the community mental health movement. Prior to the 1950's, care of the mentally ill was primarily institution based and custodial in approach. Much has been written about the long term deleterious effects of such care (Wing & Brown, 1970). This led to the 'deinstitutionalization' of patients in the late 1950's and early 1960's. It was assumed that people with major mental illness should be helped to maintain themselves in the community. Although, deinstitutionalization was a positive step, it was too idealistic. It did not take into account the fact that the long term mentally ill are a highly heterogeneous population with varying individual needs. What was achieved was merely a shift in the locus rather than the focus of care. The various issues relating to deinstitutionalization have been reviewed by Lamb (1988). However, the movement highlighted the fact, that pharmacotherapy alone was inadequate. A comprehensive system of care, encompassing a variety of therapeutic approaches, is needed to enable the mentally ill patient to function optimally and live in the community.

CHRONIC MENTAL ILLNESS

Chronic mental illness is a problem of devastating dimensions and enormous public impact. The chronic mentally ill population is a diverse group comprising of patients with different problems and varying levels of need. Schizophrenia is the prototype of chronic mental illness, and this paper will limit its review to this diagnostic sub-group. Epidemiological evidence indicates that schizophrenia, with its low incidence and high prevalence, is a condition affecting people typically in early adulthood and, in some cases, lasting for the rest of their lives. The training of mental health professionals and the delivery of mental health care has, hitherto, been centered around the handling of acute episodes of illness. However, in the case of chronic illness what is required is a longitudinal approach providing life long care (Mechanic, 1986).

IMPAIRMENT, DISABILITY, HANDICAP

Any model of psychosocial rehabilitation, in order to be effective, needs to focus not only on the impairment of the acute stage, but also on remedying disability and compensating for handicap. Since these terms are often used in rehabilitation literature they will be dealt with briefly here.

Impairment: Any loss or abnormality of psychosocial, physiological or anatomical structure or function (resulting from underlying pathology). For example, the positive or negative symptoms of schizophrenia such as delusions and hallucinations or anhedonia and apathy.

Disability: Any restriction or lack of ability to perform an activity (resulting from an impairment) in the manner or within the range, considered normal. For example, the deficient social skills seen in patients with schizophrenia.

Handicap: A disadvantage for a given individual (resulting from an impairment or a disability) that limits or prevents the fulfillment of a role that is normal for that individual (depending on age, sex, social and cultural factors) such as getting married or being gainfully employed.

In psychiatric conditions, as against physical conditions, it is often difficult to distinguish one from the other. Impairment, disability and handicap merge and coexist (Anthony & Liberman, 1986).
PROVISION OF SERVICES

Clinical experience and research have shown schizophrenia to be a multifaceted disorder in terms of its etiology, phenomenology, treatment and course. This, in turn, necessitates a wide range of services and specific interventions depending on the symptom picture and needs of the individual patient and his family at any given point in time.

The network and range of services are depicted in the form of a flow chart in Figure 1. For purposes of convenience, treatment will be dealt with in terms of the settings in which they occur: (i) inpatient (ii) out-patient and (iii) community. However, there are

![Flow Chart of Services](image-url)

**Figure 1**

**FLOW CHART OF SERVICES**

- **ACUTE STAGE**
  - Predominantly Positive symptoms

- **CHRONIC STAGE**
  - Predominantly Negative symptoms
disability / handicap

- **INPATIENT TREATMENT**
  - Pharmacotherapy
  - Supportive therapy
  - Psychoeducation

- **OUTPATIENT TREATMENT**
  - **INDIVIDUAL**
    - Pharmacotherapy
    - Supportive therapy
    - Functional assessment
    - Skill development
  - **FAMILY**
    - Psychoeducation
    - Education
    - Family
    - Therapy

- **COMMUNITY CARE**
  - Day care centre
  - Sheltered workshop
  - Residential setting

- **RELAPSE**
no hard and fast rules and any one or more of the treatments may be used in any of the settings.

I. INPATIENT SETTING

Pharmacotherapy:

This is the main form of management in an inpatient setting with electroconvulsive therapy being used as an adjuvant where indicated. Treatment may be directed at: a) rapidly bringing under control the florid psychotic symptoms seen in an acute phase, b) managing exacerbations/relapses during the long term course, c) treating nonresponders to standard treatment and, d) treating depression associated with schizophrenia (Rifkin, 1993).

Hospitalization is an expensive form of treatment and may not always be warranted. However, it helps in deciding the optimal neuroleptic, depending on its sedative, antipsychotic and side effects profile, stabilizing or monitoring the dose required, trying out newer or alternative treatments and, finally, but not the least important giving a much needed respite to the family. (Breslin, 1992; Hirsch, 1982; Kane & Marder, 1993; Talbott & Glck, 1986).

In the inpatient setting, the patient, especially in the acute phase of the illness, needs time to recover from the psychotic episode before he can be exposed to other psychosocial interventions. He would, however, benefit from a supportive relationship with the treating professional (Bloch, 1986).

Depression, anxiety, grief, shame and anger are often seen in reaction to the illness or its consequences, such as loss of job or disturbed interpersonal relations with family and friends. The therapist expresses understanding, concern and acceptance of the patient and often, needs to be pragmatic and give advice on day to day issues.

Psychoeducation:

Family members are often perceived as necessary for describing symptoms and history, but not useful in treatment. Consequently, they feel ignored. The experience of seeing a near and dear one behave in so different a manner, as is the case in a schizophrenic illness, is a bewildering and traumatic one for the family members. The inpatient setting is, therefore, an appropriate place to begin work with the family. Members of the family, especially the primary care givers, need to be provided with a) information regarding the nature of illness from a multifactorial view point, b) an understanding of core symptoms, both positive and negative, c) formal instruction with medication management, particularly in relation to side effects and d) guidance in practical issues that arise in the day to day management of a patient with schizophrenia.

Providing accurate information helps reduce distress caused by unrealistic expectations or superstitious beliefs and makes the patient and family better consumers of mental health services (Rifkin, 1993). Giving no information to relatives or remaining vague about the diagnosis and treatment, makes relatives feel fearful or guilty. Strachan (1986) suggests that even when the diagnosis is unclear, rather than being afraid of giving incorrect information or wrongly labeling the patient as ‘schizophrenic’, professionals should be clear and direct with the relatives about the lack of decisiveness, the reasons for the ambiguity and how the diagnostic decision might be clarified (e.g. further interviews, or the passing of time).

II. OUTPATIENT SETTING

The interventions in the outpatient setting can be essentially dealt with under two headings depending on whether the focus is on a) the individual patient or b) the family or significant other.

INDIVIDUAL FOCUSED INTERVENTIONS

Pharmacotherapy:

The immediate aim of the treating professional is to ensure treatment compliance with maintenance medication. Although oral and depot neuroleptics are pharmacologically equally effective, depot preparations have been found to be more effective in preventing relapse by eliminating covert noncompliance (Kane & Marder, 1993). The efficacy of antipsychotic medication for the long term maintenance treatment of schizophrenia has been established (Davis, 1975; Rifkin, 1993). However, studies are focussing on improving the benefit to risk ratio of long term treatment and exploring alternative maintenance strategies. To reduce the risk of complications such as tardive dyskinesia the continuous low dose medication strategy has been found promising (Kane & Marder, 1993), while there is controversy as to the efficacy of targeted or intermittent medication (Jolley et al, 1990). However, studies show that about 40% of patients relapse while on medication within the first year after discharge from hospital. Combined approaches that employ psychopharmacologic treatment with psychosocial interventions have been found to be effective in enhancing compliance and reducing relapse (Hogarty et al, 1986).
**Functional Assessment:**

Functional assessment of the patient, especially in the early phases of the illness, helps to plan the treatment process and allows the professional to target interventions to the patient's specific needs and state of impairment and disability (Wallace, 1986). Assessment of cognitive functions is helpful in making decisions about future educational and vocational plans (Wykes et al., 1992). The frequency of impairment in basic cognitive functions, revealed by formal testing is far higher than is evident on mental status examination. Test results are often useful in educating the family, that failure of the patient to achieve up to their expectations, is the result of an actual disability rather than "laziness" or lack of "will power" (Gold & Harvey, 1993). The utility of cognitive measures in the assessment and prediction of treatment effects has also been demonstrated (Asarnow et al., 1988; Mueser et al., 1991). In general, however, patients with a more malignant course of illness perform poorly on cognitive measures, particularly having impairments of attention, memory and problem solving than do patients with relatively less severe forms of the illness (Wykes et al., 1992).

Cognitive deficits, in turn, impair the ability to function independently. Therefore, functional assessments should include an evaluation of patient's performance in other areas, especially self care and social adjustment (Hendrichs et al., 1984). A wide range of tools are available in the form of observational, interview or self-report instruments focusing on the performance of the patient in self care, social, family recreational, vocational and financial domains (Affleck & McGuire, 1984). The user must familiarize himself with the instruments and select one which is appropriate for the setting and fits the particular needs of the patient.

Once the clinician / professional has arrived at an understanding, either through observation / clinical interviews and or formal assessment, of the patient's day to day functional skills and abilities or deficits in self care, work and leisure, he / she can choose interventions that will enable the patient to achieve the highest level of functioning in the desired activity. This may include not only skill building, but also environmental support for those who may require it. Thus goal setting is a crucial stage in functional assessment. It is imperative that the professional engage in a discussion with the patient and family to set realistic / reasonable goals which are in keeping with their perceived needs. This not only emphasizes the collaborative nature of this exercise, but ensures compliance by setting individualized treatment plans.

**Skill Development:**

Impairment in social functioning is almost characteristic of schizophrenia. However, it is not simply a by-product of positive and negative symptoms, but an independent domain of the illness (Lenzenweger et al., 1991). Poor social competence contributes to the impoverished quality of life and social isolation experienced by many patients. It interferes with functioning within the family or in the work place. In addition, social disability has been found to be a potent predictor of symptom exacerbations and rehospitalizations.

The most promising strategy for alleviating social disability and enhancing social competence has been social skills training (SST) (Wallace et al., 1980). Social skills training is a highly structured psychosocial intervention based on behavioral and learning principles and emphasizes modeling, role playing and social reinforcement. Goals are explicitly stated and complex social repertoires, such as going for a job interview, asking about medication, are broken down into smaller elements such as maintaining eye contact, and initiating communication which are rewarded with social reinforcement. Patients are first taught the elements and then gradually learn, how to perform them smoothly in sequence. In addition to modeling and role play, structured problem solving skills are employed to enable the patient to function in real life situations.

Social skills training was introduced in the 1970's, mainly in the form of single case studies. Since then, the group format has been found to be more popular as it is not only cost-effective, both in terms of time and personnel, but also enhances generalization of skills by providing a vicarious learning experience. A number of controlled studies have highlighted the efficacy of social skills training (Benton & Schroeder, 1990; Hogarty et al., 1986 & 1991). Moreover, these studies demonstrate that effects of training are maintained over six to twelve month periods and help in reducing relapse rates when combined with adequate pharmacotherapy. Hierholzer and Liberman (1986) recommend booster sessions to maintain skills learnt and used an open-ended, drop-in, group format.

While it is clear that social skills training is an effective strategy, more work needs to be done on
issues such as generalization of skills to the natural environment, optimal frequency of sessions and duration of treatment, and patient characteristics that may be contraindicated (Benton & Schroeder, 1990).

Cognitive Training:

Patients with schizophrenia exhibit a variety of information processing deficits particularly in attention, memory, reasoning and concept formation. It is argued that deficits in basic processes such as attention and memory need to be remedied before patients can learn problem solving skills which require the ability to reason and carry out logical analysis (Brenner et al, 1992). Cognitive training is provided on a series of tasks adapted from neuropsychological test procedures such as card sorting and word finding (synonyms/antonyms) which focus on frontal lobe functions (Bellack et al, 1990). However, this approach is very much in an experimental stage. Preliminary results with schizophrenia patients indicate some reasons to be optimistic about the future (Liberman & Green, 1992) yet emphasize the need to proceed with caution (Bellack, 1992; Hogarty & Flesher, 1992).

FAMILY FOCUSED INTERVENTIONS

The need to maintain the patient in the community and at an optimal level of functioning necessitates viewing the family as an important resource in the overall management. There has been a radical shift from viewing the family as a noxious agent to including the family as a collaborative partner in the overall treatment plan (Spaniol et al, 1992). This shift is a result of three major factors: a) the increasing acceptance of schizophrenia as a biological disease b) the recognition of the heavy burden on family members of caring for a patient with schizophrenia and c) research documenting that negative family affect (referred to as expressed emotion) towards the patient is predictive of symptom relapses. Each of these factors are outlined below:

a) The multi factorial etiology of schizophrenia is best understood from a biopsychosocial perspective. This led to the abandoning of purely psychogenic models and consequently, the use of terms like schizophrenogenic mother. Blaming the family that was prevalent in the early part of the century, led to vocal dissatisfaction expressed by many family members over how they were treated by professionals. In the West, a number of advocacy groups were formed, the largest of these being the National Alliance for the Mentally Ill. The group highlighted the fact that (i) families were not to be blamed for mental illness in the individual member (ii) families had a right to information about the illness and its treatment and that (iii) better resources were needed for the chronic mentally ill.

b) Family members of patients with schizophrenia experience subjective distress, financial loss, risk to personal safety etc. A number of studies, carried out in India and in the West, have documented that the burden of caring for a ill relative is high and that families are in need of support (Fadden et al, 1987; Gopinath & Chaturvedi, 1992; Lefley, 1989; Noh & Turner, 1987; Rao et al, 1988).

c) The construct of expressed emotion (EE), referred to as high levels of criticism, hostility or emotional over-involvement, was put forth by the Camberwell group (Vaughn & Leff, 1976). Since then it has been demonstrated that patients suffering from schizophrenia, in contact with a relative having high expressed emotion, are more likely to relapse (Parker & Hadzi-Pavlovic, 1990).

This construct has also been validated in India (Wig et al, 1987 a & b). In general, authors concluded that relatives being lower in EE was a major factor in explaining the better outcome of patients in North India (Leff et al, 1987). A vast amount of literature is available in this area for the interested reader (Jenkins & Karno, 1992; Lefley, 1992).

There is an increasing trend towards conceptualizing expressed emotion and family burden as interactive rather than unidirectional processes. The high EE communications are viewed as the relative's way of coping with the stress of disruptive, and often violent, patient behavior, which, in turn, exacerbate patient's symptoms and lead to the formation of a vicious cycle.

The growing acceptance of an interactive model between family stress and patient functioning has led to the development of educational / psychotherapeutic interventions. Various models and approaches to family treatment have been put forth. Prominent among these are the Crisis oriented family therapy approach of Goldstein et al (1978), Education, relatives' support group and family therapy of Leff et al (1985), Behavioral problem solving family management by Falloon et al (1985) and Family psychoeducation and survival skills by Hogarty et al (1986). Excellent reviews are available in this area (Lam, 1991; Strachan, 1986). These and other approaches share more commonalities than...
differences. They all emphasize the importance of educating the family members regarding the illness and its sequelae. The focus is on reducing the stress in the family environment and teaching family members a problem-focused coping approach. Lam (1991) identified seven common components:

(i) A positive approach and genuine working relationship between the mental health professional and the family. Relatives are respected as individuals with their own needs and their burden for caring for an individual with schizophrenia is acknowledged.

(ii) Provision of structure and stability. The course of a schizophrenic illness is a fluctuating one with a certain amount of unpredictability. Maintaining regular contact with the treating team provides some structure and stability to families. Relatives are taught how to maintain a moderate interpersonal distance with the patient and at the same time set appropriate limits.

(iii) Focus on improving coping with stress in the 'here and now' rather than dwelling on the past.

(iv) Strengthening interpersonal boundaries within the family. Problem behaviors disrupt the functioning of the family unit as a whole and weaken generational (parent-child) or interpersonal (marital alliance) boundaries.

(v) Through education regarding the biological nature of schizophrenia, an attempt is made to reduce the guilt of the family members and blame on the patient.

(vi) Behavioral techniques such as assessing strengths and liabilities and reinforcing successive approximations to desired behavior, and

(vii) Improving communication skills using rehearsal, feedback and practice to train families to express requests in clear, simple and specific ways.

While family based approaches are labor intensive, the interventions have been found to be cost effective when compared to inpatient hospital treatment (Cardin et al., 1986). Moreover, less frequent hospitalizations means less stigmatization for patient and family, less disruption in daily routine and enhanced self-esteem for the patient. However, the existing intervention packages serve to delay rather than to prevent relapse in the long term (Lam, 1991). More research is needed to focus on the active ingredients that make family intervention successful. Perhaps, as recommended by Tarrier et al. (1989), a model that necessitates working on a continual basis with families would be more effective.

III. COMMUNITY SETTING

In addition to individual and family focussed approaches, the treatment and management of chronic mental illness such as schizophrenia demands effective development and utilization of environmental resources. Restoration of social and vocational functioning is often limited by continuing deficits and refractory symptoms. Rehabilitation strategies are then aimed at helping the individual compensate for the disability by locating living and working environments that can accommodate to the residual deficits and symptoms. Community based care encompasses a variety of services including day care and residential care.

Day Care:

The term ‘day care’ in British psychiatry and the term ‘partial hospitalization’ in American literature are used synonymously (Rosie, 1987). In effect, they refer to ambulatory treatment programs that include psychiatric, psychosocial and prevocational treatment modalities designed for patients with severe mental illness. Such patients require a comprehensive and multidisciplinary treatment not provided in an outpatient or inpatient setting. Partial hospitalization may include day or night hospitalization depending on the needs of the individual patient. Day hospitalization / day care is the most common and will be dealt with briefly here.

Day hospitals and day care centers often refer to services, differing in location rather than function. While a day hospital is attached to a hospital setting, a day care center may be located in a psychiatric hospital, a general hospital, a community health center or be free standing. Usually, the former provide for more ‘acute’ short term care, while the latter provide a more supportive, long-term management and maintenance oriented service for the chronic patient.

When there is only one facility providing day care services, it must be remembered that the treatment and management of the two categories of patients differ. The ‘acute’ category is likely to comprise of patients who have been recently discharged from an inpatient setting, are still symptomatic, unable to manage on their own, but not requiring 24 hour treatment or supervision. The chronic category are symptomatically less acute and have greater long term social or vocational problems (Shepherd, 1991). Day care facilities
usually provide the full range of medical and psychosocial treatments including family interventions that have been outlined earlier. However, the emphasis is on providing a social setting that is not merely concerned with reduction of disability (such as skill deficits), but also concerned with management of social disadvantage or handicap. The idea of ‘normalization’ is concerned with reducing the stigma and providing a culturally valued means of living.

Work has traditionally been a source of social integration (Bachrach, 1991). Work, in a day care setting, is used to refer to any structured, purposeful and productive activity. Ideally there should be facilities for the assessment of work performance for training and preparation in vocational skills and placement in open or sheltered work settings. However, more often than not in the case of chronic mental illness, individuals may not be in a position to pursue competitive, paid employment. For such persons, sheltered work provided in the form of subcontract packing and assembly jobs are useful.

Yet another subset of patients may not be able to pursue any work related activity. Such patients still benefit from a setting where they can be engaged in social, leisure and recreational activities. They can be taught basic self-help skills or domestic living skills and provided a place to meet and be with people without necessarily having to make close relationships. Patients with chronic schizophrenia do better in a non-intrusive, non-demanding social environment with more object focussed activity such as occupational therapy, than intensive interpersonal stimulation such as group therapy (Linn et al, 1979). Day care settings, therefore, have the tough task of balancing adequate work oriented care and a non-threatening social environment.

Residential Care:

Residential care developed initially as a transitional facility from hospital to home. 'Half-way homes', as such facilities are known, are literally just that: an intermediary point between leaving the hospital and returning to the family. Such facilities usually have the array of both individual and family based interventions depending on the individual patient and needs of the family. While the individual focus is on developing and maintaining adequate self help and social skills for re-entering the community, the family is prepared to receive the patient, with an emphasis on psychoeducation and reduction of expressed emotions.

However, the emphasis in residential care today is on the development of a variety of facilities providing a continuum of different levels of residential support. At one end, there is a need for hostel-like facilities for well-functioning patients who are able to hold open or sheltered employment, but have minimal or no social support. Here, the emphasis is on providing shelter, a supportive environment and supervision of medication. In the West, the growing problem of homelessness has highlighted the paucity of such services.

At the other end, there is a need for residential care of a custodial nature for patients with predominantly deficit symptoms, and who respond poorly to both pharmacotherapy and / or psychosocial interventions. Such patients may require long term care with high levels of support even for activities of daily living, but do not need to be incarcerated in mental hospitals (Wing & Furlong, 1986). Such facilities are also needed because the burden of care is often too much for the families.

THE REHABILITATION TEAM

The vast array of interventions and the wide variety of settings in which these take place, obviously necessitates a team approach. Rehabilitation efforts are most successful when a multi-disciplinary team is involved comprising of psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses and occupational therapists. In addition to professional staff, rehabilitation involves active coordination and collaboration with family members, lay volunteers and nongovernmental organizations. Team work is also essential because not only does it reduce ‘burn out’ on the part of the care givers, but also reduces dependency on one therapist on the part of the patient.

ISSUES RELATED TO REHABILITATION IN INDIA

Rehabilitation in India is still in its infancy. Although, a rehabilitation sub-program, aimed at treating and maintaining psychiatric patients in the community, was envisaged in the National Mental Health Program (GOI, 1982), it could not be implemented due to a variety of reasons (Srinivasa Murthy, 1989). At the governmental level, policy makers have been unable to devote serious attention to the development of rehabilitation services for the chronic mentally ill primarily due to economic constraints. However, mental health professionals, themselves have to some extent, been complacent.
This has been partly due to the fact that psychoses, in general, and schizophrenia in particular, has been shown to run a more benign course in the developing countries including India (Leff et al, 1992; WHO, 1973 & 1979). As a result, the presence of family and social support is often taken for granted.

To make the spectrum of rehabilitation services a reality in India, mental health professionals will have to actively collaborate with the non-governmental sector. It is essential that we pool our expertise and knowledge base so that we make the optimal use of the available resources. There is a vast body of literature published in this area, both in the West and to some extent, in India, which can help us avoid the mistakes of the past and guide us in our future course of action.

Studies have shown that in India, families are more tolerant of deviant behavior and more willing to take care of the ill member (Bhatti et al, 1980; Wig et al, 1987). However, with increasing urbanization, life styles are undergoing rapid change. The nuclear family system and shrinking social networks combined with increasing financial strain is making it more difficult to care for an ill relative. Studies have documented that distress and burden of caring for an ill relative are high (Gopinath & Chaturvedi, 1992; Rao et al, 1988). This is true for both rural and urban families (Mubarak Ali & Bhatti, 1988).

Hospital based services are increasingly being made available, especially in general hospital settings. However, it is imperative that the non-governmental or voluntary sector be actively involved in the development of a network of community based services. There is an urgent need for more day care centers that can provide the much needed respite for the family (Rao et al, 1988) as well as make the individual patient feel less stigmatized and more valued.

Day care centers are the cornerstone of community care. In India, there is a need to emphasize vocational training in such centers, so that patients can relearn or retain in marketable skills (Nagawami et al, 1985). This is because, the patient may often be the sole breadwinner or is at least expected to supplement the family income. In the absence of any governmental support or disability payments, as in the West, this becomes all the more important. Even in more affluent countries, as in the United States of America, the emphasis is shifting from functioning as mere social or recreational centers to more skill oriented centers. The government and private sector need to be mobilized in this regard to provide sheltered employment or at least work opportunities in the form of subcontracting routine packing and assembly kind of jobs. Work, especially paid employment, is a major factor in enhancing self-esteem and facilitating normalization. The formation of advocacy groups would also help in this regard.

At the other end of the spectrum, we are faced with the reality that a certain percentage of patients are ‘non responders’ to treatment and run a downhill course. For such patients, we have to make provision for long term, residential care. It is essential that such services are not limited to the ‘haves’, but available to all those who most need it. The costs of schizophrenia are immense (Rupp & Keith, 1993). However, community care has been shown to be less expensive than hospitalization (Pai & Kapur, 1983, Wiersma et al, 1991) and psychosocial rehabilitation to be cost effective (Bond, 1984).

In planning and implementing services, one has to take care that they are socio-culturally relevant. Kapur (1992) has highlighted this aspect with special reference to family interventions in schizophrenia. Psychosocial interventions have to be geared to the individual needs of the patient and family, and here, the sociocultural diversity in India poses both a problem and a challenge. One should, therefore, exercise caution when using assessment and intervention techniques developed in the West and ensure, at the outset, their cross cultural validity and suitability. For example, in the assessment of social skills most Western tools emphasize interpersonal skills in the heterosexual context such as being able to ask a person out for a date which is culturally inappropriate for a majority of our patients. Similarly, the use of specialized interventions such as milieu therapy or care in therapeutic communities, whose value in patients with schizophrenia has been questioned even in the West (Morris, 1991), poses special problems in the Indian setting. For example, the attempts to minimize the social distance between staff and residents and the degree to which social interaction is encouraged may not be well received by patients and their families.

The essence of successful rehabilitation is the need to be innovative and ingenuous with whatever limited resources are available. They have to be individually tailored and socio-culturally appropriate.
CONCLUSION

"Rehabilitation consists of a long series of small steps, each depending on the success of the previous stage, but often with long periods in between during which little progress appears to be made. Benign social pressures need to be kept up throughout, because they prevent progress from being lost; Success is often measured by the fact that social disablement is not getting more marked" (Wing, 1982). In these words Wing has succinctly summed up the essence of what working in the area of rehabilitation entails.

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