Original Research Paper

Effectiveness of Supportive Therapy on Quality of Life among Person with Chronic Schizophrenia: A Randomized Control Trial

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ABSTRACT

Background: Quality of life is a multidimensional concept comprising material, physical, social, emotional wellbeing; Supportive psychotherapy has been developed as an approach to address the long-term difficulties of patients with chronic diseases and complaints. Aim of the Study: Present study was aimed to investigate the effectiveness of supportive therapy on quality of life among person with schizophrenia at occupational rehabilitation centre. Methodology: This was a hospital based quasi experimental research in which pre and post with control group design was used. Twenty male patients diagnosed with schizophrenia according to ICD-10 DCR were selected for the study. Two stage sampling was used first stage participants (with screening) were selected purposively and in the second stage systematic random technique was used for creating experimental and control groups. A self prepared Motivational Analysis Checklist and WHO Quality of Life Brief was used for pre and post assessment.Results: Study reports supportive psychotherapy significantly improves participant's quality of life.

Keywords: Supportive therapy, quality of life, chronic schizophrenia

INTRODUCTION

Today the issues on quality of life are discussed widely in different scientific fields. In sociology quality of life is understood as subjective understanding of well-being taking into account individual needs and understanding. In economics it is the standard of living, in medicine it is ratio of health and illness with the factors influencing healthy lifestyle. Health factor is often given a priority in quality of life though the quality of life concept must be understood more widely. There is no universally accepted definition of quality of life. Usually it is referred to the definition of World health organization introduced in 1995 (Quality of life) is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, values and concerns incorporating physical health, psychological state, level of independence, social relations, personal beliefs and their relationship to salient features of the environment quality of life refers to a subjective evaluation which is embedded in a cultural, social and environmental context.[1]

Quality of life is determined by a lot of factors and conditions: dwelling, employment, income and material well-being, moral attitudes, personal and family life, social support, stress and crisis, condition of health, prospects of health care, relationship with the environment, ecologic factors, etc.[2,3]

In many fields, including medicine, health sciences, and social sciences, the concept of quality of life has attracted much research focus.[4] Although there are different definitions of the concept, there is a general agreement among researchers,[5,6] that quality of life is a multi-dimensional concept comprising material well-being (finance, income, housing quality, transport), physical well-being (health, fitness, mobility, personal safety), social well-being (personal relationships, community involvement), emotional wellbeing. The study of quality of life and the focus on patient's subjective sense of well-being is a fairly new phenomenon that has attracted professional attention only within the past 2 decades. [7] Between 1850 and 1950, medicine was dominated by the

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quest for cures: treating chronic illness as well as helping patients manages long-term impairment received less attention.

However, this trend now has shifted. Issues of life quality became the key issued when complete cure is not possible. Illness that cannot be eliminated must be managed, and the treatment goal focuses in maintaining maximum function and a meaningful existence or quality of life. In psychiatry, the concept of life quality has been considered an important aspect of mental health.[8] However, how psychiatric clinicians evaluate an individual's subjective experience has changed with the rise and fall of psychoanalysis. In psychoanalysis, trying to understand the subjective experience has focused on examining dynamic unconscious process rather than external realities. With the advent of cognitive behavioral approaches, clinicians emphasized the impact of a patient's environment and subjective appraisals of symptoms and life problems. Concept of social adjustment and levels of functioning became relevant.

Though quest for providing better measure of quality of life in schizophrenic patients has developed considerably, assimilating the increasing awareness of the multidimensionality of treatment outcome and the importance of patient satisfaction in health care, yet the construct of quality of life has and will remain an important area of investigation in years to come.[9-11]

Schizophrenia is a pervasive psychiatric disorder that typically has its onset in early adulthood and persists for the remainder of the lifespan. The person with schizophrenia may feel alienated from and shunned by others. Friendships and work roles may be lost. Many patients with schizophrenia have psychological distress and receive some form of psychotherapy for improvement. Several different psychotherapeutic approaches for schizophrenia have been developed and studied. Of these approaches, cognitive behavior therapy (CBT) has the strongest evidence base and has shown benefit for symptom reduction in outpatients with residual symptoms. In addition to CBT, other approaches include compliance therapy, personal therapy, acceptance and commitment therapy, and supportive therapy. CBT for schizophrenic disorders has been increasingly established. The focus of research is now on the mechanisms of change. In this context, supportive therapy (ST) plays a major role as a non-specific control condition. The three different goals of supportive techniques are to provide emotional support, to enhance functional recovery, and to alter the underlying illness process in this patient population.

Supportive psychotherapy has been developed as an approach to address the long-term difficulties of patients with chronic diseases and complaints. [12] The techniques of the approach are rehabilitative[13], emphasizing adjustment and coping with ongoing difficulties. They are compatible with a recovery philosophy of 'learning how to live, and how to live well, with enduring symptoms and vulnerabilities'.[14]

The therapeutic techniques of supportive psycho-therapy are as follows:

- A style of communication characterized by emphatic validation, praise and advice, and gentle confrontation
- Environmental interventions (e.g. health promotion, enabling access to community resources and support)
- Psycho education (including identifying and managing early warning signs of relapse)
- Improving self-awareness (e.g. of defenses) and developing coping/adaptive strategies to promote a sense of agency, control and self-management

A needs-adapted approach: perhaps an emphasis on fostering personal growth, separation and individuation; or a focus on maintenance, preventing deterioration and weathering relapses.

Aim: The aim of the present study was to investigate the effectiveness of supportive therapy on quality of life among person with schizophrenia at occupational rehabilitation centre.

METHODOLOGY

Venue of the Study: The study was conducted in Ranchi Institute of Neuro Psychiatry and Allied Sciences, (RINPAS) Kanke, Ranchi. This is 500 bedded hospital and post graduate teaching institute and tertiary referral center for the patients with psychiatric disorder. Patient those who meet the criteria and were admitted in the hospital were selected for the study.

Research Design: This was a hospital based quasi experimental research in which pre and post with control group design was used.

Sampling technique: Two stage sampling was used first stage participants (with screening) were selected purposively and in the second stage systematic random technique was used for creating experimental and control groups.

Sample: For present study twenty 20 male patients diagnosed with schizophrenia according to ICD-10 DCR[15] (WHO, 1992) were selected from different wards of Ranchi Institute of Neuro-Psychiatry and Allied Sciences, (RINPAS) Kanke, Ranchi. Experimental group consisting of 10 participants was created randomly from the selected participants and rest 10 participants are putted as control group.

Inclusion criteria:

1. Individual diagnosed with schizophrenia according to ICD-10, DCR.
2. Age range between 21 to 45 years.
3. Male patients.
4. Education at least up to 5th standard.
5. Score of more than 20 in Self prepared Motivational Analysis Checklist
6. Duration of illness more than 2 years.
7. Those who gave the written informed consent.

Exclusion criteria:

1. Individual having organic illness and mental retardation.
2. Individual with substance dependence.
3. Individual attending occupational therapy sessions.

Tools:

1. Semi-structured socio-demographic and clinical data sheet
2. Self prepared Motivational Analysis Checklist
3. Quality of Life Bref[15]

RESULTS

Table 1 shows socio demographic profile of participants from experimental and control groups. 35% of the participants are primary educated, 40% are secondary educated, 10% are higher secondary educated and 15% are graduates. Result shows that there was no difference between the status of education of both the groups. 30 % of the participants are farmer 15 % of them are business

Table 1
Comparison of socio demographic variables between experimental and control group

Variables	Experimental Group N=10(%)	Control Group N=10(%)	χ^2	df	P
Education					
Primary Education	4(40)	3(30)	.476	3	1.00
Secondary Education	4(40)	4(40)			
Higher S. Education	1(10)	1(10)			
Graduation	1(10)	2(20)			
Occupation					
Farmer	4(40)	2(20)	4.00	4	1.00
Business	2(20)	1(10)			
Daily Labour	NIL	2(20)			
Unemployed	2(20)	4(40)			
Student	2(20)	1(10)			
Family Type					
Nuclear	6(60)	6(60)	.000	1	4.00
Joint	4(40)	4(40)			
Domicile					
Rural	8(80)	6(60)	.952	1	3.00
Urban	2(20)	4(40)			

man 30 are un employed and 15% are still perusing their education specifically 20 % participants in control group are daily wages labour but none of the participants are in this category in experimental group. No difference is present between both the groups. 60% participants in the both the groups belonged to nuclear family and 40% belonged to joint family. In domicile of the two groups the table showed no significant difference between the groups. In the experimental group 80% of the participants belonged to rural area and 20% belonged to urban area. In the control group 60% of the participants belonged to rural area and 40% belonged to urban area.

Table 2 shows the comparison on the age, duration of illness and number of hospitalization between the both groups. Mann Whitney U test was used for the purpose since the above variables were continuous variables. There was no significant difference between experimental and control group on age, duration of illness and number of hospitalization. Both the groups were similar in these socio-demographic variables age, duration of illness and number of hospitalization p values is respectively .849, .879 and .549 for the above variables.

Table 3 shows comparison between the experimental and control group pre intervention. The comparison was based on the six domains of QOL (overall QOL, health QOL, physical QOL, psychological QOL, social QOL, and environmental QOL). Mann Whitney U test was used for this purpose. Result shows that there was no significant difference in the pre research condition of both the groups, when compared on all domains of QOL.

Table 4 shows comparison between the pre and post level of quality of life of the experimental group participants. Result shows participants improved significantly on every domain of quality of life scale. Result showed that overall quality of life pre assessment score is 2.00+0.47 and post assessment is 3.20+0.42. The health domain of quality of life pre assessment is 1.70+0.67 was improved in post assessment to 3.60+0.52

Table 2
Comparison of socio demographic variables of participants from experimental and control group

Variable	Experimental		Control		Mann Whitney	Z	p
	Mean	Sd	Mean	Sd			
Age	31.00	7.46	31.60	7.53	47.50	.190	.849
Duration of illness	5.95	3.45	5.80	3.48	48.00	.153	.879
No. of Hospitalization	1.40	.699	1.20	.422	44.00	.600	.549

Table 3
Baseline comparison of Quality of Life between experimental and control group

Variables	Experimental group	Control Group	Mann -Whiteny U	Z	P value
	Mean Rank	Mean Rank			
Overall QOL	10.95	10.05	45.500	.402	.688
Health	10.50	10.50	50.000	.000	1.000
Physical	10.25	10.75	47.500	.195	.845
Psychological	11.70	9.30	38.000	.951	.342
Social	10.40	10.60	49.000	.081	.936
Environmental	10.80	10.20	47.000	.231	.817

Table 4
Comparison of Pre and Post assessment of quality of life among experimental group

Variables	Pre		Post		t (df=9)	P value
	Mean	SD	Mean	SD		
Overall QOL	2.00	0.47	3.20	0.42	6.000	.000#
Health	1.70	0.67	3.60	0.52	10.585	.000#
Physical	17.70	2.16	24.20	1.93	7.344	.000#
Psychological	11.70	1.15	19.30	1.54	13.328	.000#
Social	5.00	1.24	8.10	0.99	11.343	.000#
Environmental	16.60	2.11	24.70	1.63	13.842	.000#

#=P>0.001, *=P>0.01 Level, **=P>0.05 Level.

level (t= 10.85). Physical domain of quality of life was improved significantly in post (24.20) assessment from pre (17.70) assessment. In psychological quality of life was improved significantly from pre 11.70 to 19.30 in post assessment. Social domain of quality of life pre score was 5.00+1.24 and improved 8.10+0.99. Similarly in environment domains of quality of life scale post (24.70) assessment reported significant improvement from the pre (16.60) assessment.

Table 5 shows comparison between the pre and post assessment of quality of life of control group participants. Result reveals improvement on overall quality of life, from pre assessment (2.40±0.51) to post (3.20±0.42) assessment. The health domain of quality of life also shows improvement from pre assessment (2.20±0.67) to post assessment (3.10±0.32). Physical domain pre and post assessment mean and sd 17.60±1.17 and 22.20 ± 0.63 and t value was 11.50 which reveals significant improvement. Psychological domain of quality of life also improved significantly improved from pre (11.30 ± 0.67) assessment to post (17.20 ± 0.78) assessment t value was 16.95. Social domain's pre assessment was 4.80 ± 0.91 and post assessment score 6.70 ± 0.67 and t-value is 8.143 again reported significant improvements. Similarly in Environmental domain of quality of life pre assessment 16.40 ± 2.22 was significantly improved to 21.60 ± 1.17 in post assessment.

Table 5
Comparison of Pre and Post assessment of quality of life of control group

Variables	Pre		Post		t (df=9)	P value
	Mean	SD	Mean	SD		
Overall QOL	2.40	0.51	3.20	0.42	6.00	.000#
Health	2.20	0.67	3.10	0.32	9.00	.000#
Physical	17.60	1.173	22.20	.632	11.50	.000#
Psychological	11.30	.674	17.20	.788	16.95	.000#
Social	4.80	.918	6.7	.674	8.14	.000#
Environmental	16.40	2.221	21.60	1.173	9.75	.000#

#=P<0.001, *=P<0.01 Level, **=P<0.05 Level.

DISCUSSION

Schizophrenia is a psychotic disorder (or a group of disorders) marked by severely impaired thinking, emotions, and behavior. Schizophrenic patients are typically unable to filter sensory stimuli and may have enhanced perceptions of sounds, colors, and other features of their environment. Most schizophrenics, if untreated, gradually withdraw from interactions with other people, and lose their ability to take care of personal needs and grooming. Schizophrenia affects individual, social and occupational functioning of people. Schizophrenia is considered as one of the top ten causes of long-term disability worldwide.

Supportive therapy plays a major role as a non-specific control condition. The three different goals of supportive techniques are to provide emotional support, to enhance functional recovery, and to alter the underlying illness process in this patient population. Supportive psychotherapy has been developed as an approach to address the long-term difficulties of patients with chronic diseases and complaints[12]. The techniques of the approach are rehabilitative[13], emphasizing adjustment and coping with ongoing difficulties. They are compatible with a recovery philosophy of 'learning how to live, and how to live well, with enduring symptoms and vulnerabilities'.[14]

Present study was conducted in order to find out the effect of supportive techniques combined with occupational therapy on males with schizophrenia, initially the baseline assessment and at the end post assessment was conducted in both experimental and control group to measure socio occupational functioning, quality of life, vocational and social skills and self esteem of the participants.

Findings shows pre and post assessment of quality of life in experimental group show that there had been significant improvement after the participants of experimental group received supportive techniques with regular occupational therapy. Result shows improvement in control group who joined occupational therapy unit when their scores on pre and post assessment of quality of life. After joining occupational therapy unit both the groups, experimental and control, showed improvement but participants in experimental group after receiving supportive techniques showed significant improvement in their quality of life in compare to control group.

Findings of the present study states that when supportive therapy complies with occupational therapy to individuals with schizophrenia it shows significant improvement in their socio-functioning and quality of life.

Findings of the present study showed that the experimental and control group are having similar type of quality of life in every domain (Over all QOL, health QOL, physical QOL, psychological QOL, social QOL and environmental QOL). Study findings shows after receiving supportive technique participants of the experimental group showed significant improvement in each domain of the quality of life (Over all, health, physical, psychological, social and environmental) in comparison to control group.

Study suggested that supportive techniques and occupational therapy had positive effect on enhancing quality of life of the participants. Findings shows significant improvement in the control group participants could be attributed by existing regular inpatient care, regular medications and facilities available in occupational therapy unit which patients received during their stay in the hospital. Peiris et al.[16] stated that providing an additional day of rehabilitation improved functional independence and health-related quality of life at discharge and may have reduced length of stay for patients receiving inpatient rehabilitation, that supporting to our finding. High level of occupational engagement was related to higher ratings of self-related variables, fewer psychiatric symptoms, and better ratings of quality of life, and vice versa.[17] Thus, the findings of the present study have been similar to findings of previous studies, can be concluded that person with schizophrenia can be improved with occupational trainings.

Findings of the present study are shows post assessment of both the groups revealed that participants receiving occupational training with supportive techniques had improved quality of life by the end of the treatment in compare to participants receiving regular hospital treatment and receiving occupational training.[18] stated that age is not a factor for the effective rehabilitation. As it could be seen that there have been a scarcity of studies where supportive techniques had been combined with occupational therapy for person with schizophrenia, the

few studies in this direction has similar findings with present study.

CONCLUSION

Supportive therapy if supplemented with occupational therapy has a more beneficial effect on the QOL perceived by person with schizophrenia. Findings also show that quality of life had a positive correlation with good socio-occupational functioning of the participants.

REFERENCE

1. WHOQOL Group. The World Health Organization quality of life assessment (WHOQOL): position paper from the World Health Organization. Social science & medicine. 1995 Nov 1;41(10):1403-9.
2. Juozulynas A, Ceremnych E, Kurtinaitis J, Jankauskienė K, Reklaitienė R. Quality of life and health. Health Sciences 2005;1(15):71-4.
3. Phillips PJ, Scruggs WT, O'Toole AJ, Flynn PJ, Bowyer KW, Schott CL, Sharpe M. FRVT 2006 and ICE 2006 large-scale results. National Institute of Standards and Technology, NISTIR. 2007 Mar 29;7408(1).
4. Shek DT, Chan YK, Lee PS. Quality of life in the global context: A Chinese response. Social Indicators Research. In Shek DT, Chan YK, Lee PS. Quality-of-life research in Chinese, Western and global contexts. Springer Science & Business Media; 2005 Jun 8 (pp. 1-10).
5. Felce D, Perry J. Quality of life: Its definition and measurement. Research in developmental disabilities. 1995 Feb 28;16(1):51-74.
6. Wallander JL, Schmitt M, Koot HM. Quality of life measurement in children and adolescents: issues, instruments, and applications. Journal of clinical psychology. 2001 Apr 1;57(4):571-85.
7. Sim K, Mahendran R, Siris SG, Heckers S, Chong SA. Subjective quality of life in first episode schizophrenia spectrum disorders with comorbid depression. Psychiatry research. 2004 Dec 15;129(2):141-7.
8. Awad AG, Voruganti LN, Heslegrave RJ. A conceptual model of quality of life in schizophrenia: description and preliminary clinical validation. Quality of Life Research. 1997 Jan 1;6(1):21-6.
9. Lehman AF, Possidente S, Hawker F. The quality of life of chronic patients in a state hospital and in community residences. Psychiatric Services. 1986 Sep;37(9):901-7.
10. Ritsner M. Predicting changes in domain-specific quality of life of schizophrenia patients. The Journal of nervous and mental disease. 2003 May 1;191(5):287-94.
11. Lambert M, Naber D. Current issues in schizophrenia: overview of patient acceptability, functioning capacity and quality of life. CNS drugs. 2004 Dec 1;18(2):5-17.
12. Fenton WS. Evolving perspectives on individual psychotherapy for schizophrenia. Schizophrenia Bulletin. 2000;26(1):47.
13. Frank AJ, Moll JM, Hort JF. A comparison of three ways of measuring pain. Rheumatology. 1982 Nov 1;21(4):211-7.
14. Roberts G, Wolfson P. The rediscovery of recovery: open to all. Advances in psychiatric treatment. 2004 Jan 1;10(1):37-48.
15. World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization; 1992.
16. Peiris CL, Shields N, Brusco NK, Watts JJ, Taylor NF. Additional Saturday rehabilitation improves functional independence and quality of life and reduces length of stay: a randomized controlled trial. BMC medicine. 2013 Sep 10;11(1):198.
17. Bejerholm U, Eklund M. Occupational engagement in persons with schizophrenia: Relationships to self-related variables, psychopathology, and quality of life. American Journal of Occupational Therapy. 2007 Jan 1;61(1):21-32.
18. Bell KR, Temkin NR, Esselman PC, Doctor JN, Bombardier CH, Fraser RT, Hoffman JM, Powell JM, Dikmen S. The effect of a scheduled telephone intervention on outcome after moderate to severe traumatic brain injury: a randomized trial. Archives of physical medicine and rehabilitation. 2005 May 31;86(5):851-6.