Discussion, Conclusion and Recommendations
Discussions

Psychosocial rehabilitation is the universally accepted term which refers to social rehabilitation, involving cognitive and functional gains as well as the development of social skills that can be achieved for clients undertaking rehabilitation.

When most people hear the word ‘disability’ they almost always think of a physical disability. It is important for those affected by a mental illness to recognise that disability can be a consequence of any illness – a consequence that prevents someone from engaging with the world around them in a way taken for granted by the rest of the population. Many people experience some of the symptoms of a mental illness but are still able to work or enjoy an active life in the community. There are others however who are more severely affected by the illness, resulting in reduced quality of life and community participation. It is the disabling effects of a mental illness or psychiatric disorder that is the focus of psychosocial rehabilitation.

Symptoms such as panic attacks, mood swings, and episodes of psychosis, depression and anxiety are not just traumatic in
themselves but may result in the person struggling to maintain the basic skills required for daily living. The skills and confidence required for everyday communication, making decisions, planning, processing information, concentration, seeing a task through, maintaining relationships and self-care routines can all be eroded by both the illness and, importantly, the person's response to it. Combined with this can be the numbing or 'fogging' side-effects of medication used to treat the symptoms, affecting the person's ability to tune in to their environment and interact accordingly. For many this can result in a disengagement from usual activities, social contact and situations that seem to make too many demands.

The disability is compounded by the accompanying social withdrawal. It is generally more difficult to admit to psychological frailty than to a physical injury or poor physical health.

It is therefore very important to educate the community about mental illness and to work with individuals to help them recognize that mental illness is not something to deny or retreat from, but is a common condition that can be treated and managed. The coordination of
clinical treatment and psychosocial support services is crucial to
achieving this outcome.
**What do we mean by psychosocial rehabilitation?**

Psychosocial rehabilitation has received increasing attention over the past ten years, during the period that ‘care in the community’ has become the norm for people affected by mental illness (Anthony, 1996; Barton, 1999). An important potential benefit of psychosocial rehabilitation suggested by these studies is a reduction in the frequency and severity of symptoms and improved quality-of-life.

The most accepted definition of psychosocial rehabilitation is from Cnaan et al:

> The process of facilitating an individual’s restoration to an optimal level of independent functioning in the community . . . psychosocial rehabilitation encourages people to participate actively with others in the attainment of mental health and social competence goals. [Cnaan et al, 1998]

This process has been codified by Cnaan and others (1990) in a set of principles recognised by the International Association for Psychological Rehabilitation Services (IAPRS). These include:
**IAPRS Principles of Psychosocial Rehabilitation**

- Recognition of under-utilisation of human capacity.
- Equipping people with skills.
- People have a right to and responsibility for self-determination.
- Services should be provided in as normalised environment as possible.
- Differential needs and care.
- Commitment from staff members.
- Care is provided in an intimate environment without authoritative shields and barriers.
- Early intervention
- Environmental change.
- Work-centred process.
- Emphasis on social rather than medical model of care.
- Emphasis on the here-and-now rather than problems from the past.
This rehabilitation process has three stages: assessment, planning and intervention – with a focus on the particular individual’s needs at each part of the process (Anthony & Liberman, 1986).
Importance of psychosocial rehabilitation

Being able to take some control over one’s symptoms and having the confidence to set goals, plan ahead and develop skills is a key factor in the process of rehabilitation and, for many, the start of the process of recovery. It is important that this taking control can extend to the rest of the person’s life, and central to this is having somewhere to go to in the wider community that supports people to make these steps in a safe non-judgmental setting. This is very much the role of psychosocial rehabilitation services.

Many people who have experienced a mental illness will talk of the loneliness, isolation, loss of meaningful relationships and disconnection from the community they feel.

Recovery cannot take place in a vacuum. In addition to clinical treatment, it is crucial that there is also somewhere to go in the day, to feel welcome and included, to be part of a community, to learn new skills, to assist and share experiences with others and contribute and to feel valued. There is no motivation to learn new skills, whether they be cooking or computers, if someone’s days are empty and
friendless. Alcohol and daytime TV can easily be used as a form of anaesthetic to numb the depressing reality of the situation. We all need to feel part of a group, but if someone’s sole social activity is a weekly barbeque, this is not helping the person to lead a more fulfilling life in the wider community.

An obvious but sometimes forgotten benefit of having somewhere to go in the day is that it quite simply fills up the time. To have endless empty days stretching ahead can be very stressful. One’s thoughts and sense of identity inevitably revolve around the past and it becomes increasingly difficult to have either the motivation and confidence to think of the future, or plan ahead for it.

The findings of the present study indicate that majority of the clients attending a psychosocial rehabilitation programme suffer from mental illnesses like schizophrenia. Almost 6 out of every ten people suffering from mental illnesses had schizophrenia according to the study.
The present age of most of the clients is 31-35 years and 41-45 years which indicates that the illness is long term. Almost 80% of the clients studied attending the rehabilitation programme were within the ages 41-45 years.

It was observed that more number of males compared to females come to attend the rehabilitation programme.

It was found that most clients with a mental illness attending a rehabilitation programme were educated up to the secondary level (10\textsuperscript{th} standard) which indicates that due to the illness they could not pursue their studies. Only 1% of the clients were illiterate.

Most clients were single which shows that either there were active symptoms during marriageable age or the clients were idle and did not have a career.

Most clients had an early onset as the age of getting the illness in 21% cases each was 16-20 years or 20-25 years. Almost 92% of the
clients had an onset before the age of 35 years. Only 1% had a late onset at 46-50 years.

Of the 102 clients interviewed it was clear that most people with a mental illness experienced mood swings followed by fear followed by auditory hallucinations, followed by bizarre thoughts. These are positive symptoms experienced by individuals suffering from Schizophrenia.

It was found that in most individuals diagnosed with mental illness, treatment started with pharmacological therapy (oral or injectable medicines) in an OPD set up.

Most people with a mental illness have been administered ECTs along with medications as a form of therapy to cure the symptoms.

It was found that most people seeking treatment visited a faith healer as an alternative form of therapy.
In spite of visiting a faith healer and seeking pharmacological treatment the positive symptoms reduced somewhat in 60% of the clients.

But almost 93% of the clients felt the improvement in symptoms was due to pharmacological interventions.

Almost 40% of clients felt there were no negative symptoms following pharmacological therapy. Approximately 26% of the clients felt they observed negative symptoms while the remaining 34% felt there were some negative symptoms which indicates that negative symptoms are difficult to treat with only medicines.

The negative symptoms observed in most clients were social withdrawal, followed by sleep disturbances, followed by lack of interest in activities once enjoyed, followed by difficulty in expressing self, followed by lack of motivation followed by poor interpersonal relationships, followed by lack of personal care, followed by impoverished speech, followed by appetite disturbances.
Most of the clients were referred for rehabilitation to a half way home followed by day care centre, followed by only counseling, followed by only occupational therapy. 

Most of the clients were referred for rehabilitation by their psychiatrist, followed by psychiatric social worker. Some clients read about the rehabilitation services through mass media.

The findings indicate that most people felt that rehabilitation would help to keep the clients occupied, followed by some (42.2%) who felt it would enhance their job prospects, followed by some (40.2%) who felt it would enhance their social skills.

Most clients started rehabilitation at ages 31-35 years. As the age increased the percentage of those starting rehabilitation reduced. Similarly only 2% started rehabilitation at a very early age (< 15 years). It is assumed that the illness has an early onset (almost 59% before the age of 25 years) and by the time the medicines are administered and the clients shows some improvement he/she crosses the age of 30 years. Probably it is only then is he/she fit to undergo structured programme like psychosocial rehabilitation.
Most clients undergo various alternative therapies in a structured rehabilitation programme. Most clients it was found undertook yoga, followed by individual counseling, followed by group therapy, followed by educational activities, followed by vocational activities, followed by music therapy, followed by recreational activities, followed by dance therapy, followed by art/craft therapy, followed by kitchen skills, followed by occupational therapy, followed by animal assisted therapy.

It was found that most clients enjoyed recreational activities and group activities which shows that when put in a similar group they shed their negative feelings and bond with others over a period of time.

Most clients attending the rehabilitation programme reported to have benefited significantly from the programme.

The obvious benefits of rehabilitation, it was reported by maximum number of clients was that there was improvement in personal hygiene, followed by improvement in sleep, followed by reduced
irritability and anger spurts, followed by reduction in time while using the toilet, taking bath, dressing etc., followed by improvement in concentration, attention and motivation, followed by improvement in body language that includes eye-to-eye contact, facial expressions, posture, etc., followed by ease at understanding simple instructions and ability to do household tasks as and when assigned, followed by enhanced motor skills like writing, walking etc., followed by reduced medication, followed by enhanced conversational skills like initiativeness to talk, spontaneity, reaction time etc., followed by enhanced interpersonal relations, followed by improvement in linguistic skills and numerical skills, followed by ease with traveling independently, followed by ability to express positive emotions with ease and spontaneity, followed by relative ease at handling simple tasks like finding an address, handling money, running errands, ability to handle bank or post office work etc.

It was also found in the study that the clients did other things such as household chores, studying further and working part time besides attending the rehabilitation programme.
The study results also identified other services such as job placement that would benefit the clients after attending the rehabilitation programme.

Another very important finding of the study says that most clients did not experience a relapse after attending a rehabilitation programme.

Most clients it was found were under partial remission (almost recovered).
Conclusion

The objective of the study was to investigate the positive impact of psychosocial rehabilitation following pharmacological treatment which has been achieved. The positive impact is that first and foremost most clients did not experience a relapse following a rehabilitation programme. Secondly functional recovery has been achieved due to psychosocial rehabilitation which has helped in treatment of negative symptoms (appetite and sleep disturbances, social withdrawal, lack of motivation, impoverished speech, flat affect, poor interpersonal relationships, difficulty in expressing self, loss of interest in activities once enjoyed, lack of personal care, taking too long to do activities of daily living such as bathing, cleaning, etc.), where pharmacological treatment has limitations. Anti psychotic drugs are often effective in certain symptoms of schizophrenia and other mental illnesses, particularly hallucinations and delusions; unfortunately the drugs may not be as helpful with other symptoms, such as reduced motivation and emotional expressiveness.

The various factors which have influenced functional recovery include age of onset of the illness, gender of the clients, regularity in attending the rehabilitation programme, age of starting rehabilitation,
activities undertaken in rehabilitation, activities enjoyed and prevention of relapse.
The benefits of psychosocial rehabilitation as seen in this study:

Apart from potential symptom-related outcomes, people who attend rehabilitation programs report that a principal benefit is the opportunity to meet others and do things socially, overcoming the painful isolation and loneliness experienced.

Potential benefits of psychosocial rehabilitation as seen in this study include:

- Skills development – such as budgeting, self-care, communication and vocational skills
- Improved general health – including better diet, reduced substance abuse and general fitness
- Improved confidence – boosting of self-esteem and social competence through development of new skills or re-learning old skills
• Social networks - development of new friendships for ongoing social support

• Increased opportunities to return to work or study.

There are also potential cost efficiencies to government. A study undertaken by the University of South Australia and SANE Australia (Ireland & Morgan, 1996) found that regularly accessing a psychosocial rehabilitation program was associated with reduced demand for clinical services, thus reducing the total health service costs. This has also been proved in this study that clients undertaking social rehabilitation have lesser chances of relapse.

Families also benefit from sharing the caring. Attendance at a rehabilitation program often allows relatives and friends a break from their supporting role, giving them time to pursue their own interests (Greenberg, Greenley & Brown, 1997). By supporting and sustaining the caring relationship, rehabilitation programs benefit family and other carers as well as the person with the illness.
Another important benefit is improved understanding of mental illness by the general community. The more people meet and mix with others who have a mental illness, the quicker they will realise the absurdity of the false stereotypes promoted by the media, hopefully contributing to a more tolerant and inclusive society. Psychosocial rehabilitation programs which link with existing services such as Neighbourhood Houses and Leisure Centres and support people to access mainstream clubs and groups, are not only assisting people to connect with their local community but are also helping to educate its members. Personal contact is likely to facilitate positive and less s

Although not evenly spread throughout India, many psychosocial rehabilitation services are able to provide a range of services that encourage participation and personal development for the individuals attending. It is the supportive environment that combines peer support, skills development and structure that fosters an atmosphere of recovery.
Recommendations

Recovery, in the context of mental health, is a term developed at the Boston University Centre for Psychosocial Rehabilitation. As Deegan (1988), Lamb (1994) and others emphasise, recovery does not mean being symptom-free or cured, but refers to a process of accepting, adapting and moving on to make a new life for oneself.

It is important to make the distinction between rehabilitation and recovery.

Rehabilitation refers to the services and technologies that are made available to disabled persons so that they might learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of disability (Deegan 1988).

“Recovery involves a process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from one’s disability and then rebuilding a life in the broader community despite or within the limitations imposed by that disability.” (Davidson, 2003).
Rehabilitation services must provide the right environment for recovery to occur. A key component is the importance of being able to take control of one’s life, to have a positive sense of personal identity whilst accepting the illness will not be cured but can be managed. It is in this context that the term ‘moving on’ could be misleading. It may not be possible to leave the illness or trauma totally behind, but it may well be possible to ‘move with’ some of the symptoms or disabling features and ‘rebuild a life in the broader community’. If someone believes they have to be symptom-free to experience a sense of recovery they may be setting themselves an unrealistic goal – but to accept that some of the symptoms can co-exist with recovery promotes an attitude of not so much ‘moving on’ but ‘moving with’.

The more that rehabilitation services provide a supportive environment that promotes the following features, the more likely it is that a sense of self worth and recovery will develop.
Positive factors in recovery (Davidson, 2004)

- A sense of belonging and acceptance from caring others
- Renewed hope and commitment
- Involvement in meaningful activities in the community
- Redefining the illness as only one aspect of a multidimensional sense of self (rather than having my self and life defined by the illness)
- Finding ways to manage the symptoms and impairments associated with the illness
- Experiencing successes and pleasure
- Giving back to, and regaining citizenship in, the broader community.
Not only do the individuals with a mental illness need to make adjustments to live a more meaningful life, so some of the services need to build 'ramps' between their programs and local community resources. Once someone has come to terms with their mental illness and is at a point where they can engage in the community, it is important that mainstream community groups are accessible to them. Education of these services to the needs of people with a mental illness is an important component in the grafting of specialist support into mainstream services.

Not everyone travels smoothly in one direction during the process of recovery, and support and treatment will need to be sensitive to varying demands over time. Withdrawal from or a change in medication, an increase in stressors, or just the course of the illness, will mean that many find they have relapsed and are struggling with the symptoms of the illness again. The severity of the relapse, the person's ability to cope with it, the support of friends and family and the support services available will all influence the outcome. For many each relapse is less traumatic as they learn how to recognise the early warning signs and take prompt action, whether this be
taking a short break, increased visits to the doctor, peer support or rehabilitation program.

Psychosocial rehabilitation services can play a key role in the process of recovery but should be part of a longer journey that moves people from disability to meaningful participation and inclusion in society.

A comprehensive system of counselling, education, peer support, clinical treatment, therapeutic interventions, information and support to carers, and rehabilitation programs all play a significant part in the individual’s recovery to a level of optimal functioning in the community. There needs to be a responsive system of treatment and support, acknowledging that the illness is one part of the person’s life not the only focus of it.
**Life Skills Manual based on the findings in this study:**

Major mental illness is associated with a constellation of signs and symptoms such as hallucinations, delusions, thought disorder, anxiety, depression etc. People recovering from these disorders also experience difficulties in discharging the responsibilities associated with adult role functioning. The broad areas of psychiatric disability include:

- Personal Disability
- Disability in the family role
- Social Disability
- Occupational Disability

This manual will focus on some aspects of Disability in Activities of daily living (ADL)

The daily routine of a person is largely influenced by the gender, background, education, social class, living conditions, choice and personal preference etc. Every household will follow some sort of a routine, and therefore the term ADL is used to refer to those activities and behaviours that one has to carry out on a daily basis as part of overall routine of one’s household and includes tasks for survival maintaining good physical health and a reasonable quality of life.
Outlined below are three groups of activities that can be considered as part of an ongoing routine in most families in India:

1. Household Tasks such as making a bed, washing and maintaining clothes neatly, cutting vegetables, dusting, sweeping the house, maintaining a clean living space, washing utensils, fetching water or helping store water, garbage disposal etc.

2. Basic Cooking Skills such as learning to light the stove, heating milk and making a cup of tea or coffee, making a simple breakfast, cooking a simple meal etc.

3. Outdoor Tasks for Independent Living such as shopping for household requirements, using public transport, using the phone, paying electricity or telephone bills, accessing public services like railway booking or post office work, using bank facilities, accessing medical services etc.
**The Training Module:**

The living skills training starts after the clarification of illness history, the skills’ assessment and the behavioral analysis. The initial education and the training procedures depend on the information gathered through the interview of the client, the family members and the assessments.

This part of the training includes the basic education to the family members and the immediate dealing of the most problematic behaviours. The education is essential to make the family members get involved in the training. This is taken care by the psychoeducation.

Initially the family members have to be told about the illness and the effectiveness of this training. This is mainly to motivate the members and to make them accept the fact that the individual can become self-sufficient to an extent. Then they are explained about the basic principles of learning. This is done by using many examples and anecdotes. The concept of positive reinforcers making the frequency of certain behaviours high and stable, and negative reinforcers,
making the frequency come down. This is to be explained and demonstrated to the family members. They should be made to understand why the complex execution of the target behaviours have to be broken into small units. The family members also should be given adequate encouragements to take an active role in this regime of behaviour modification. Also they should be instructed to keep a behavioural diary as suggested in the appendix. Once this has started then the individual can be initiated into the training programme.

1. **Motivation Enhancement Training**

This is the primary focus of the training. This proceeds on two levels. One for the client and the other level for the family members.

Objectives:

With the client
- to motivate the client to participate in the training process
- to motivate the client to keep a regular timing in attending the training programme.
- To motivate the client to have a belief in the training.
- To motivate the client to start a new schedule in daily life
To motivate the client to understand the positive changes that would come from this training programme.

With the family
- motivation for the need of the training
- motivation to have patience and perseverance
- motivation to actively participate and to become part of the training process to make it effective

Procedure:
- to share the responsibility of the home based training process with all the members so that everyone in the family participates which in turn increases the frequency of contact between the client and the family thereby reducing any expressed emotions and enhancing the quality of interaction.

The focus of this motivation enhancement would be through many examples and quoting results from the various studies. The teaching of learning principles and the procedures of behavior modification should be through interactive classes with the family members. A close monitoring is essential in the initial stages to
see whether the family members are following the suggestions in its exactness. This is required for two reasons, i.e., to demonstrate the changes that are brought about by the training and secondly to make them understand that it is a slow process but effective. This becomes crucial because if they are not doing it properly then the training would be ineffective and the members lose the interest in the training. This would be an obstacle in the continuation of the training programme itself.

Process

- identification and charting out the units of behaviours that are to be learned by the client.

- Identification and charting out a schedule of activities from the morning till night for the client.

- Identification and charting out a schedule of reinforcements (material and verbal)

- Constant verbal suggestions and encouragement and promptings for the successive approximation of the units of behaviours charted out.

- Accessibility of the therapist to the family and the client.
- Active physical and verbal promptings.
- Usage of reinforcements at the appropriate time in the training process.

Once the learning process starts and you find an interest in the client then slowly the material reinforcers should be withdrawn and the verbal and social reinforcers can be introduced. The primary or the material reinforcers are used only when new units of behaviors are taken up. After the usage of verbal and social reinforcers the concept of token economy is introduced in a graded manner. This would constitute the final phase of training in the motivation enhancement training.

**II Attention Enhancement Training**

This training can be done either in a group or in an individual setting.

Objectives:
- to enhance the ability to focus the attention.
- To enhance the attention span
- To enhance the observational ability
- To increase the quality of perceptual ability
- To enhance the attention and grasping ability in communication.
- To deal with silences and become more attentive to the environment.

Procedures:
- Client to be silent while the therapist points to various objects in the room and says the name of the object loudly followed by the client repeating the word and pointing to the object.
- Client is made to follow or mirror the movements with the therapist, eg: hand stretching, hand moving in a circle, hands stretched out and exaggerated leg movements to the side.
- Asking very direct questions to the client from a prepared list, eg: naming objects and people's name, counting loudly with the fingers, counting one's own fingers one by one and saying out loud the names of family members.
- Sorting out particular coloured beads from a group of beads, eg: fifty of yellow beads and hundred of red ones. Here, there
is initially no time limit but the therapist can encourage the client to do it as quickly as possible.

- Sorting out coloured cards from a jumbled group of differently coloured cards. The cards should be brightly coloured and should catch the attention of the client. Fifty of one colour and hundred of multi coloured cards can be used.

- Imitating the therapist in the body movements that portrays the various greeting messages that are suitable for the client's environment. As the movement is executed the verbal message also should be said out loud, like 'namaste', 'handshake ' with the appropriate greeting.

- For very short duration make the client look at the flame of a big candle in silence. The therapist has to model this first. The time durations can be anywhere between one minute to a maximum of two minutes. This helps in the focusing the attention. In the initial stages the time can be just few seconds, as long as the attention of the client lasts.

- Keeping the educational background of the client, give homework assignments like simple arithmetic in a homework book. This exercise can start from simple drawings to complex
figures, arithmetic and then to words and sentences. The client can also be asked to maintain a daily recording diary or write news headlines.

Process:
Each of the procedures should be taken for eight days maximum and then another exercise should be taken up. If the previous one is not learned, it should be taken up again until mastered. This is to maintain the interest, motivation and anticipation in the programme.
The motivation in the client should be generated by the verbal and non verbal attitude of the therapist.
Each session is taken up with the explanation of the rationale, the benefits and how it is going to help the client in the everyday life. These are explained through examples from daily life situations and by quoting others in the family performing them effectively. Using therapist as an example can be quite effective in making the client grasp the point.
The procedures used in this module are imitation, prompting (physical and verbal), demonstrations, reinforcements and modeling.

A continuous involvement should be ensured from the client. This can be effectively achieved by selecting themes and narrating it to the client each day, moulded into a thematic story.

**III Verbal Communication Training**

This module can be conducted in a group or with an individual.

Objectives:

- to make a meaningful conversation.
- To understand the essentials of a social conversation
- To have a socially appropriate, continuous conversation
- For the clear diction of the words.
- For an adequate expression and reception of messages

Procedures:

- ask the client to say simple words after the therapist. This can start off with simple and then slowly proceed on to complex words and sentences. The words should be ones that the client
has to use in the daily life. Attention is given for the diction and the pronunciation of the words.

- Greeting skills with the appropriate expressions are taught and encouraged to use them outside the session with the family members, eg: like the common greetings from the natural environment of the client.

- Picking simple themes and holding a two way conversation with the client. Feedback should be given as suggestions after every role rehearsal, eg, themes like asking for something at home with the elders, with peers and with younger ones, going to a shop to buy a particular thing, commuting in a city transport bus, meeting somebody new, interacting in a group. These themes are prepared by the therapist before each session keeping in mind the need of that particular individual.

- A warm, accepting, non judgemental and a positive attitude be shown by the therapist.

Process :
- this entire module is taken up through verbal teaching, prompting and role plays. The role plays include both role
rehearsals and role reversals. Elements of theatrical dramatics can be included in this, like exaggerated movements and actions accompanying the verbalization.

- Parts of conversing effectively should be taken up in the home as part of the home based training program. They have to show a very positive reaction to the client and encouragement should be given. The appropriate use of reinforcements are of crucial importance here. The therapist can give small homework to the client, eg: ask client to learn about a certain topic and come back the next session and give a small description about it. These topics should be of interest to the client, like asking to describe the activities performed the previous day.

**IV Affective Re-training**

Can be conducted in a group or in an individual session.

Objectives:

- for the expression of adaptive emotions in a socially appropriate manner.
- For the appropriate expression of negative feelings like anger etc in a socially appropriate manner.

- to have the experience of emotions along with suitable facial and bodily expressions.

- For the recognition and acceptance of emotions and to cope with intense emotions.

- To have a control over the facial expressions in various situations.

- To understand the various emotions expressed by others and to react in an appropriate manner.

Procedures:

- the client should be taught what the different emotions are and how they are overtly expressed, i.e., through role play sessions, and modeling. The commonly experienced emotions like anger, happiness, sadness are demonstrated by the therapist. This is for the client to understand the concept of emotions and their expressions.

- Select one specific theme or a situation from the clients environment which has a specific emotion and this can be
enacted out with conversations and the emotion. Feedback coupled with reinforcements can be used in guiding the client.

- Clarify with the client how in general, the commonly felt emotions are expressed out and keeping this as a cue can bring in modifications to the expressiveness.

- Using a mirror the various aspects of facial expressions are taken up and rehearsed along with the therapist so that the client comes to identify each emotion and their facial expressions.

- Training the client's body language in the expression of emotions. The gestures, postures and the different verbalizations are taken up and role modelled.

- Encouraging the client to be free in expressing the emotions felt the previous day, how it was dealt with and how best it can be modified if there is a need. Home work assignments like noting down the different emotions he/she could notice from the family members and discussing them in the session, asking the family members to encourage the client to express the emotions to them (both positive and negative emotions)
- Taking up various situations that the client can come across in the everyday situations and having role play sessions with the emphasis on the emotional content and how best they can be expressed out. In the role play sessions the participation of the family members are also encouraged to make the sessions as natural as possible. Elements of Psychodrama can be incorporated into the role play modules.

Process:
- the different training procedures adopted in this module would be differential reinforcement techniques, modeling feedback, imitation, discussions, home work assignments, lecture classes about specific themes and situations, elements of psychodrama and structured role plays. The themes for the role plays have to be fixed by the therapist prior to every session and the home work assignments have to be a follow up of the content of that day's session.
- The role play sessions should have the therapist taking the lead role, encouraging the client's involvement in it and a proper modeling of the various expression of emotions. The sessions.
can have more than one person as co-therapist. The themes for the session should be selected and the parameters should be fixed by the therapist. This is essential for the effectiveness of the sessions. The aim is to keep the interest alive for the client and for an effective learning to take place. There should be adequate time given for overlearning to take place as this has to be tried out in the natural environment and the client should get a feeling of competence.

V Living Skills Training / Social Skills Training

Objectives:

- to make the client adequate in the various social behaviours
- to make the client efficient in the greeting and conversational behaviours, with socially appropriate body language.
- in initiating and continuing a conversation.
- in the various socio-behavioural interactional patterns with elders, peers, youngsters, with strangers, with colleagues and in the presentation of the self in an assertive manner.
- in effectively performing social roles like a productive, and an independent individual within the family.
- Encouraging the client to take up an interest or a hobby as part of the leisure time activities.

Procedures:

- In this module initially certain topics are chosen to be taken up for discussions and didactic classes. These topics can be about trust and trusting, concept of hope and positiveness of the future life, questioning and emphasizing points in a conversation, thanking behaviours and anticipation of social consequences. These topics are to be discussed with plenty of examples from the client's natural environment and examples from the people that he/she comes into contact frequently. These aspects are taken up with the family members in sessions. They are encouraged to have role rehearsals at home as part of the home based training program. If the therapist feels that the client is able to comprehend, then the concept of 'self' and 'self esteem' are taken up as topics of discussion. The importance of presentation of the self in everyday life situations and its consequences is also taken up. The
need and the consequences of being productive and contributing to the efficient functioning of the family.

- Everyday situations like crossing the road, commuting in city buses, handling small amount of money, getting used to the concept of drawing salary at the end of the month. This is essential as the client has to be weaned away from the immediate reinforcements and should understand the idea of delayed gratification.

- Encouragement is given to the client to take up some leisure time activities like, doing some household activities, gardening, taking up picture card collection etc. Family members are also counseled on this and encouragement should be given to the client from that quarter also.

Process:

A list is made of all the various topics to be discussed. Constructs like the ‘self’ are to be taken up with a lot of examples and taught through role play sessions. If the training process has been going effectively and adequate rapport is present, this itself would serve as the motivating factor for the client to participate in
the didactic classes. It is in this module that an overall training or a recapitulation can be done to find out which are the areas in which the client needs further training.

**VI Problem Solving Skills Training**

Objectives:

- to face the every day hassles and find solutions for them in an adequate manner.
- To anticipate obstacles and problems in life, to perceive them adequately, to find the various alternative solutions and to effectively implement them.
- To take simple decisions and anticipate the consequences
- To take suggestions when faced with problems from the family members and can have a meaningful interaction with the client
- To effectively implement the solution for a problem
- To develop healthy, positive and effective coping strategies in the future life, anticipating difficulties that can come up.
- To have positive relationships with colleagues after the client is placed in a working atmosphere
- To anticipate certain difficulties because of the illness in the working situation and also the negative consequences that can come up from the colleagues due to the label of the illness.

Procedure:
- Encourage the client to identify the problems that are faced and to talk it out with the therapist and the family members.
- Encouraging the client to think of the various solutions to a problem and to find the practicality of them. This is achieved by taking up concrete examples from the client’s environment.
- To start thinking about problems and to anticipate more in the future life.
- The important steps to be taught to the client are: a) defining a problem: this would include as to how to identify a problem and to find out the nature and the intensity of the problem and b) defining the goal: in this, the issues discussed would be the probable solutions to the problem, the methods of reaching the goal and the kind of behaviours and interactions the client will have to adopt in reaching the solution.
- Encourage the client to break down the problem into simple elements so that the problem perception becomes clear and finding the solution becomes easier.

- How to give self reinforcements and to feel positive after a problem is tackled effectively by the client. The method of "self pat".

- Involving family members to encourage, stimulate and guide the client in the method adopted by the client in the problem solving skills.

Process:

- Points to be kept in mind in a stepwise manner which the client has to rehearse along with the therapist according to Wasik, 1984, would be:

  Problem identification
  Goal selection
  Generation of alternatives
  Consideration of consequences
  Deciding
  Implementation and
Evaluation

- through role plays the method of discrimination of solutions and the selection of one of them are taken up

- if the implementation becomes negative, how to cope with failures, how the self image has to be kept positive and how to tackle the problems are taught. In this aspect using positive imageries and physical exercises are taken up. Relaxed morning walks and a schedule of body warming exercises can be taught to the client.

- Visual imageries should be ones that are easily comprehensible by the client and they should reflect the client’s environment.

The imageries can be given as homework assignments to be covertly imagined for 4-5 minutes everyday. There should be at least five positive imageries listed after consultation with the client, eg: the client doing some work and everyone appreciating him, receiving encouragements and reinforcements leading to a positive image in the social environment from which he/she hails.

- taking up examples of problems that have been faced by the client and that which can occur in his environment, and
developing methods of effective coping strategies so that the client understands the processes of taking up a problem and finding solutions.

- Cognitive restructuring on certain aspects can be taken up in this module. They can be how normal the client is and that he/she is no different from others, how effective the client can become in everyday life situations, and how to cope up with negative consequences or negative cognitions. Challenging negative cognitions by logically looking at all aspects of the problem is one effective method to prepare the client for his/her future life.

- The physical exercises taught to the client can be parts of the progressive muscular relaxation techniques, body warming steps, walking, some elements of yoga and elements of breathing exercises.
Note:

After training in these modules, a post assessment should be done using the living skills assessment schedule. This will demonstrate the effectiveness of the training and also if there is a need to have more of the training in any specific area. A detailed clinical interview is conducted to get information on family functioning. If there is any deficit in any area it has to be tackled.

If the training is effective, then a follow-up schedule should be drawn up with the client as well as the family members so that booster training sessions can be given.

Booster Sessions

After the active part of the training is over, a regular follow-up is essential. In each of the follow-up session, a detailed clinical assessment is done with the client and with the family members. If the interview reveals any deterioration in any of the areas, then booster sessions have to be conducted. These would be intense, focussed and would be conducted for a maximum of 5-6 sessions. Encouragement and supportive work is done with the family so that the home based training is made effective.
Another area that has to be looked into is the drug compliance of the client. If the compliance is poor or if there are any indications of a relapse, then those issues are to be tackled.

The important fact to be taken into consideration is the quality of interaction between the client and the family members. If there are any aberrations in that, then a joint family session can be conducted. The family has to be told about the importance of quality interaction with the client and how much it can be of help to the rehabilitative process.