CHAPTER 2

REVIEW OF LITERATURE

The research in schizophrenia has over the years branched out to incorporate various aspects related to the field. This chapter is an attempt to look at the various studies that have contributed to the knowledge on several concepts of the present study. The review of these studies will help to understand the existing concepts and gaps in the literature. The focus of this chapter is to understand the different types of studies that have taken place in identifying the life of people living with schizophrenia. It tries to cover research works on various aspects of living with schizophrenia, participation of PLS in the community, and QOL. Earlier studies did not give importance to the perception of people living with schizophrenia regarding their life. Therefore, in the present chapter first person accounts of people living with schizophrenia were the first to review. This helped in capturing the experience of living with schizophrenia from their perspective. Indian studies have less contribution in first person accounts on living with schizophrenia. Review of literature is divided into two sections. First section deals with studies on concepts of the present study and second section deals with methodology. Studies related to concepts of the present research work are categorized into four; living with schizophrenia, psychosocial rehabilitation, participation in the community, and quality of life of people living with schizophrenia. Studies on methodology include qualitative approach and ethnography.

Living with Schizophrenia

This section deals with various studies on first person account, emotional responses of PLS, social exclusion, work, medication issues, recovery and functioning of people living with schizophrenia. The idea of understanding the process of schizophrenia from the perspective of people living with schizophrenia attained significance a few decades back. The realization that it is important to know the perspective of people living with schizophrenia about their state of life paved way for this understanding. Sue E. Estroff (1989) attempted to understand the concepts of personhood and subjectivity in person living with schizophrenia. The questions he raised were who existed before the illness,
what they endured during the illness, and who they became after illness. This study was an attempt to contribute a methodological viability in studying subjective aspects of self and schizophrenia. He believed that daily experiences of success and failure, medication, symptoms, and responses from others will influence participants’ perception. Estroff found that there is an inconsistency in the explanations given by psychiatrists and patients, and relatives and patients. The question of identity after the onset of schizophrenia raised many concerns. Author pointed that this question led to the need for studying the processes and experience of change, loss, and persistence of self accompanying schizophrenia (Estroff 1989). The relevance of this study is the importance given to identifying the voice of people living with schizophrenia.

An article written by an Anonymous (1990) a person living with schizophrenia shared her experience of living with schizophrenia. Author recollected the onset of schizophrenia and its course. Though, she was able to function very slowly and with lots of effort, she turned silent and withdrawn. However, her ability to study and write was not affected by schizophrenia. This was during the initial years of illness, later when delusions aggravated she failed to function and was eventually hospitalised. Family support, care, and medication helped her to preserve daily functioning. After second episode she did a small research on her own so she was able to understand what her illness was all about. She was able to get back to her work which she did not quit and attended college on part time basis. Using different aids such as family, friends, relatives, living theatre, church, work, and college she fought delusions. This network enabled her to accept herself and also gave courage to fight schizophrenia. This article encompasses the experience of living with schizophrenia. It points at the need for understanding the individual experiences of schizophrenia and also the relevance of supportive network in facing the challenges of schizophrenia.

Ruocchio (1997) says that no one can understand the inner chaos of a person living with schizophrenia. In schizophrenia individual is afraid of her/his own mind which torments the person during the psychotic episodes. An outsider will not be able to see the inner turmoil of the person living with schizophrenia, but the manifestation of schizophrenia. It is not possible for the individual to control what to convey and what not.
The only possibility is to share these experiences with those people who can understand. Sometimes it becomes difficult to fight and has to fall completely into the psychosis. In understanding schizophrenia one needs to know what mind thinks. The individual has to travel with it to the darkest alleys it goes and communicate it to the world. The two realities of external and internal world are difficult to explain. It is easier for the person to accept the inner reality than the external one. The article is an eye opener for practitioners on what really happens inside a person living with schizophrenia. It also justifies the stand that it is always better to get the first person account of living with schizophrenia.

Clafferty et al. (2001) dealt with the issues psychiatrists have to face while telling diagnosis to people living with schizophrenia. The study was conducted among psychiatrists in Scotland. The study results showed that telling diagnosis to people living with mood disorder was not a problem. In case of people living with schizophrenia there were two responses. 59 percent of psychiatrist told the diagnosis in the first episode whereas 89 percent told when the episodes recurred. The psychiatrist reported that they used different names along with schizophrenia while informing the diagnosis to people living with schizophrenia. Most of the psychiatrist used the terms schizophrenia, or psychosis, or psychotic illness, or major mental illness, or mental breakdown. Majority of the respondents of the study was of the opinion that the psychiatrist with other staff is the right person to tell the diagnosis. Authors also suggested taking care of the risks while communicating the diagnosis to the individual. Article shows the dilemma in conveying the diagnosis to people living with schizophrenia.

Blarkom (2006) in his article explains the relevance of person centered approach in schizophrenia. Schizophrenia is a time bound illness, it gradually develops over time. The concept of empathy gained attention in the field of psychiatry when the need of a more in depth understanding of the illness experience emerged. The last two decades saw the changing attitudes of psychiatrist to understand the subjective experience of people living with schizophrenia. This idea was further strengthened by researchers insisting that the perception of person living with schizophrenia is influenced by the illness, their individuality, and culture they live in. They also underlined the relevance of human
suffering and pain experienced by the person living with schizophrenia than symptoms and other aspects of illness. The drawback of person centered approach was its denial to recognize schizophrenia as an illness. It is necessary to understand the process of illness to recognize the individual’s experience on suffering. More anthropological studies are essential to understand the process of individual’s experience in order to get a comprehensive picture on living with schizophrenia.

Kring (1999) deals with emotions and emotional changes in people living with schizophrenia. In their opinion PLS do have strong emotions, but some are unable to express it. Earlier psychological theorist also observed this, but studies were limited to reach a conclusion. Various reliable clinical rating scales made the study more feasible. The shortcoming of scales was that they measured only one emotion. Research works using multidisciplinary approach suggests that there is a disruption in emotion. Medication side effect is not the primary reason for diminished facial expression. People living with schizophrenia exhibit observable facial expressions only while undergoing very intense emotional experiences. Emotions help in social functioning and treatment. Inability to convey emotion can lead to misunderstandings. Research findings on emotion in schizophrenia suggests that various interventions such as social skills training can be strengthened by including components that specifically target emotional disturbances. It is not clear that difficulty in expressing emotions is a result of schizophrenia or existed before the onset of it. There is a lack of studies looking at the emotions of PLS. Therefore, more studies are needed on the disruption of emotions and its relevance in the context of meaningful social relationships.

Kinderman and Cooke (2000) gives detailed account on the social exclusion experiences of people living with psychiatric illness. People living with mental illness are subjected to discrimination and prejudice. They are excluded from the society in various ways. Their economic status is bad and has to depend on family to meet the needs. The unemployment rate in people living with mental illness is high since they do not get job opportunities. People living with schizophrenia do not have a wider social network due to the stigma. Social exclusion can result from problems in social functioning or due to the diagnosis of mental illness. Social inclusion can be promoted through community
education, strengthening social roles, paid employment, recreation, community care, and movements by people living with mental illness. Representation of people living with mental illness in mass media is of violence and aggression which adversely affect the movements. The role of media in reducing stigma is important. The article mainly focuses on situation of people living with mental illness in developed countries.

Mueser et al. (2001) analyzed work in schizophrenia. Previous work experience, educational level, extends of cognitive impairment, and social functioning were the factors that influenced the prospect of work. Studies showed that after the onset of schizophrenia people encountered a decline in the employment rate and socio-economic status. Low rate of employment had implications on financial resources. This led to dependence on family members for every single need. Stigma and discrimination paved way to isolation and poor self esteem. The study also showed that there was a desire among people living with schizophrenia to work. It reported that social functioning before the onset of schizophrenia, history of work, and severity of the symptoms were the major factors influencing employment. Educational level was also reported as equally important as work history and social functioning. The impairment in cognitive abilities decreased the chances of employment. The article pointed at the difficulties an individual had to face once she/he was diagnosed with schizophrenia.

Fleischhackee et al. (2007) studied the issue of non compliance of medication in schizophrenia. As per the study findings the rate of non compliance was 10-15 percent in hospitals settings and 40-50 percent in community based settings. Though the term compliance was controversial, authors continued to use it since application of the term was important in the context of their study. Compliance did not limit to medication, but to other forms treatment such as psychotherapies, and other therapies. As per records only one third of people living with schizophrenia were compliant, one third were partially compliant, and another one third did not follow their prescriptions. Non compliance of medication led to dysfunction in daily life activities and decrease in quality of life. The author concluded that two factors led to non compliance; lack of understanding of illness and need for continuous treatment. He suggested that PLS should be considered as a partner in treatment than a passive recipient of treatment. The article
threw light on the importance of medication and the need for participation of PLS in the treatment.

Lysaker et al. (2008) in their article attempts to review evolving definitions on recovery in schizophrenia. The definitions focus on the sense of hope, self reliance, and personalized awareness of strengths and challenges. On one side schizophrenia brings heavy burden of disability and on the other side PLS experience long periods of relatively good functioning including symptoms remission, healthy levels of self esteem, and meaningful community participation. Focus of recovery has shifted from stability or absence of hospitalisations or full blown symptoms to symptoms remission, acceptable levels of functioning, and perception about self. There are 10 components of recovery; self direction, individualization, empowerment, holistic, non-linear, strengths, peer support, respect, responsibility, and hope. These components points out recovery as an initiative from PLS which calls for faith in self and a belief in the possibility of wellness. Therefore, recovery is an individualized process taking place across various facets of life with the support of each other. Another definition by Davidson et al. (2006) list out nine components; renewing hope and commitment, redefining self, incorporating illness, overcoming stigma, assuming control, becoming empowered, managing symptoms, being involved in meaningful activities, and being supported by others. As per this conceptualization the essential element of recovery is the effect of subjective changes in a manner where people will understand and experience themselves as individuals.

Harvey et al. (2009) compared the results of performance based measurement of functionality in schizophrenia in Sweden and United States. Details were collected from case managers and case records on various aspects such as independent living, work, and relationship status. The results showed that there was no difference between rural Sweden and New York City participants in daily living skills, functional outcomes, and case manager report on real world functioning. Performance differences on neuropsychological tests were moderate. Correlation between the functional capacity, neuropsychological performance, and real world functioning appeared similar in both the countries. There were differences in residential outcome of the two countries. The difference in social services system might be the cause for lack of association between
residential outcomes and daily living skills. In rural Sweden the disability compensation and housing rent enabled the participants to lead a better life whereas the expenditure in terms of housing was high in an urban city like New York. This variation made a huge difference in independent and daily living. The article looked at the correlation between one or two domains of functioning and real world functioning from the perspective of case managers. It did not cover the influence of symptomatic behavior, social support system, and treatment modalities on the outcomes.

Cross cultural studies

Murphy (1968) discussed the various socio cultural factors influencing schizophrenia. Problem with psychodynamic and sociological theories was that each one was linked to a particular set of observations and not applicable to others. Theory discussed in this article was associated with the influence of social factors on schizophrenia. It attempted to bring together observations from family psychiatry, sociology, epidemiology, empirical psychology, and clinical work. Author’s assumption was that there was a chance to inherit schizophrenia. It might be affected by physical agents after birth, but the chances varied in degree so that in many instances schizophrenia did not appear unless the weakened functions were put under strain. From the evidence of community studies, author arrived at a general theory relating community conditions and the risk of developing schizophrenia. This theory mentioned that schizophrenia was induced or promoted when a community demands lines of action which were seemingly unachievable. Family studies showed that not a single type of family process but a single type of experience of receiving inadequate, conflicting, and hence confusing messages that paved way to schizophrenia. It also had to do with social relationship of a relatively complex or subtle character. While the process lasted, the individual was prevented from acquiring other means of satisfying relevant needs. Epidemiological studies showed high rate of schizophrenia among war veterans and migrants. Studies on psychological deficits pointed at the importance of communication pattern. Studies indicated that schizophrenia behavior might have resulted from ambiguity of communication. In the conclusion author questioned various theories and suggested the need for combining all theories together to find a new approach.
Sartorius et al. (1974) describes the pilot study of schizophrenia as a yearlong study conducted by World Health Organization. It was one of the pioneering efforts in cross cultural schizophrenia research. The study was aimed to find answers for certain methodological issues pertaining to research in cross cultural settings. It also had to locate the nature and distribution of schizophrenia across the countries chosen for study. Study was conducted in three phases using three instruments. The most important result of this study was the development of standardized instruments of international applicability in assessing psychiatric illness. These instruments were culturally sensitive and reliable. They could be used to carry out large scale studies across the countries. Other outcome of the study was that it raised the level of knowledge about the nature of severe mental illnesses.

**Indian Studies**

Thara and Joseph (1995) studied gender differences in symptom pattern, course and disability in PLS for a period of ten years. The techniques and tools of the study were Present state examination (PSE), Psychiatric and Personal History Schedule to record historical and socio-demographic information, Interim Follow up Schedule to record clinical and treatment details. At the end of every year the PSE and PPHS were repeated. The clinical and socio-demographic details compared were age of onset, socio-economic level, marital status, educations, occupations, family history of mental illness, all PSE syndromes, pattern of course, and disability. Among the findings the significant one was the lack of association between age of onset of schizophrenia and sex. Males living with schizophrenia seemed more disabled at the end of tenth year. Age at onset and pattern of re-hospitalizations did not differ in the two sexes. The limitation of the study was that the samples were predominantly outpatient sample. Though the study provided a base to assess the gender differences, it did not make a comparison between the gender differences in occupation level.

Wig (1997) wrote about the condition of schizophrenia in India. Schizophrenia became identified as one of the major health problems. Author gave an account of world scene and Indian research in schizophrenia. As per the article schizophrenia was regarded primarily as a brain disorder in which the course and outcome were modified by
psychosocial factors. The course and outcome were varied and heterogeneous. The management of people living with schizophrenia should be a combination of psychosocial approaches and pharmacological treatment. The prevalence rate of schizophrenia in India ranged from 2-3 per 1000 population. The contribution of psychiatric field in India was mainly on community care of people living with schizophrenia. The Indian judiciary passed the historic judgment on keeping a non-criminal person living with mental illness under custody as unconstitutional. He concluded that the intervention for people living with schizophrenia need to focus on fighting stigma and better use of existing knowledge and technology.

Sabhesan and Parthasarathy (2005) studied various dimensions of executive functions such as goal formulation, planning, behavioral programming, and effective performance in people living with schizophrenia. The results showed that age and duration of illness had a consistently inverse, but statistically non significant relationship. The deficits of executive functions were not related to increasing age or length of illness and were independent components of schizophrenia. Poor raw scores reflected the general intellectual decline among schizophrenia. Negative symptoms had a consistent negative relationship with executive functions though not statistically significant. There was a need to understand executive function and its relationship between specific dimensions especially while planning for potential pharmacological and rehabilitative interventions. The study did not try to explore the impact of distortion in executive functions on lives of people living with schizophrenia. It contributed more to neuro-psychological literature than to rehabilitation, but underlined the need to consider disruption in executive function as an important area of rehabilitation.

Thara (2005) explained the impact of schizophrenia and the disability it caused in youth. The disability arising out of schizophrenia affects the personal care and hygiene, interpersonal relationships, social interactions, work, attention, concentration, and memory. In India majority of people living with schizophrenia stay with their families. Therefore, the human and economic burden it creates is significant. The economic burden is divided into direct and indirect costs. Direct cost includes expenses of hospitalisations, medications, and other treatments. Indirect costs are loss of productivity and time spent
by care givers. The reason for considering schizophrenia a brain disorder is due to the 
documentation available on biological changes in the brain. There is no significant 
gender difference in the occurrence of schizophrenia. Studies show that contrary to 
earlier beliefs people living with schizophrenia can get back to work, be married, and 
lead productive and meaningful lives. This can be due to many factors such as effective 
medication, better community care, and increasing awareness about the illness. Even 
though disability arising out of mental illness is covered under PWD Act 1996 difficulty 
in measuring disability makes it challenging to ascertain the disability. The burden is 
covered entirely by family since no medical insurance is offered for schizophrenia. 
Stigma and discrimination towards people living with schizophrenia is still a major issue. 
The services available in urban area are different from those in rural area. India still needs 
to develop adequate policy to meet mental health needs. A network of services in the 
government, nongovernmental organization, and private sectors need to be in place.

The studies reviewed above shows the various aspects of living with schizophrenia. 
Estroff (1989) pointed at the relevance of subjective experience of self in schizophrenia. 
Anonymous (1990), Ruocchio (1997), gives first person accounts of schizophrenia. 
Clafferty et al. (2001), Blarikom (2006), Corin (1998), and Klienman (1991) advised the 
effectiveness of person centered approach in schizophrenia, the benefit of telling the 
diagnosis of schizophrenia in treatment, and the need to know the pain and sufferings of 
PLS. These studies guided in looking into the perception of PLS regarding the aspects of 
(2001), and Harvey et al. (2009) shows the implications of schizophrenia in an 
individual’s life. In order to understand the nuances of living with schizophrenia it is 
important to know the implications of schizophrenia. Lysaker et al. (2008), Davidson et al. 
(2006) and Fleischhackee et al (2007) explains the concept of recovery in schizophrenia and the consequences of medication non compliance. These two concepts 
are significant in the treatment and rehabilitation of PLS. the cross cultural studies by 
Murphy (1968) and Sartorius (1974) expound the differences in the occurrence and 
distribution of schizophrenia across the cultures. Thara and Joseph (1995), Wig (1997), 
Sabhesan and Parthasarathy (2005), Thara (2005) elucidates the situation of schizophrenia in India. These studies also throw light on gender difference, implications
of schizophrenia, relevance of community care, and extent of disability in PLS. These studies helped in conceptualizing and contextualizing the issue of living with schizophrenia.

**Psychosocial Rehabilitation**

Wing (1981) discussed the drawbacks of existing techniques on diagnosing schizophrenia and its impact on rehabilitation. Rehabilitation was aimed at reducing the social disablement resulting from schizophrenia as far as possible. Author mentioned two types of impairments; out of acute episode, and impairments out of chronic slowness and social withdrawal. Level of impairment was also aggravated by the environment in which the person lives. Thus earlier works on rehabilitation was focused on providing opportunities for employment and social interaction. Author prefers to use the term ‘management’ to rehabilitation since it represent constant revision of aims and methods over a long period of time. The success of rehabilitation depends on to what extent the disabled individual will be able to live in a near normal social environment. The implication of rehabilitation is that it is a process of enabling and increasing the options available to people living with disability, so that they are given the opportunity to find the highest quality of life possible. Author suggests that different techniques need to be used to tackle the issues in people living with schizophrenia. For this purpose protected day or residential environment and continuing medical or social supervision/care are required. These services should be enacted with the help and support of family.

Hume and Pullen (1986) discussed about the adjustment strains of family members of person living with schizophrenia. The adjustments include the rescheduling of family life to cope without the absent member, take over his/her family responsibility, and also schedule regular visits to the hospital in daily routine. Authors points out four major areas where family needs help such as information about the illness, empathy, advice, and help with relationships. In case of PLS who do not have any family members or relatives to provide support, significant others like friends or work mates can take the role of the caretaker. Family therapy should be focused on giving support to the family. Authors also gives a brief account of crisis intervention which should be reality based and problem oriented. The emphasis is on what is happening in the present moment and helping the
whole family to return to a more stable state. The family is the important source of support and care for the person suffering from schizophrenia. The stress in the family needs to be understood and addressed while designing the rehabilitation program.

Liberman (1994) examines the need of psychosocial treatments in schizophrenia. Psychosocial treatments are based on the stress, vulnerability, and protective model of symptom formation. As per this model the focus of psychosocial treatment must be in strengthening the coping skills and social support system of the person. The failure of antipsychotic medication in reinstating the basic living skills required for a community living emphasized the requisite of psychosocial treatments. These psychosocial treatments include individual, group, and family therapies. Psychosocial treatments are effective when coupled with pharmacotherapy and pharmacotherapy is effective with psychosocial treatments. The role of a case manager in effectively carrying out psychosocial therapies is crucial. Author insists the need for more studies in the effectiveness of psychosocial treatments coupled with pharmacotherapy. Psychosocial therapies should enable the recipient in carrying out daily life activities effectively, cope with life situations and stressors, and maintain a social life. Author gives us an outline of why psychosocial therapies are important in the treatment of schizophrenia.

Harding and Zahniser (1994) bring out seven myths of schizophrenia and try to clarify it. Author gives an account of seven myths regarding schizophrenia and its clarifications. First myth is that a PLS will always remain a PLS, but the reality is that there are outcomes refuting this claim. Myth two is regarding the diagnosis of schizophrenia remaining same over the period of time whereas there is an inconsistency within the diagnostic category. Third myth is that rehabilitation follows treatment, but it actually starts the very moment of treatment. Myth four is regarding the importance of psychotherapy in schizophrenia and reality is that supportive psychotherapy is a crucial part of rehabilitation. Fifth myth is that PLS must take medicines lifelong, but this may be applicable to a small percentage of people living with schizophrenia. Myth six is regarding the belief that PLS can only do low level jobs which is again untrue and they can perform any kind of work. Seventh myth is that family is the source of illness, but reality is that family acts as the biggest support and resource for PLS. The article may
help to contribute a more balanced and contemporary view of the person with schizophrenia in order to reenergize clinicians and rejuvenate treatment approaches.

Litterell et al. (1996) reported the findings of a longitudinal study about the role of hope in treatment of people living with schizophrenia. The authors located a study on hope in individuals diagnosed with schizophrenia, but from the perspective of the professional caregivers rather than PLS. There were two objectives for the present study. The first objective was to evaluate the combination of psychosocial and pharmacological interventions on the level of hope in individuals with unmanageable schizophrenia. Second objective was to evaluate the association between hopefulness, psychopathology, suicide attempts, re-hospitalization, and reintegration outcomes. The findings of the study indicated that increased level of hope in individuals with schizophrenia may be associated with improvement in symptoms. Decreased symptoms and increased hopefulness were felt to enhance treatment interventions and improve reintegration outcomes. The article pointed out the role hope plays in the outcome.

Kuipers (1996) discussed the social outcomes of living with schizophrenia. There were instances where people living with schizophrenia recovered after the first episode. There were some PLS who had an up-and-down course with recurrent relapses. The instances where PLS remain severely disabled and was in need of continuing and high contact care from services had also been reported. Social outcome of schizophrenia comprises of restrictions in social activities, financial and employment difficulties, behavioral problems, and emotional responses. The social interventions in schizophrenia consisted offering help to carer, understanding schizophrenia and medication, emotional adjustment, and stigma. The psychosocial interventions such as cognitive behavioral treatment for hallucinations and delusions, identifying stressful situations and coping mechanisms, provision of structure and meaningful activity, supportive therapy and discussion of the impact of the illness, relaxation and distraction techniques were likely to help PLS and family. There was evidence of the effectiveness of a range of social treatments that can prevent and reduce social disability in patients, reduce burden in carers and improve the quality of life for individual and family members.
Becker et al. (2002) did a study on the care for people living with schizophrenia in five European countries (Denmark, England, Italy, Spain, The Netherlands). Study sites were Amsterdam, Copenhagen, London, Santander, and Verona. The study results showed that there was a variation in unmet needs across the study regions. There were not much significant changes in service utilization and cost but there was a significant change in service utilization. In terms of care giving each site varied significantly. The study showed that information about illness and involvement of relatives was the area with poor performance. In quality of life domain social relations and health were the factors that had a strong impact on service satisfaction. Employment and financial stability were the aspects that scored lower in subjective quality of life. In the south part of Europe family support is a prominent feature that helps participants. The services provided by Copenhagen came out to be better than other places. The study concluded that mental health care provisions differ in each of the countries in the study.

**Indian studies**

Pillai and Nagalakshmi (1974) discussed the effect of ‘Nurse-Patient relationship therapy’ in socializing with people living with chronic schizophrenia. The aim was to study the role of Nurse-Patient relationship therapy in influencing, interrupting, and altering the course of mental illness and helping the PLS form useful relationship with others. They started by making PLS conscious about their personal hygiene and helping them in maintaining it. Participants were taken out for picnics and films. Gradually new and improved patterns of behavior became noticeable especially in social functioning. All PLS started attending occupational therapy sessions they used to avoid earlier. Participants showed better performance in memory functions. Intellectual efficiency of these participants also started to improve after therapy. Regarding interpersonal relationship almost all the participants refused to share any details. This study showed that ‘Nurse-Patient Relationship Therapy’ seem to be one of the important factors in the treatment of PLS in addition with other treatment. Authors suggested that in rehabilitation of PLS family and community should take adequate responsibility.

Thara et.al. (2004) discusses the Indian mental health scenario in terms of services available and research carried out. Family is the primary caregiver and greatest source of
support in treatment and rehabilitation. There is no liaison between public and private sector. Mental hospitals in India offer poor services and often violate human rights. General hospital psychiatric units are helpful in improving quality of care, reducing stigma, and active liaison psychiatry. Voluntary agencies are contributing to the mental health scene for the past twenty years. Support groups of family members of people living with schizophrenia actively participate in treatment and rehabilitation. Openness of traditional healer to accept biomedical model has helped in attaining better results. Religious centers are still considered as important treatment centers, but incident at Yerwadi points at the need for supervision of such centers. Indigenous medicine such as Ayurveda, Siddha, and Unani are even now sought-after. Among the total population of people living with schizophrenia one third has not approached for treatment at any point of time. This happens even in families with highly educated members. National mental health programs and community mental health programs have brought a little change in the attitude towards people living with schizophrenia.

Sheth (2009) provides a detailed account of why deinstitutionalization failed miserably and explains the situation in India. The aim of deinstitutionalization was to rehabilitate PLMI in mental asylums back into the community. The intention was to help people living with mental illness to stay in the community. Instead of helping to get back to a community life deinstitutionalization landed many of them on streets, prisons, beggar houses, shelter houses, etc. Lack of housing services, mental health services, and social support system led to the failure of deinstitutionalization. The situation in India is not different as people living with mental illness are still deprived of their rights. One appropriate way to counter this is by giving occupation in industrial sector according to the degree of disability in the person. The issue of housing for people living with mental illness is another area that needs to be addressed. For those PLMI who stays with their family, day care centers will be suitable to avail psychosocial care. Building quarter homes near to mental hospital for those PLMI who do not have any social support system will provide them with a home and adequate care. In case of people with chronic schizophrenia long term care can be provided through establishing small hospitals with adequate facility in each district. The role of judiciary in upholding the rights of people
living with mental illness is important. The article does not address the issue of lack of professional resources in the field of mental health.

Thara and Patel (2010) explain the role of non-governmental organizations (NGOs) in the field of mental health in India. The recognition that NGOs are significant in promoting mental health activities paved way for more NGOs in the providing mental health care services. NGOs became professional in approach and started receiving funds from various sources. The way in which an NGO works is secular in nature. NGOs working in the field of health filled in the gaps in providing health care provisions to the under privileged sections. Most of NGOs working in the field of mental health is concentrated in urban areas. Earlier NGOs focused mainly on people living with intellectual disability, but recently they started giving equal preference to severe mental disorders also. NGOs working in this field aims at providing treatment and rehabilitation, community support, research, and advocacy. The major challenge in running an NGO is funding. Since governmental support is less NGO has to search for alternate sources. Recently the growing awareness on the need of research has led many NGOs to include research as a part of their activities. Partnership with government in providing mental health services will definitely widen the scope for NGOs in offering affordable and accessible mental health care.

Wing (1981) discussed the problems in diagnosing schizophrenia and its impact on rehabilitation. He pointed at the need for a proper diagnostic measure in order to provide better psychosocial care. Hume and Pullen (1986) stressed the adjustment family has to make when a family member is living with schizophrenia. The study indicated the need for involving family in the process of rehabilitating people living with schizophrenia. Liberman (1994) explained the importance and need of psychosocial rehabilitation for people living with schizophrenia along with pharmacological treatment. There are many myths regarding schizophrenia. Harding and Zahniser (1994) tried to clarify the myths and reveal the realities regarding various aspects of living with schizophrenia. Litterell et al. (1996) elicit the role of hope in recovering from schizophrenia. The authors mentioned that for better outcome hope is important in treatment and rehabilitation of people living with schizophrenia. Kuipers (1999) narrates the social outcomes of living with
schizophrenia which consists of stigma and discrimination for PLS and family. He also mentioned the significance of psychosocial rehabilitation in bringing better social outcomes. Becker et al. (2002) studied the difference in the mental health care services in various European countries. The study showed that there is a wide variation in provision of services in each country.

The Indian studies mainly discussed about the situation of mental health in India and relevance of psychosocial care in treatment. Pillai and Nagalakshmi (1974) studied the role of nurse patient relationship therapy in treating PLS. The study results were supportive of the assumption that nurse patient relationship therapy in fact brings better outcomes. Thara et al. (2004) discussed the mental health scenario in India. Authors elicited both positive and negative aspects of Indian mental health situation. Sheth (2009) critically analyzed the process of deinstitutionalization and its impact on the lives of PLS. He also examined the situation in India and suggested alternatives for people living with schizophrenia without adequate social support system. Thara and Patel (2010) explained the role of NGOs in meeting the rising demands of mental health care. They underlined the fact that government is not able to provide mental health care to entire population. Therefore, NGOs can fill the gap in service provision. The above mentioned studies show the various aspects of psychosocial rehabilitation and its impact on PLS.

**Participation in the community**

Ng (1992) explained about community meeting in psychiatric unit or institutions. The study was conducted in a psychiatric hospital. Community meeting is a form of regular, frequent meeting in a psychiatric unit or institution. It consists of all staff and patients of the unit. It is meant to increase the communication between PLMI and staff. However, the use of the community meeting as a mode of treatment in psychiatry has been very recent. There is no fixed method, format or direction for community meetings. Community meetings by workers in different hospital units are different from one another. The variations are generally in the form of settings, size, attendance, frequency, distribution, purpose, and method of the community meetings. There are many studies that show the effect of community meeting in the treatment of PLMI. Author concludes that the wide and varied practice of using community meeting in psychiatric wards is due
to the belief that it is a useful treatment mode in enhancing communication and interaction skills in PLMI.

Pearson (1992) explains community care in China. As per the study stigma on people living with mental illness is high in China. The Chinese community does not support the notion of people living with mental illnesses staying separately from family. Therefore, people living with mental illness stay with their family. There is little support available in China beyond what is provided through the workplace by government or by other official channels such as the Civil Affairs Departments and the street organisations. There are no voluntary or informal sectors in China to provide support additional to that supplied by the state, family, and collective organisations. Other than psychiatric care units community support initiatives are based on work. The missing factor is residential services. The central government expects the provincial and local governments to largely fund community services for people living with mental illness. At local level the provisions of community service are firstly dependent on the wealth of a particular area/locality, and secondly the priority is given to welfare issues in general, and within that framework the mentally ill in particular.

Holmberg and Kane (1999) explored health and self care practices of persons with schizophrenia. The rate of physical illness was high in people living with mental illness which was also a reason for higher morbidity. People living with schizophrenia were at higher risk due to various deficits leading to inadequate health and self care practices. Studies showing the health and self care practices of people living with chronic mental illness were insufficient. The current study explored various health and self care practices of outpatients. Existing literature were compared with the results of the study in order to evaluate health and self care behaviors in PLS. Results showed that participants felt less self-actualized with fewer positive nutritional habits and less interpersonal support. They practiced fewer health enhancing behaviors. Only a few participants’ were engaged in exercise, eating nutritious food, and avoiding high fat food. Smoking and sleeping for long time was high among participants. A few participants reported to use alcohol in smaller amount, but the evidence showed alcohol consumption was very high. The results showed the need to change health behaviors to reduce the risk of premature death.
Smoking and overeating were the common negative health habit along with excessive alcohol consumption. Limited sample size prevents from generalizing the results and more studies are required to establish the influence of health care practices and morbidity rate in PLS.

Pieris and Craik (2004) discussed the supporting and constraining factors for people living with persistent mental illness in the community while participating in leisure activities. The participants of the study were diagnosed with major mental illness including schizophrenia. Leisure was considered as one of the important aspects in enhancing balance and quality of life in people living with severe mental illness. In the present study authors tried to understand the perception of the participants on their participation in leisure activities. As per participants view there was factors that support participation in leisure activities and factors that block participation in leisure activities. The study showed that social network in people living with schizophrenia was very limited. Therefore, this finding was crucial in encouraging more interaction in people living with schizophrenia. The factors that support participation in leisure activities are formal and informal social network. Factors hindering participation in leisure activities were limited finance, transportation facility, and physical difficulties. Absence of close relationships was also pointed out as a major difficulty in taking part in leisure activities. The study discussed leisure as a component of occupational therapy. Authors suggested that leisure forms an important and occupational therapist should work on motivating leisure activities in people living with severe mental illness. However, this study points out that leisure activities are significant in improving social involvement of people living with schizophrenia.

Prince and Gerber (2005) explain that community integration is a three dimensional process with physical, social and psychological integration. These three aspects are examined in relation to subjective well being (SWB) of people receiving services from assertive community treatment (ACT) teams. Community based programs for people living with psychiatric disabilities consist of optimizing their abilities in day to day living, social interaction, and a sense of belonging to the community. This study aims to examine the relationships between these three aspects and subjective well being in a
sample population with psychiatric disabilities receiving services from ACT. The outcome of the study shows that both physical and psychological integration are related to SWB, but social integration was not. These findings indicate that greater presence in the community (i.e., completing activities of daily living) is associated with increased level of subjective well being. Psychological integration is also positively associated with reports of SWB as measured by global satisfaction scale. The question on why social integration is not associated with SWB remains unanswered.

Levy et al. (2005) discussed the relevance of staff -resident relationship in community mental health hostels in Israel. Community based shelter facilities especially hostels became prevalent in rehabilitating PLS after the advent of deinstitutionalization. The introduction of community based hostels for PLS called for well trained staff. It also pointed out the issues of managing highly symptomatic PLS at the shelters. In this context the relationship between the staff and residents determined the effectiveness of rehabilitation. In this article resident PLS were less symptomatic and participated well in rehabilitation activities. The residents at the hostels were able to keep in touch with their family members. The study showed a correlation between symptomatic behavior, and social and occupational functioning of the PLS. Professionals with more experience and many years of working in community hostels were more prone to reject symptomatic PLS. Authors suggested that more studies need to be carried out in the area of staff burnouts and its impact on rejection and criticism

Chadwick (2006) examined the effects of social difficulties such as invalidating, stressful relationships and lack of social support on cognitive processes in psychosis. The author observed that most of the studies taken place in this field was about the cause effect relationship rather than social situation and the dynamics of social relationships on cognitive process. The author explained his own experiences and also of other people whom he studied. The methods used in this study consisted of biographical and ethnographic methods. These methods helped in deriving insights from personal experience of psychosis. Interactions with people living with psychosis in hospitals, hostel care and group were useful in the study. He mentions that the professional should listen to what people living with psychosis wanted to say than tell them that all these are
part of symptoms. The important point the author make is that a practical and qualitative way of looking at the experience of people is essential in any study regarding the influence of social stresses and negative social experiences on cognitive functioning.

Oshima and Kuno (2006) wrote about the role psychiatric hospitals and family plays in caring for people with serious mental illness in Japan. This study explored the effect of community care, by examining the living arrangements of individuals with schizophrenia, who were treated in one of the most progressive systems in Kawasaki. In Japan, psychiatric hospitalization has been one way to reduce the burden on the family. In congruence with the social and cultural expectations, the Mental Health Act demands family to take custodial responsibility for their relatives with mental illness. Thus the high expectation and responsibility placed on the family in conjunction with the generous availability of psychiatric beds has created hospital-based mental health system in Japan. The study examined the different types of living settings of people living with schizophrenia in Kawasaki as compared with a similar group of PLS nationally. The findings of the study indicated that a relatively well developed community care system in Kawasaki resulted in the presence of higher rates of people living with schizophrenia in the community. However, for the younger generation the rates of community versus hospital did not differ between the Kawasaki and national treated populations.

Lencucha et al. (2008) studied how people living with schizophrenia form and maintain social relationship. They also looked at the role occupation played in developing social relationships using grounded theory. Contrary to the earlier belief studies showed that people living with schizophrenia derive joy from social relationships. Daily life occupations and social life were intertwined with each other because people give meaning to occupations based on the interactions with others. Occupation here referred to any activity people did to engage self in everyday life. Occupation was important since people living with schizophrenia had difficulty in focusing on daily life activities and initiating social interaction. Findings of the study showed that five themes influence the formation and maintenance of social relationships. They were environment with routine, cooperation, adherence, hope, and understanding. There were four types of relationships;
family, intimate, associative, and occupational. The study results supported the assumption that occupations helped in forming and maintaining social relationships.

Urilic and Lentin (2010) explained the need for occupations since it enhanced participation in various areas of life. The study was conducted in an urban community in Australia. The focus of the present article was to examine the daily life occupations of PLS. The article also attempted to understand the subjective experiences of PLS, the elements forming their participation, and the value of occupations in their lives. The study followed the naturalistic inquiry method. The outcomes of the study show that there are various aspects that are supporting and hindering participation in occupations. These aspects were grouped under three main themes; 'struggling to survive in the present, enabling and constraining factors in the home environment, and the importance and value of work' (313-14). The opportunities for participation were influenced by the environment of the participants. Employment was considered as an important occupation that added value to participants’ lives. Authors suggested supportive employment as per the degree of deficits in PLS. Authors also suggested the need of more studies to understand the influence of occupation in the process of recovery.

O'Brien (2012) discussed about the mental health community in the context of Community Rounds Project in Calgary. The intention of the project was to build a network among the mental health community by encouraging cooperation between various personnel’s in the sector. The collaboration between mental health care organizations in the community became necessary to provide accessible mental health care to all those who are in need. The communication between people living with mental illness, their family, professionals, and organizations was significant for better mental health care services. This understanding and need paved way to the development of Community Rounds project. The focus was to build a mental health system in the community from the perspective of people living with mental illness, their family, professionals, and mental health care organizations. The strength of the community in the study context was the support from leaders of the organizations. This article pointed at the relevance of participation of consumers in disseminating mental health care services.
Indian studies

Bhargava et al. (1989) studied social network of people living with schizophrenia. Social network was defined as a matrix of individuals and their relationships. It comprised of three different categories. First category consisted of those who came in contact with the person living with schizophrenia repeatedly over a long duration of time, for example, PLS’s family, community and at her/his place of work. Second group involved of those people who influenced the individual and influenced by her/him. The third category encompassed of those people whom the individual could lean on during a personal crisis. The information was collected from PLS, family, and significant others. The areas covered composed of marital and sexual sphere, personal and family sphere, adjustment pattern outside the family such as occupational sphere, peer group, religious sphere, and community sphere. The result of the study showed that there was no appreciable difference between the ‘social network’ of the people living with schizophrenia and people living with other mental illness. The author suggested further studies to look at the influence of cultural factors on social network.

Murthy (1992) said about the development of community mental health in India. He compared the policies and plans during pre independence and post independence period. The approach towards community mental health became preventive, promotive, and curative since the introduction of National Mental Health Programme 1982. The integration of mental health services in primary health care was a mile stone in the dissemination of mental health care in India. The development of psychiatric units in general hospitals helped in availing accessible mental health care services. This helped in the greater acceptance of psychiatric services by the public without the fear of social stigma. Also these units brought a change in the mental health training of professionals and research. The next aspect in the development of community mental health was introduction of community care approach. The motivation for this was the responsibility of the country to provide health services to all. The magnitude of severe mental disorders in the community and availability of simple interventions for these conditions also paved way to accepting community care as the suitable method for rehabilitation of PLS. This
was supported by the experiences of community mental health care at Bangalore and Chandigarh centers.

Sethi and Chaturvedi (1992) discussed the importance of family and social support system in the treatment and care of people living with mental illness. Social interaction schedule was the major instrument used to quantify the type and duration of interaction. PLMI from urban area spend significantly more time than PLMI from rural area in interacting with members of the group outside the household. The findings showed that lack of support was directly related to mental disorders that were lacking the support then more was the incidence of mental disorders. Support system was a group of social factors that provided the individual with physical, emotional, or psychological, and social support. The social network concept became significant in this context. This system was a network of a few or many people, who were related to the individual and buffer, or reinforce, or nurture him/her. The study findings reported that support systems enabled mobilization of psychological capacities, inner resources, promotion of mastery, sharing of real life tasks, provisions of extra material supplies, guidance and information.

Thara et al. (2010) discussed the various aspects of community psychiatry. Community psychiatry referred to the development of mental health services in the community. This concept gained attention during the era of deinstitutionalization. The idea was to identify the mental health needs of the people, locate adequate resources at accessible places, and provide treatment. The various features of community psychiatry were location near the people in need, team of professionals from different disciplines, availability of continuous care, participation of users, and comprehensive care. In India community psychiatry started as an alternative to inadequate facility in mental hospitals. It was important to incorporate traditional healers since many people prefer to take help from them. The emergence of non-governmental organisations helped to fill the gaps in the delivery of mental health services in the community. Authors considered research articles published in Indian Journal of Psychiatry for the present article. Therefore, the perspectives discussed in other journals and unpublished documents were not analyzed.

The above mentioned studies described the various ways in which PLS participate in the community. Bhargava et al. (1989) indicated the relevance of social network among
people living with mental illness. They also underlined the types of social networks exist in PLMI. Murthy (1992) entailed the process through which community mental health evolved in India. Seth and Chaturvedi (1992) stressed the role of family and other social support system in recovering from schizophrenia. Ng (1992) explained the relevance of community meeting in psychiatric ward in enhancing interaction between patients admitted in a hospital. Interaction is a crucial element in social life. Pearson (1992) gave details regarding the nuances of community care in China. In China, family has the responsibility of people living with schizophrenia. Indian situation is not entirely different from this notion. Holmberg and Kane (1999) studied health care practices and morbidity in people living with schizophrenia. This study showed the importance of further research works on health care practices of people living with schizophrenia, since they have a tendency to develop physical complications.

Pieris and Craik (2004) discussed participation of PLS in leisure activities. The study shows that participation in leisure activities is important in improving social involvement. Prince and Gerber (2005) explained the need of integrating PLS into the community. The study proved that community integration is the key to improvement and active social life. Levy et al. (2005) explained the importance professionals’ knowledge and attitude on PLS residing in a community hostel. Chadwick (2006) studied the effect of social difficulties on the cognitive process of PLS. The study looked at the perception of PLS and reported the need for allowing PLS to voice out their experience. Oshima and Kuno (2006) reported a comparison of mental health service system in Kawasaki with national guidelines in Japan. The article was an eye opener on the role of psychiatric hospitals in treatment and rehabilitation. In India, psychiatric hospitals still play a significant role in treatment, but the poor facilities and lack of resources are the hurdles. Lencucha et al. (2008) studied the way in which PLS initiate and maintains social relationships. The study shows that contrary to the general belief people living with schizophrenia are able to maintain relationships.

Thara et al. (2010) shared the evolution of community psychiatry based on the publications in Indian Journal of Psychiatry. Urilic and Lentin (2010) identified the role of occupations in enhancing participation of PLS in the community. Occupations include
daily activities of life to vocational activities. O’Brien (2012) explored the integration of various service organizations in mental health as a community to provide effective services to consumers. The study showed that the consumers should be allowed to work on the process of collaboration. The Indian studies explain community mental health care in India. All these studies helped in understanding the concept of community in the context of people living with schizophrenia.

**Quality of life (QOL)**

Hansson et al. (1999) made a cross sectional multi centric study to assess the relationship between subjective quality of life, objective life situations, clinical features, and satisfaction in various areas of life. Various standardized scales were used to measure quality of life, symptomatic behavior, psychosocial functioning, need assessment, and social network respectively. Most of the respondents lived alone, but twelve percent were employed. The study showed that subjective life satisfaction in four areas of life such as health status, safety, recreation, work affects global subjective quality of life. Depression and anxiety adversely affected subjective quality of life, but findings did not show that psychotic symptoms have any influence on subjective quality of life. Self esteem showed a positive influence on global subjective quality of life. Authors suggested that community care interventions should aim at improving the perception of people living with schizophrenia, understanding about illness, and coping with it. The study did not look into the perception of people living with schizophrenia in understanding their quality of life.

Laliberte-Rudman et al. (2000) explored the perspective of people living with schizophrenia on meaning of quality of life. They tried to make an assessment tool to evaluate the perspective of people living with schizophrenia. The study results showed seven factors that influenced the quality of life of PLS. The factors were activity level, social interaction, managing time, being normal, disclosing illness to others, financial stability, and managing illness. In order to support the themes authors used narratives from the interviews. The factors adding meaning to quality of life was compiled under three themes; managing time, connecting and belonging, and making choices and maintaining control. While comparing the study results with existing instruments authors
found that certain factors overlap especially finance, activity level, and social interaction. The existing instruments did not address the extent to which these factors are helping them. In case of social interaction only frequency was assessed not the efficacy of the interaction which was equally important as frequency. Time was an important factor influencing quality of life since people living with schizophrenia had difficulty in organizing time. The reason for not disclosing illness was the fear of stigma and discrimination. The study showed the relevance of identifying subjective perception of people living with schizophrenia on their quality of life in terms of social belongingness and time management.

Gee et al. (2003) tried to understand quality of life in people living with schizophrenia using grounded theory method to get an insider perspective. The existing scales and questionnaires were not prepared to capture the perceptions of people living with schizophrenia. This created a gap in understanding the QOL domains important to people living with schizophrenia. Health related quality of life need to be assessed from the perspective of the concerned individual. Study results showed that quality of life domains in people living with schizophrenia was spread across eight areas. The domains included difficulties in interpersonal relationship, decreased control over behavior, less opportunity for work, financial difficulties, symptoms, medication side effects, mental distress due to schizophrenia, stigma and discrimination, worries about future, and positive results and experiences. The biggest achievement of the study was the reflection of the voice of participants. Samples were selected from rural and semi rural areas, and hence study results may be different from urban population.

Yeung and Chan (2006) explored the influence of clinical characteristics and objective living conditions on quality of life of people living with schizophrenia in a community based residential setting. The process of deinstitutionalization encouraged a shift from curing the illness to prevention of mental illness, and promotion of quality of life in people living with mental illness. In Hong Kong, due to deinstitutionalization the care of PLS shifted from hospitals to community based rehabilitation facilities. Understanding QOL was important in developing economic strategies of better mental health care. The samples for this study were selected from various community based
residential settings such as long stay care home, halfway house, supported hostel/housing, living with family, and living alone. WHO Quality of Life Measure-Abbreviated version-Hong Kong was used to measure QOL. The study results showed that QOL in people living with schizophrenia was not good compared to those who do not have any mental illness. Study also found that clinical characteristics influenced QOL of people living with schizophrenia than objective living conditions. The study showed that people living in long stay care home was more impaired than other residential facilities. It was also revealed that community or social functioning influenced all the domains of QOL in PLS. The study results were not intended for generalization therefore, further research works need to be carried out.

Sharir et al. (2007) studied social support (SS) and Quality of life of people living with severe mental disorders including schizophrenia in a residential setting. The study samples were chosen from three residential settings. Quality Of Life Questionnaire Interviewer Rating Version questionnaire and Multidimensional Scale of Perceived Social Support (MSPSS) were used to evaluate quality of life and social support respectively. The study results showed a close relationship between social support and quality of life of people living with mental illness in a residential setting. The total quality of life was high and this could be due to the availability of better mental health services and housing facility. The increase in social support might be the result of participants’ increased self care and maintenance of personal space. Friendships and support from other residents also positively influenced the quality of life. There were variations in the quality of life in the three residential centers which authors attributed to the male-female distribution in each center and geographic location of the centers. The instruments used were mostly related to mental health services therefore other factors influencing quality of life has not been assessed.

Narvaez et al. (2008) attempted to understand subjective and objective aspects of quality of life in schizophrenia in terms of clinical, functional, and cognitive features. They assessed the clinical, functional, and cognitive aspects predicting subjective and objective quality of life in schizophrenia especially in relation with negative symptoms. The authors used clinical, functional, neurological and quality of life measures to
understand severity of symptoms, living skills, intellectual skills, and quality of life in various domains respectively. Important finding of the study was that psychotic symptoms were the factors that influenced quality of life in people living with schizophrenia. Depressive symptoms were significant for subjective quality of life and negative symptoms for objective quality of life. Negative symptoms also affected their participation in activities of daily living. The study findings showed that a better cognitive functioning was not an indication of better subjective quality of life. Authors suggested the need for further studies to confirm this finding. The study did not consider the level of participation in activities. It also left out the performance of PLS in social skills which was crucial in determining quality of life.

Eklund et al. (2012) explored the aspects that people living with schizophrenia considers as bringing meaning to their life. Though meaning in life differed in each individual it was influenced by the culture and norms of the society they belong to. Meaning in life was highly influenced by the occupation of the individual. Occupation had a broader meaning than job. It consisted of many activities such as taking care of own health and self, self-esteem, well-being, social involvement, achievement, productivity and recovery from illness. Study showed that participants expressed five major categories contributing to meaning in life. They were social contacts, engagement in occupation, precious memories, experiencing health, and positive feelings. These categories were interrelated to each other in a way that they influenced each other. Study results showed that engaging in occupations of any sort and a daily routine give more meaning in life than any other factors. The findings of the study cannot be generalized and need to be considered as contextual. Participants did not attribute identity as part of meaning in life.

**Indian studies**

Solanki et al. (2008) conducted a cross sectional study in outpatients at SMS medical college Jaipur to examine quality of life in people living with schizophrenia. They also wanted to know the impact of clinical and socio-demographic factors in determining quality of life. The respondents of the study were predominantly male and most of them were married. The study showed that social relations were poor and affected their quality
of life. Employed respondents reported a better quality of life leading to the assumption that employment influence quality of life. The world wide unemployment rate among PLS is high whereas in the present study the rate of unemployment was lower. This might be due to the availability of less complicated nature of work in developing countries. Stigma and discrimination against people living with schizophrenia also lowered the quality of life. Poor social relationship was related to negative symptoms. Employed respondents showed a better social relationship status since they were eager to have a family, friends, and a better social circle. Family income had a positive impact on social relationship whereas duration of illness, past history, and family history did not have any influence on quality of life. The study cannot be generalized as the sample size is small and the instruments used were not specifically designed for measuring QOL in PLS.

The above mentioned studies explored various aspects of QOL in people living with schizophrenia. Hansson et al. (1999) studied the subjective quality of life of PLS and tried to locate the various factors that influence the subjective QOL. The study used various scales to identify the relationship between various aspects of subjective QOL, but did not try to look at the perception of PLS regarding the QOL. Laliberte-Rudman et al. (2000) tried to understand the perception of PLS regarding the meaning in life and its influence on their QOL. Gee et al. (2003) explored quality of life using grounded theory approach. The idea behind using grounded theory was to get an insider perspective of QOL which is rarely explored in schizophrenia.

Yeung and Chan (2006) studied the influence of clinical characteristics and objective living conditions on quality of life of PLS in different community based residential facilities. Sharir et al. (2007) looked into the social support system and quality of life of people living with schizophrenia at a residential setting. The study reported a close relationship between quality of life and social support of system in people living with schizophrenia. Narvaez et al. (2008) studied the objective and subjective elements of QOL in terms of clinical features, functional and cognitive capacity of PLS. The study reported that clinical features influenced quality of life.

Eklund et al. (2012) explored the aspects PLS consider as meaning full or brings meaning to their life. The study reported the relevance of occupation in improving QOL
of PLS. The Indian study by Solanki et al. (2008) showed a better employment rate in PLS. The study also pointed at the family support and income also influenced the quality of life. All the studies helped in understanding the various aspects influencing the QOL of PLS. Quality of life consist of both subjective and objective factors. It is important to understand the perception of individual regarding her/his quality of life.

Methodology

Goffman (1961) study on Asylums was the pioneer work in the field of mental health. His work changed the usual protocols of studies till that date in the field of psychiatry. He tried to give a picture of what was meant by institutions in general, and how people living in those institutions perceived life in that settings (for example, social institutions). His immediate objective was to learn social world of the hospital inmate as per their subjective experience. He further explained how total institutions were different from ordinary arrangement of living. The most interesting part of this book was the method author used to gather data. To get an insider view Goffman used participant observation as the method of data collection. He entered the hospital as an assistant to athletic director and later a student of recreation and community life so that he can spend more time with patients and avoided contacts with staff. He revealed his purpose of study to the top management and obtained their permission.

Janesick (1994) describes the various aspects of qualitative research. The foundation of qualitative design is to understand participant’s world and the meaning of shared experience in a given social context. Qualitative research begins with the question of what she/he wants to know. There are three stages of qualitative design. The warm up stage or design decisions made at the beginning of the study. Total workout stage during which design decisions are made throughout the study. The cool down stage is the stage when decisions are made at the end of the study. Because working in the field is unpredictable, a good deal of time the qualitative researcher must be ready to adjust schedules. She/he should be flexible about interview times and adding or subtracting observations or interviews. If necessary she/he should allow participants to withdraw from the study in the event of trauma or tragedy, and even to rearrange terms of original agreement. The qualitative researcher uses inductive analysis, which means that
categories, themes, and patterns come from the data. The categories that emerge from field notes, documents, and interviews are not imposed prior to data collection. Validity in qualitative research has to do with description and explanation.

Stake (1994) explains case study method in qualitative enquiry. As a form of research case study is defined by interest in individual cases. A case study is both the process of learning about the case and the product of learning. Case researchers explore both what is common and what is particular about that case, but the end result will be unique. Qualitative case study is characterized by the main researcher spending substantial time, on site, personally in contact with activities and operations of the case, reflecting, revising meanings of what is going on. With much qualitative work, case study research shares an intense in personal views and circumstances. Case study is a part of scientific method, but its purpose is not limited to the advance of science. Case studies are of value in refining theory and suggesting complexities for further investigation, as well as helping to establish the limits of generalization. The purpose of case study is not to represent the world, but to represent the case. The methods of qualitative case study are largely the methods of disciplining personal and particular experience.

Broom and Willis (2007) explains two paradigms in research (positivism and interpretivism). They also critically examined it from a political and ideological point of view. In authors’ opinion the difference between quantitative and qualitative approaches is in their basic assumption that guides research design and data collection. Most of biomedical research comes within the realm of positive paradigm due to the assumption about objectivity, neutrality and generalizability of data. The drawback of this paradigm is that it cannot explore the happenings in a person’s life and relationships that may have influenced health problems or getting help delayed. Interpretivist researchers focus on the understandings of the research participants in order to identify the ontological position by which those individuals actively negotiate meaning. The drawback of this paradigm is that there is no consensus among qualitative researchers on appropriate methods for data collection and analysis.
Indian Studies

Carstairs and R.L.Kapur (1976) The Great Universe of Kota was a research study designed in consideration with the cultural pattern of India, especially south part of India. This study was carried out in a village in Mangalore at Karnataka state. The village comprised of three major caste Brahmans, Bants and Mogers. Even though they stayed in one village there were cultural differences, and the researchers explored the prevalence of mental disorders in these three groups. The researchers also tried to identify how the three castes perceived mental disorders based on their cultural patterns. Study was basically quantitative in approach even if they used some qualitative methods such as participant observation and unstructured interview schedule. The ultimate aim was to study the prevalence of mental disorder in those three caste groups. The results showed there were differences in the way three caste groups identified mental disorders.

The works by Goffman (1961), Janesick (1994), Stake (1994), Broom and Willis (2007) explains the various features of qualitative studies and ways in which qualitative research has taken place. The Indian study by Carstairs and R.L.Kapur (1976) pointed at the culture sensitivity that has to be taken into consideration while conducting research on mental disorders. All these studies were helpful in choosing the correct methodology for data collection and analysis.

Matrix 1: Concepts and review of literature

<table>
<thead>
<tr>
<th>Living with Schizophrenia</th>
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<th>Participation in the community</th>
<th>Quality of life</th>
<th>Methodology</th>
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- Treatment: Liberman (1994)
- Myths in treatment of schizophrenia: Harding and Zahniser (1994)
- Hope and recovery: Litterell et al. (1996)
- Social outcomes: Kuipers (1996)
- Care for People living with schizophrenia: Becker et al. (2002)
- Social difficulties: Chadwick (2006)
- Care in Japan: Oshima and Kuno (2006)
- Social relationships: Lencucha et al. (2008)
- Understand quality of life: Gee et al. (2003)
- Social support (SS) and Quality of life: Sharir et al. (2007)
- Subjective and objective aspects: Narvaez et al. (2008)
- Meaning to Quality of life: Eklund et al. (2012)