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SOCIAL FUNCTIONING OF PATIENTS WITH SCHIZOPHRENIA IN SRI LANKA

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Abstract: The current study was the first large-scale study of the functioning level of Sri Lankan Schizophrenia / Psychotic patients and the first-ever study of this patient population by a psychologist and therefore would shed light on the psychological perspectives on this population. Most judgments regarding the level of functioning of schizophrenia patients are derived from Indian studies. India is Sri Lanka's closest neighbor and therefore most Indian research assumptions are usually generalized to Sri Lanka. Yet the current study reports similarities as well as differences among Sri Lankan Schizophrenia patients when compared to Indian patients. These differences are attributed to the different social composition of Sri Lanka compared to the Indian society, despite the many shared similarities of the two countries. Women appear to have better social functioning compared to men. High rates of prosocial behavior and voting were observed in the sample. 77.5% of the sample reports never engaging in physical activities while 39.5 % reports engaging in religious activities often. The study was conducted with a sample of 200 out-patients (n=200) from the National Institute of Mental Health (NIMH), Sri Lanka. A translated, validated version of the Social Functioning Scale (SFS) was used in the study. A convenient sample was used.

Keywords: Sri Lanka, social functioning, schizophrenia, psychosis

Introduction

What is Schizophrenia?

Patients with Schizophrenia experience chronic impairments, while the impairments are pervasive; they encompass a wide range of aspects of functioning of an individual. A significant proportion of Schizophrenia patients experience long – term impairment, which result in significant impairment in people's personal, social and occupational lives

The debilitating nature of schizophrenia is, well captured by a self-description by a patient, who has been quoted by Kraepelin.

"My whole mental power has disappeared; I have sunk intellectually below the level of a beast" (O'Carroll, 2000).

The National Institute for Clinical Excellence (NICE) guidelines for the UK defines schizophrenia as "one of the terms used to describe a major psychiatric disorder (or cluster of disorders) that alters an

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individual's perception, thoughts, affect and behavior" (National Collaborating Centre for Mental Health, 2010, p. 16).

The Royal Australian and New Zealand College of psychiatrists' clinical practice guidelines for the treatment of schizophrenia and related disorders, defines schizophrenia as follows.

Schizophrenia now refers to a group of disorders characterized by positive psychotic symptoms at some stage of illness, where mania and major depression are not prominent or persistent features, and where negative and cognitive symptoms are likely to be prominent and associated with a variable level of disability" (Royal Australian & New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia & Related Disorders, 2005)

Social functioning in Schizophrenia

Research suggests strong associations between certain aspects of neurocognitive functioning and social functioning (Addington and Addington, Neurocognitive and Social Functioning in Schizophrenia, 1999) a wide range of cognitive deficits such as deficits in the domains of attention, motor skills, executive function and intelligence are affected. An interesting fact is that cognitive impairments pre- dates the illness and seems to be difficult to explain solely by the latter course of the illness such as medication side effects or the effects of relapses. Despite these and their strong influence on the level of functioning of patients, evidence has failed to explain core features of the illness in terms of neuro-cognitive deficits.

When the functioning of Schizophrenia is considered the level of social functioning holds high importance as this aspect is easily affected with the onset of the illness.

Though the level of social functioning is a much-discussed topic in schizophrenia, there is little consensus on the definition of this concept. "Social functioning has been defined globally, as the capacity of a person to function in different societal roles such as homemaker, worker, student, spouse, family member or friend" (Brissos, Molodynski, Dias, and Figueira, 2011). The importance of the measurement of the level of social functioning in patients with schizophrenia is well demonstrated in the DSM – IV –TR by the statement that the level of social functioning is integral to the assessment of the efficacy of antipsychotic drugs in schizophrenia.

Deterioration of functioning is not solely due to the impairment caused by the disorder. "Unpleasant side effects of treatment, social adversity and isolation, poverty and homelessness also play a part" (National Collaborating Centre for Mental Health, 2010). Thus, gaining a better understanding of the functioning of this group of patients is extremely important. Reducing other adverse variables for functioning can help patients increase their quality of life, level of functioning and be better able to adapt themselves to living with a chronic condition. This can result in a better prognosis of Schizophrenia patient.

Outcomes for schizophrenia are believed to be better in developing countries compared to developed countries (Bhugra, 2005). Studies from India report better social functioning and overall quality of life in patients with schizophrenia. One such study reports "67 percent of the 88 patients in the study were employed and that most of them were in full-time employment in mainstream jobs with minimal or no

disability or support in the workplace" (Srinivasan and Tirupati as cited in Basi, Mathews, and Mathews, 2006). Though schizophrenia is perceived in the West as a severe, debilitating, chronic mental illness resulting poor functional outcomes, at least two major international studies, the International Pilot Study of Schizophrenia (2) and the Determinants of Outcome of Severe Mental Disorders (3), have provided convincing evidence for a better outcome in India and other "less developed" countries than in the West (Basi, Mathews, and Mathews, 2006)

Basi, Mathews, and Mathews (2006) further argue that the reason for poor outcomes for schizophrenia in western countries might be the result of perceiving the illness as a purely "biological" one, resulting in reduced functional recovery and outcome. The severe stigma faced by the patients may also have a major role in keeping patients with schizophrenia on the fringes of the society, making it extremely difficult for them to find employment, thus drastically reducing opportunities for better functioning.

The better functional outcome of schizophrenia in non-western countries could be due to more positive cultural perceptions, expectations and beliefs about the illness. It may be that these positive beliefs act as a self -fulfilling prophecy in helping patients return to pre-morbid functioning levels quickly. The more negative beliefs and expectations of the western societies may be having the effect of a self – fulfilling prophecy resulting in poor outcomes. Thus "It is obvious that although schizophrenia may have a biological basis, good outcomes depend on a pharmaco-psycho-social approach, and the psychosocial aspect may well have the greatest impact on improved outcomes" (Basi, Mathews, and Mathews, 2006).

Thus, schizophrenia is understood as a complex clinical manifestation, which causes serious disability in all areas of functioning in an individual's life. Thus, the level of functioning is believed to be the most important aspect of prognosis and treatment efficacy. This marked functional deterioration is observed to vary based on many diseases related variables such as the quality of the intervention, premorbid personality, level of adherence to antipsychotic medication etc. Thus, it appears important to study the level of functioning as a whole and other disease related variables which can substantially vary the functional outcome of patients with schizophrenia.

The current study attempts to obtain a comprehensive understanding of the level of social functioning, which captures the most important aspects of the overall functional capacity. This is expected to support clinicians in understanding the efficacy of current treatments provided and better understand prognosis and the course of illness of the patients udner their care.

As the level of social functioning is seen as an important indicator of the efficacy of any treatment modality and as the level of social functioning is observed to be better in developing societies, it would be interesting to study this aspect in a sample of Sri Lankan patients.

At present such studies have not been reported in Sri Lanka. Most studies which have reported better outcomes than in developed societies have been carried out in Indian societies. As the nearest neighbour to India, Sri Lanka shares a lot of ideological and other sociological variables with Indian society. Yet there can also be observed very complex differences in the Sri Lankan community as opposed to India. Thus, it would be interesting to investigate these aspects in a Sri Lankan community sample. Increased understanding of the level of functioning of patients with schizophrenia in Sri

Lanka will be quite useful in treatment planning for clinicians. The current study is important specially because there are no similar studies reported in Sri Lanka.

Materials and Methods

The study population

A total of two hundred (200) participants (schizophrenia patients) took part in this study from the National Institute of Mental Health (NIMH) clinics, equally divided by gender and who were adequately stabilized at the time of participation. Only English or Sinhala speaking patients were included in the sample, as the researcher is not competent in Tamil. Of the entire sample of male and female participants who participated in the study, all except one patient were Sinhala speaking.

Judgmental-nonrandom, convenient sampling (Based on medical judgment on the suitability to participate) was used to obtain the sample in clinic setting of NIMH. The participants had to have received a diagnosis of Schizophrenia from a consultant psychiatrist.

With a sample size of 200, the researcher expected to study 28.6% of the target population, as at any given time roughly there are about 700 inward patients with schizophrenia at NIMH. The reasoning behind this was that, as the research uses a convenient sample, the sample should include at least 1/4th of the patient population to be comfortable with results. This was discussed with the principal supervisor. Studying 1/4th of the entire population was decided as large enough for the study. In arriving at this decision, the sample sizes of other schizophrenia research were reviewed and it was understood that most studies contained sample sizes less than 100 and less than 25% of the entire population. As it was not possible to exert rigorous scientific control over the study situation, it was decided to have a large sample, i.e., Larger than the average sample sizes used in most studies. This "largeness" was decided after reviewing previous studies.

Exclusion criteria

Patients with a diagnosis of pervasive developmental disorders were excluded. Those who did not speak either English or Sinhala were also excluded.

Data collection procedure

Social Functioning Scale (SFS) was used to measure the level of social functioning of patients. Administration of the SFS was done by the principal researcher, in an available space of the clinic after obtaining verbal consent. As some clinic patients send their relatives to obtain monthly drugs, data was obtained both from patients and relatives using the Relatives Version and the Individual's version of SFS as appropriate. Both of the versions consist of the same items, adjusted to address the patient or the relative.

Before administering the tests, their suitability to participate in the study was discussed with the members of the medical team.

Only patients with sufficient insight (according to the evaluation of the medical team) to give consent were allowed to participate and the plausible effects of the participation on psychotic symptoms (such as paranoid delusions) were discussed with the medical team prior to testing.

The participants were debriefed both prior to and after the test administration about the nature of the study, its possible risks and benefits in a simple pre-prepared format. The patient's or relative's verbal consent was obtained prior to administering the tests and including other patient related data in the research.

Instruments used in the study

Social functioning scale (SFS)

A translated and validated version of the Social Functioning Scale (Birchwood et al, 1990) was used for assessing the level of social functioning of the patients. The Social Functioning Scale (SFS), (Birchwood et al., 1990) is a 79-item questionnaire that assesses the following seven domains of social behaviour: social engagement/withdrawal, interpersonal behaviour, pro-social behaviour, recreation, independence-competence, independence - performance and employment/occupation in patients with schizophrenia. The Social Functioning Scale (SFS) was chosen based on its vast evidence base. It has been translated, and validated, in many languages (E.g., the Spanish version, Norwegian version) (Torres and Olivares, 2005). It has also been used in a wide variety of Schizophrenia related research, and shown to be valid and reliable (Birchwood, 1990). The SFS has been shown to have good internal consistency (Birchwood et al, 1990) (Henry, Bailey, and Rendell, 2007).

There are two versions of the SFS: The individual's Version and the Relative's version. Both the versions were translated and validated using the same procedures for this study, after obtaining permission from the main author.

The SFS was systematically translated in three rounds by a panel of three experts (Sumathipala and Murray, 2000). The content and consensual validation of the scale was carried out.

Results and Discussion

According to the distribution of SFS scores, there is observed a better level of social functioning in women compared to men. This is also a higher than the mean level observed in the original validation of the SFS in a UK population. (Birchwood et al., 1990) This could be seen as a reflection of better social inclusion and a reduced level of stigma experienced by patients with schizophrenia in developing countries, as observed by prior research. This could also reflect that the quality of life for schizophrenia patients is better in Sri Lanka compared to that in developed countries as the level of social functioning has demonstrated a strong relationship with the resulting quality of life.

Neurocognitive deficits are strongly associated with both functional outcome and functional recovery. (Addington and Addington, Neurocognitive and Social Functioning in Schizophrenia, 1999) As Sri Lankan patients show higher levels of social functioning, this could be an indication of better cognitive functioning.

It is also observed that though there is a statistically significant difference in the overall social functioning of men and women, there is no such observed difference in any sub-domains of social functioning as assessed by each sub-scale of the SFS. This may mean that there are no specific areas in which either males or females are particularly strong or weak.

Further high pro-social behavior was observed in the sample. 49% of the sample reports often attending social occasions such as funerals & weddings. It very interesting that, 75.5% of the population reports voting often for elections. Only 13%reported never voting for elections.

77. 5% of the patients report never engaging in physical activities. This has strong implications on the national policy of Schizophrenia as physical activity is not only required for general wellbeing, but also specially indicated with the side effects of antipsychotic medications.

Further 39.5 % reports engaging in religious activities often, while only 9.5% reported never engaging in religious activities.

Conclusions and recommendations

As patients are observed to be high in social functioning and receive family support, family interventions can be used to facilitate the relationship between the families and patients, not only to help patients continue to receive family support, but also to improve the quality of life and communication between the patients and families and would result in manageable amounts of expressed emotion (EE), helping reduce further relapse. This would be especially important as there is a substantial amount of inpatients deserted by their family members at NIMH.

As patients are already high in prosocial behaviour, more community-based intervention modalities can be used in improving their global quality of life. The existing social institutions such as religious institutions, etc. can be included in such efforts.

As the need for outdoor sports and physical activity appears to be imminent, interventions targeted at this would be highly important.

The high level of social functioning may mean that interventions to include the patients in the Gross Domestic Production (GDP) in a meaningful way, such as supported employment programs, would be of great value. The need for such interventions is especially important, given the high unemployment rates among the patient group.

Designing Interventions for the subset of patients who are poor in the level of functioning and other illness related variables is of prime importance. Psychometric tools developed for Sri Lanka are of prime importance in distinguishing such patients.

As antipsychotic medication alone has limited efficacy in improving the condition in schizophrenia patients, research has identified individual and family psychological interventions as a compulsory treatment in both acute and stabilized states of schizophrenia. The individual and family psychological therapies are of vital importance in early interventions for schizophrenia too.

There are no psychologists attached to the NIMH, As such, psychological interventions are not part of the routine care of the NIMH.

Yet integrating psychological treatments to current treatments received by patients is of prime importance. This is especially so given the research emphasis on multimodal treatment and psychological interventions being a compulsory component of this. Yet , though in all well-developed mental health systems psychologists play a leading role in the treatment of mental health problems in general and schizophrenia in particular, this is not observed in Sri Lanka. Therefore it is of prime necessity to constitute a cadre of psychologists at NIMH and revise the organization of the institution to include the role of the psychologist in consultation with the leading mental health facilities in the world. This is especially so given the fact that NIMH is considered the place of excellence for mental health.

Study limitations and further research

The study has several limitations. The study has used a convenient sample. Many confounding variables were not controlled in the methodology. It has used subjective estimates of the majority of the variables studied. Therefore, it would be important to use a more random sample in more controlled conditions to explore the same variables, coupled with more objective measures of the variables studied.

Also, as this study does not have any similar studies in a Sri Lankan patient sample for comparison purposes, the need for similar studies to arrive at any conclusive evidence cannot be overemphasized. Therefore, further studies on similar illness related variables and result observed is of primary importance.

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