ABSTRACT

The present study was carried out in two phases. Phase one being the comparative study and phase two being the intervention study. In the starting pool, a comparison was made between the schizophrenia caregivers and the depressive disorder caregivers. The second part of study examined the effect of social skills training on predominant negative symptoms of schizophrenia compared between an experimental group and a control group. One hundred follow-up patients with schizophrenia and one hundred patients with depressive disorder formed the study sample. After the comparative process all one hundred schizophrenia patients’ were included in the social skills training model.

Background:

Family care burden among schizophrenia and depressive disorders has not been addressed in the research. Family burden was significantly high in patient with schizophrenia except the effect on physical health of other family member. Comparing burden in these two groups may help in the psychosocial management.

Patients with schizophrenia often have social skills deficits. Social skill training (SST) is a structured learning oriented approach for patient with schizophrenia. Strategies used for teaching of interpersonal skills that are based on social learning theory. Effectiveness of SST improves communication, which achieves patient’s goals in social situations.

Aim:

The aim of the study was to examine family care burden in families of schizophrenia patient and compare them with patients having depressive disorders and to assess effectiveness of SST in patient with schizophrenia.

Materials and Methods:

The study sample included follow-up 100 patients with schizophrenia and 100 patients with depressive disorder. Purposive sampling method was used in this study. The samples were collected from the psychiatry out-patient and in-patient department. The patients fulfilling ICD-10 DCR criteria for schizophrenia and
depression were included as cases. Patients within the age group of 18–51 years with 2 or more years duration of illness, who gave informed consent for the study were taken up for the study. Patients were excluded if they were found to have organic mental disorder or other co morbid psychiatric disorder. A semi structured proforma was prepared for this study, which included registration number, diagnosis, age, sex, marital status, religion, educational status, occupation, duration of illness, family status, history of mental illness in the family, patient income, and domicile. Pollack and Perlick scale was used to identify key caregivers. Family Burden Interview Schedule (FBIS) includes 24 items classified into six categories viz., financial burden, and disruption of routine family activities, family leisure, family interactions, and effect on physical and mental health of others. Ratings are carried out on a three-point scale and schedule has a separate category to rate “subjective” burden.

A total of one hundred patients with schizophrenia (all types ICD- 10 DCR) were randomly screened out with more than 2 years of illness, by using Clinical Global Impression Scale (CGI) and Positive and Negative Syndrome Scale for Schizophrenia (PANSS) to rule out positive symptoms. CGI scale was used to rule out predominant positive symptoms. Thereafter participants were rated on PANSS to assess the predominant negative symptoms. Those who score more on negative symptoms were included in the study. Hence, out of one hundred patients, we could get eighty three patients with predominant negative symptoms, and such patients were included in the intervention. Hence, intervention group consisted of eighty three patients diagnosed with persistent forms of schizophrenia living in the community of their respective residence. These patients were on medication, but currently in remission. All the eighty three samples were randomly divided into two groups frothy-frothy two in each experimental and control group by using odd and even ID number and formed a universe of intervention. Further experimental group participants were randomly divided into four groups comprising of eight- ten patients. Each participant in both groups were evaluated during first session and at end of 20 sessions to measure the efficacy of SST by using a pre-post test design. Both the groups of patients were rated on Scale for Assessment of Negative Symptoms (SANS) and Social Adaptive Functions Evaluation (SAFE) before, and after the completion of intervention to evaluate the effectiveness of SST. The SAFE was used to measure client’s ability to function in everyday social situation and SANS was to estimate
The efficacy of SST on negative symptoms of schizophrenia. The independent variable was SST. The dependent variable consisted of 19 domains of SAFE and SANS scale. Pre-Post design was evaluated by paired t-test by comparing with p value < 0.05 as statistically significant value. SST sessions were configured utilizing SST for schizophrenia: A step-by-step guide (2nd ed) by Bellack et al. (2004). The researcher conducted the SST in Psychiatry Outpatient Department (OPD).

Three sessions were held in a week comprising 10 patients in each group. The sessions were lasted for 1.5-2 hours over a period of 6 months in the same hospital OPD setup. In each session of the intervention phase, the initial 15 minutes were utilized for warming up and homework task, later 25 minutes were utilized for explanation, demonstration and role play; 40 minutes were utilized for introducing new skills and remaining 20 minutes were utilized for assigning homework.

The researcher took one session for all before starting the intervention to explain present research study design, aim and objective of research, what SST will be done, what the session consists of, what their is role in the session and the benefit of the sessions. Before each session the respondents were reminded that it was voluntary participation, therefore people were free to drop the session at any point.

Forty one respondents were included in the experimental cohort, where they took part in social skill training in four groups and forty two respondents were recruited in the control group. Two respondents in the experimental group dropped out from the study before intervention, three because of medical illness. Two respondents in the experimental cohort withdrew because he refused to continue during the process of intervention. Three respondents in control cohort withdrew due to relapse. Seven subjects in the control cohort were excluded from the study because they were unable to participate due to transportation scarcity and one other due to death. Hence, the statistics analysis included 34 respondents in experimental cohort and 31 respondents in the control cohort.

Respondent’s conversations were observed at the close of each role play. These instructed participants provided feedback as how distribution of scenes was demonstrated. The principal outcomes were thoroughly debated and provided positive reinforcement. The role plays were accomplished in each intervention sessions.
Respondents were provided positive reinforcement during the sessions as well as real life setting.

Instruction techniques were used to transmit the dissimilarities among assertive passive and aggression style of conversation. In role-play exercises respondents had an opportunity to provide feedback to each other regarding their performances in simulated arena. Few important factors were considered during the sessions, like therapist moved slowly so that the respondents were not overwhelmed by attempting to modify too many social skills at one time. In addition therapist did not intensify the patients' feeling of social incompetence. An additional precaution was considered that was to transfer of social skills from the sessions to real life situation.

Results:

Two groups of patients with schizophrenia and depression have differed on variables like age, gender, marital status, education, occupation, duration of illness, family history of psychiatric illness, and patient income. These groups did not differ on other socio-demographic variables like, urban/rural distribution, type of family, and religion.

Two groups of caregivers of patients with schizophrenia and depression have differed on variables such as age, gender, education, occupation, family income, length of contact with the patient, and relationship with the patient.

Caregivers of patients with schizophrenia in comparison to depressive disorder has significantly increased mean FBIS score (P<0.001). The family burden was significantly high in family caregivers of patients with the schizophrenia except the effect on physical health of other family members.

The present study found correlation between caregiver’s demographic variable of schizophrenia and family burden in the domains of age of caregiver, education, family income, and length of contact with patient at the 0.005 level of significance.

The family burden in schizophrenia even influenced by patient demographic variables such as, age of patient and duration of illness at the 0.005 level of significance.
The pre intervention and post intervention score of SAFE of the control group did not show significant differences (p=0.053). There was a significant difference between the pre and post intervention SAFE scores in the experimental group were noted (p<0.002). The result indicated no significant decrease in SANS score in experimental group compared to control group (p= 0.072). However, result indicated significant improvement in Alogia, Apathy, and Anhedonia (p=0.007, p= 0.030, p= 0.025). The results clearly reveal that the SST may be effective in Alogia, Apathy and Anhedonia but in not other domains of SANS.

Conclusion:

The present study finds significant difference in demographic variables in schizophrenia and depressive disorders. The present study result indicates that significant difference in caregiver’s demographic variables in schizophrenia and depressive disorders.

To conclude caregivers of patient with schizophrenia experience high level of burden than the caregivers of patients with the depressive disorders. This study tested relationships with related socio demographic factors among caregivers of patients with schizophrenia. Family care burden was associated with caregivers with advanced ages, low education level, poor family income, and length of contact with patients. This study tested relationships with related socio demographic factors of patients with schizophrenia. Family care burden was associated with patient advanced ages, duration of illness, and poor patient income.

SST is effective in improving social skill functioning of patients with schizophrenia. The improvement may be seen in social functioning, modification of inappropriate interpersonal relationship. SST is effective in Alogia, Apathy and Anhedonia but not other domains of negative symptoms. SST is useful option in the treatment program of people with schizophrenia.

Key words:

Depressive disorders, family care burden, schizophrenia disorders, chronic schizophrenia, social skill training