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Psychiatric Social Work Intervention for Social Rejection of persons with Schizophrenia in Rural Areas – An Intervention Study

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ABSTRACT: *It is widely acknowledged that schizophrenic patients have major deficits in social functioning in the community. The intervention to improve these deficits is inadequate in rural areas in India. The aim is to ascertain impact of structured psychiatric social work intervention for management of social rejection of persons with schizophrenia in rural areas. The sample consisted of thirty persons with schizophrenia and significant family members. A proportionate sample covering heterogeneous socio demographic background was drawn using simple random sampling technique. It was followed a Before-After Experimental Research Design Without Control Group. The social rejection and orientation towards mental illness were assessed before and after psychiatric social work intervention using Patient Rejection Scale and Orientation towards Mental Illness Scale. After psychiatric social work intervention overall there were changes in the domains of social rejection and orientation towards mental illness. The results have indicated that the psychiatric social work intervention has contributed to improve the social functioning of the patients in rural areas. Results have shown the changes in all the domains of social rejections and orientation towards mental illness significantly. Conducting similar studies in different settings would contribute to the psychiatric social work knowledge in future.*

KEYWORDS: *Schizophrenia, Social Rejection, Orientation towards Mental Illness, Psychiatric Social Work Intervention, Families, Rural Areas.*

I. INTRODUCTION

Schizophrenia is one of the major mental disorders severely affecting both men and women predominantly between the ages of 15 to 45 years. Schizophrenia may develop so gradually that no one realizes as something wrong with person for a long period of time. Sometimes it may also develop suddenly with dramatic changes in behaviour occurring over a period of few weeks or even a few days. Emil Kraeplin, who first term this illness as 'Dementia Praecox' described it as progressive and deteriorating course of illness. Accordingly schizophrenia destroys the inner unity of the mind and weakens volition and drive that constitute our essential (Kraeplin, 1971). The persons with schizophrenia are incapacitated to engage and sustain social bonds, and even the society reacts negatively to the social and personal deviance caused by the illness. Because its manifestations are so personal, it elicits fear and misunderstanding in society instead of sympathy and concern.

Severe impairment is the result of symptoms (positive and negative) of schizophrenia. This inturn affects the individual's ability to understand and act according to social cues, and would diminish markedly. Patients experience unemployment, social isolation, homelessness and dependency on family members. The relationship of patients with their family members and peer groups changes partly because of their unexplained behaviours and the stigma associated with the illness. Similarly, cognitive deficits like decreased attention, concentration and lack of motivation lead to deterioration in their work capacity and are responsible for unemployment among these patients. This further leads to social maladjustment (Appelo, et al., 1992).

Schizophrenia remains unparallel as a stigmatized disease with all the social consequences of personal shame, family burden, inadequate support for after care and rehabilitation. Families of schizophrenic patients suffer heavy financial and emotional burdens (Thara and Joseph, 1995). Families become frustrated and angry as their savings dwindle often about little improvement in the patient. Family members are not sure of the right way of help. Most of the family members continue to be unaware about the causes, treatment, factors related to relapse, aftercare and rehabilitation. The management of social disability among schizophrenic patients in the community by the family members has been considered an important area by mental health professionals. Efforts were being made by many researchers for the management of social disability among schizophrenic patients (Hogarty and Goldberg, 1973; Linn, et al., 1979; Stein and Test, 1980; Bentlay, 1990, Ponnuchamy, 2012).

Families in India are supportive to the mentally ill persons in general. The persons with mental disorders are well accepted and tolerated by Indian families. Relatives of patients with schizophrenia experience more burden and distress due to the patient's symptoms, social and occupational dysfunctioning. By family psychoeducational intervention and involving the family in the management of their patients, they can be helped to cope with the sorrows and problems faced by their patients. Due to their relatives suffering from schizophrenia, the care givers have high expectations in terms of information about the illness, medication, side effects, management of unpredictable and disturbed behaviours at home, and training to handle day-to-day issues (Ponnuchamy, et al., 2005).

Working with families in a systematic and purposive manner becomes an essential and integral component in the management of persons with schizophrenia in the community. The inputs offered to the caregivers are education, providing information, support, problem solving and training etc. However, providing these services to families in the institutions is expensive and stigmatized. Decentralization of mental health services and community care has become a worldwide trend including India. In India, the National Mental Health Programme (1982) advocates community care, in which the families continue to play a major role in care of the mentally ill member in the community. Further the difficulties faced by the carers in the process of care giving are now well acknowledged by the mental health professionals. The recent trend is also focusing on managing the psychiatrically ill person by the family within the community than in the hospital.

Psychiatric Social Work as a professionalized activity that focuses on reducing the psychosocial problems of clients. The social work practitioners have postulated that the psychosocial functioning or dysfunctioning was mostly determined by the interaction between the individual needs, aspirations and functional capacities on one side, and environmental (situations) expectations, opportunities and resources on the other side. Hatfield et al (1979) emphasized on the modification of client system and the environmental system for better psychosocial functioning. In summary, the review of literatures indicates the concept of social disability in terms of social adjustment is much relevant to the field of mental health as most of the mental illnesses contribute to the psychological, social disturbances to the patient and family members. Outcome researches in schizophrenia have shown long standing disabilities among the schizophrenic patients in the community. Psychoeducation as well as Skills Training are conceptualized to be the essential element of social work intervention. The social interventions provided by the social workers found to have meaningful benefits with persons with schizophrenia in the west. In the Indian context particularly in rural settings, studies on the effectiveness of social work intervention with schizophrenic patients are inadequate. This attempt is made to focus in this direction.

II. MATERIALS AND METHODS

Many Psychiatric Social Work interventions have yet to receive adequate testing and scientific evaluation. Recognizing suitability of particular interventions for particular practice situations must be supported by adequate scientific evidence, which will further contribute to the profession. Further, recognizing that social work research especially in the context of service delivery is a prerogative for social workers. The existing intervention studies (Hogarty and Goldberg, 1973; Linn, et al., 1979; Stein and Test, 1980; Bentlay, 1990; Viswanath and Padmavathi, 1992) in the areas of social work practice in mental health field are urban based and involves long duration of intervention. Rural areas do not have sufficient inputs from the mental health professionals. In India, the National Mental Health Programme advocates implementation of mental health services through District Mental Health Programme, in which a team of Psychiatrist, Psychiatric Social Worker, Psychologist and Psychiatric Nurse deliver the services. In this context, it is needed that how far the management of social adjustment among schizophrenic patients in the rural areas is effective if it is done through Rural Mental Health Camp. There is no intervention study through Rural Mental Health Camp in the rural areas in the field of mental health. There is a lacunae in this area. Hence, this study is designed for this purpose.

The aim of study was to ascertain impact of structured psychiatric social work intervention for social rejection and orientation towards mental illness of persons with schizophrenia in rural areas through rural mental health camp. The present study was undertaken to understand the level of social rejection both before and after the persons were exposed to the psychiatric social work intervention package. The course of study was aimed to develop and implement the social work intervention package with the patients and the significant family members in the conjoint sessions. It was decided to test the efficacy of the intervention at the end of two months, fourth months and six month intervals after the intervention. In view of this nature of research work, a "Before-After Experimental Research Design Without Control Group" was considered for the present study. In this design a single test group was selected before the introduction of the intervention. The intervention package was then introduced and its effectiveness was measured again. The efficacy of the intervention was demonstrated by the changes that occur after the intervention was administered as against the baseline assessments.

All the patients and significant family members who were availing the services of Monthly Community Mental Health Camp conducted by the Richmond Fellowship Society Sidlaghatta Rural Branch, Sidlaghatta, in rural Karnataka, India consisted the universe of the study. About fifty three cases were diagnosed according to ICD-10 to have schizophrenia (all type) by the psychiatrist in the Monthly Rural Mental Health Camp during the period from January 2004 to till July 2005. Out of fifty three patients, eight patients were not included in this study due to exclusion criteria. Off these patients, the researcher has drawn thirty samples using Simple Random Sampling technique. The size of the sample for this study consisted of 30 persons with schizophrenia and their significant family members. A proportionate sample covering heterogeneous socio demographic background was drawn. The inclusion criteria were person having a diagnosis of Schizophrenia (any type) as per tenth version of International Classification of Diseases – 10 (ICD-10) of WHO (1992) diagnostic criteria, and age group between 18 to 45 years. The exclusion criteria were persons with any associated psychiatric problems like substance abuse, mental retardation, affective disorders or any other disorders, and patient who is actively symptomatic.

The tools used for data collection were socio demographic data sheet, Patient Rejection Scale (Kreisman et al, 1979) and Orientation towards Mental Illness (Prabhu, 1983). The Social Demographic Data Sheet was intended to collect information on age, gender, education, religion, marital status, occupational status, income, duration of mental illness and the diagnosis of patients. The profile of the family members consists of relationship with the patient, age, gender, education, types of family, occupational status and income. The Patient Rejection Scale is intended to assess rejecting feelings of family members towards their mentally ill members. This scale is a very brief instrument consisting of only 11 items. Each item is in the form of a statement, which is designed to tap the extent to which the patient's family feels angry or critical toward the patient. This scale can be completed in a few minutes by the self-reporting family member. The items in the Patient Rejection Scale show conceptual similarities with the two components of Expressed Emotion such as hostility and critical comments. In addition, its higher cost-effectiveness compared to other instruments with similar uses, makes this tool very advantageous in its applicability. This instrument was applied in different cultural contexts. A published report had shown striking resemblance between responses of a New York study sample and that of a West German sample to the items (Watzl, et al., 1986). Similarly, it has also been found that there are marked similarities between responses from an Indian sample and that of the Western samples to the constituent items of the scale except for two items.. As an estimate of reliability, Patient Rejection Scale has a co-efficient alpha of 0.78 at 4 months after discharge and 0.79 at 8 months post-discharge. Moreover, these values are consistent with a correlation value of 0.72 between the two follow-up interviews. Similarly the co-efficient alpha for a German version of the same scale was 0.72. In addition, the Spearman Rank Correlations between response frequencies of New York and German study samples "calculated across the 11 items separately for each scale point are rho = 0.97, rho = 0.81, and rho = 0.95". This agreement among raters and between cultures is statistically highly convincing. The construct validity of this scale was measured with the support from correlations between the scale's rating on rejecting feelings and attitudes of the family towards the mental patient and patient's report of the way their families treat them. Similarly, the score shows correlations with criticism and hostility components of Expressed Emotion. Other data for validity of the scale, which the authors provide include the correlations between scale's score with relapse and rehospitalisation, indices of patient's psychopathology, and family burden. The instrument can be administered either as a self-report measure or through interview method. Items are rated as way often, sometimes, or never and scored 3, 2 and 1 respectively. For the five positive items the scores are reversed. When the scores of all the 11 items are scored, it gives a consolidated overall index of patient rejection. The scale theoretically ranges between 11 to 33 with the higher score indicating a higher rejection towards the patient. The lower score could hint a marked tolerance by the family or improved status and functioning of the patient.

The Orientation towards Mental Illness scale is a 67-item scale that aims to measure the individual's degree of unfavourable orientation to mental illness. It taps various aspects of orientation to mental illness, providing scores on 13 factors, which can be broadly grouped into 4 categories. The four categories are area of causation, perception of abnormality, treatment, and after effects. The thirteen factors are Folk belief, Psychosocial stress, Orgnanic causation, Non-restrained behavior, Weak cognitive control, Fidgety behavior, Bizzare behavior, Folk therapy, Psychosocial manipulation, Physical methods of treatment, Hopelessness, Hypofuctioning, and Rejection of the mentally ill. The respondents are required to indicate the degree of his or her agreement or disagreement on a five point likert type scale, ranging from completely disagree (1) to completely agree (5). The scores on each item are summated and a total score on each factor is obtained. The higher the total scores the more unfavourable orientation. Initially a 235 items scale was formed from a pool of 900 items, which was evaluated and scrutinized by seven mental health experts with more than 15 years of clinical experience. The items were evaluated with regard to content, structure and stability of items. Responses to these 235 items were then subjected to factor analysis and a factorially validated 95 items scale was developed. The questionnaire was then readministered to 300 respondents, randomly selected, in order to

check the stability of the factors. It was found to replicate the factors obtained earlier. The author also evolved a shorter version consisting of 67 items, which was equivalent to the original one in all respects. The author omitted those items, which were found to be stable across different populations. The present study used this shorter version. The score range falls between 67 to 335 and it requires about 20 – 30 minutes to complete the scale.

The process of psychiatric social work intervention that thirty patients and significant family members involved in the study was divided into 3 groups. The samples were divided according to the convenient of geographical areas with the help of staff of Richmond Fellowship Sidlaghatta Rural Branch at Sidlaghatta, Kolar District, Karnataka State. Each group consisted of 20 members both the patients and significant family members. Each group was exposed to two group sessions. The intervention package consisted of two components such as psychoeducation and skills enrichment for a group of patients and families. The period of intervention was 2 months i.e., two monthly sessions. Each session lasts for 90 minutes were used. The data was collected from patients and family members at the beginning of the intervention, immediately after intervention, second month after intervention and fourth month after intervention. Quantitative analysis was carried out using Statistical Package for Social Sciences (SPSS Version 11). The objectives of the quantitative analysis were to understand the distribution of the sample on the socio demographic and other variables, to assess the efficacy of the intervention package. To meet these requirements, descriptive statistical techniques such as frequency, percentage, mean, standard deviation were used on the individual, family and illness variables. Paired t-test was used to test the difference between baseline scores and immediately after intervention assessment, between baseline scores and second month after assessment, between baseline scores and fourth month after intervention assessment. In addition Repeated Measure Analysis of Variance was used to assess the extent of changes in the variables over the period of intervention and during second month after intervention and fourth month after intervention on social adjustment. Enough freedom was given to the participants to either participate or not participate in the intervention programme. Informed consent was acquired from all the participants after explaining the purpose of the study and procedures involved in this study. Information collected was used only for research purpose and confidentiality was ensured.

III. RESULTS

I. Socio-demographic Characteristics of Rural Persons with Schizophrenia: (N=30)

Table – 1

Sl.No	Socio-demographic characteristics of patients	Number	Percentage
1	**Age**		
	18 - 20 years	2	6.6
	21 – 30 years	11	36.7
	31 – 40 years	11	36.7
	Above 40 years	6	20.0
2	**Gender**		
	Male	18	62.1
	Female	12	38.9
3	**Religion**		
	Hindu	26	86.7
	Muslim	4	13.3
4	**Marital Status**		
	Single	9	30.0
	Married	16	53.4
	Widowed	3	10.0
	Divorced	2	6.6
5	**Education**		
	Illiterate	14	46.7
	Primary	9	30.0
	High School	5	16.7
	Higher Secondary	2	6.6
6	**Occupation**		
	Cooly (daily wages)	8	26.7
	Land owner (agriculture)	4	13.3
	Not working	18	60.0
7	**Income (per month)**		
	Nil	18	60.0
	Rs. 1 - 200	3	10.0
	Rs. 201 - 300	3	10.0
	Rs. 301 - 500	3	10.0
	Rs. 501 - 1000	1	3.3
	Rs. 1001 – 2000	2	6.7
8	**Duration of illness (in years)**		
	Below 2	1	3.3
	2-4	14	46.7
	4-6	3	10.0
	6-8	5	16.7
	Above 10	7	23.3
9	**Diagnosis (ICD – 10)**		
	Simple Schizophrenia	2	6.7
	Catatonic Schizophrenia	2	6.7
	Hebephrenic Schizophrenia	1	3.3
	Paranoid Schizophrenia	24	80.0
	Undifferentiated Schizophrenia	1	3.3

Table 1 Social Demographic data of the patients displays that majority (73.4%) of the patients were between 21-40 years of age group. Overall, 62.1% of the patients were male and 86.7% of them were Hindus. Also shows that the majority (53.4%) of the patients were married and 46.7% of them were illiterate. A majority (60.0%) of the patients were not working and had no personal income and 46.7% of the patients had mental illness for 2 to 4 years. A majority (80.0%) of the patients had the diagnosis of Paranoid Schizophrenia.

II. Socio-demographic Characteristics of Family Members of Rural Persons with Schizophrenia: (N=30)

Table – 2

Sl.No	Socio-demographic characteristics of family members	Number	Percentage
1	**Age (in years)**		
	20 – 30	3	10.0
	31 – 40	9	30.0
	41 – 50	2	6.7
	51 – 60	11	36.7
	61 above	5	16.6
2	**Gender**		
	Male	14	46.7
	Female	16	53.3
3	**Education**		
	Illiterate	15	50.0
	Primary	4	13.3
	High School	8	26.7
	Higher Secondary	2	6.7
	Diploma	1	3.3
4	**Type of Family**		
	Nuclear family	17	56.7
	Joint family	11	36.7
	Extended family	2	6.7
5	**Occupation**		
	Cooly (daily wages)	20	66.7
	Land owner (agriculture)	6	20.0
	Private Sector	1	3.3
	Own shops	3	10.0
6	**Income (per month)**		
	Rs. 500 below	1	3.3
	Rs. 501 - 1000	10	33.3
	Rs. 1001 - 2000	12	38.9
	Rs. 2001 - 3000	5	16.7
	Rs. 3001 above	2	6.7

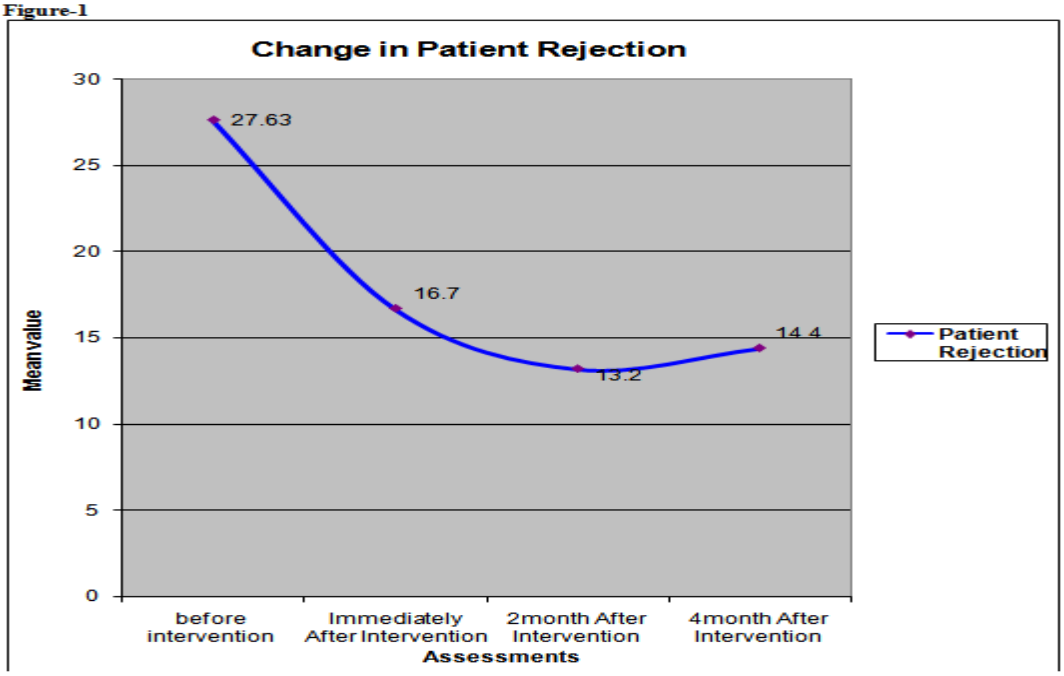
Table 2 Social Demographic data of the family shows that majority (36.7%) of the family members were between 51 – 60 years old. Around 53.3% of the family members were female and 46.7 of them were male. Majority (50.0%) of the family members were illiterate. A majority (56.7) of the families were nuclear and 66.7% of the family members were coolies. Majority (38.9%) of the families had a monthly income of Rs.1001 – 2000 per month.

III. Extent of Changes in Patient Rejection:

III.1. Extent of Changes in Patient Rejection over different time periods among Rural Persons with Schizophrenia: (1=Before intervention, 2=Immediately After intervention, 3=Second month After intervention, 4=Fourth month After intervention)

The results of Repeated Measure ANOVA conducted on Patient Rejection to verify the differences in the mean scores at the four time intervals (1 – 2, 1 – 3, 1 – 4, 2 – 3, 2 – 4, 3 – 4 assessments). It indicates that there was a significant ($P<0.001$) reduction in the mean scores on Patient Rejection during this period. Moreover it also indicates that improvement in the patient rejection was sustaining during the subsequent assessments followed by the psychiatric social work intervention. The overall change in mean value of this domain is shown in figure: 1

Figure-1

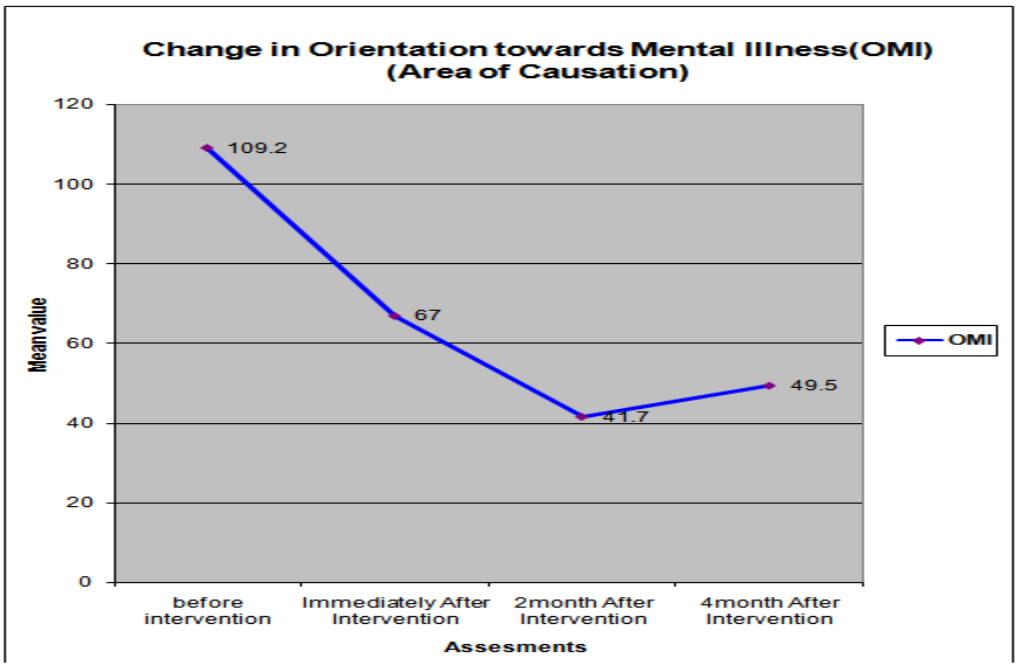


IV. Extent of Changes in Orientation towards Mentally Illness Domains:

IV.1. Extent of Changes in Orientation towards Mentally Illness Domain *(Area of Causation)* over different time periods among Rural Persons with Schizophrenia: (1=Before intervention, 2=Immediately After intervention, 3=Second month After intervention, 4=Fourth month After intervention)

The results of Repeated Measure ANOVA conducted on Area of causation to see the differences in the means scores at the four time intervals (1 – 2, 1 – 3, 1 – 4, 2 – 3, 2 – 4, 3 – 4 assessments). It shows that there was a significant ($P<0.001$) reduction in the mean score on this domain of OMI during this period. Moreover it also indicates that improvement in the area of causation was sustaining during the subsequent assessments followed by the psychiatric social work intervention. The overall change in mean value of this domain is shown in figure: 2.

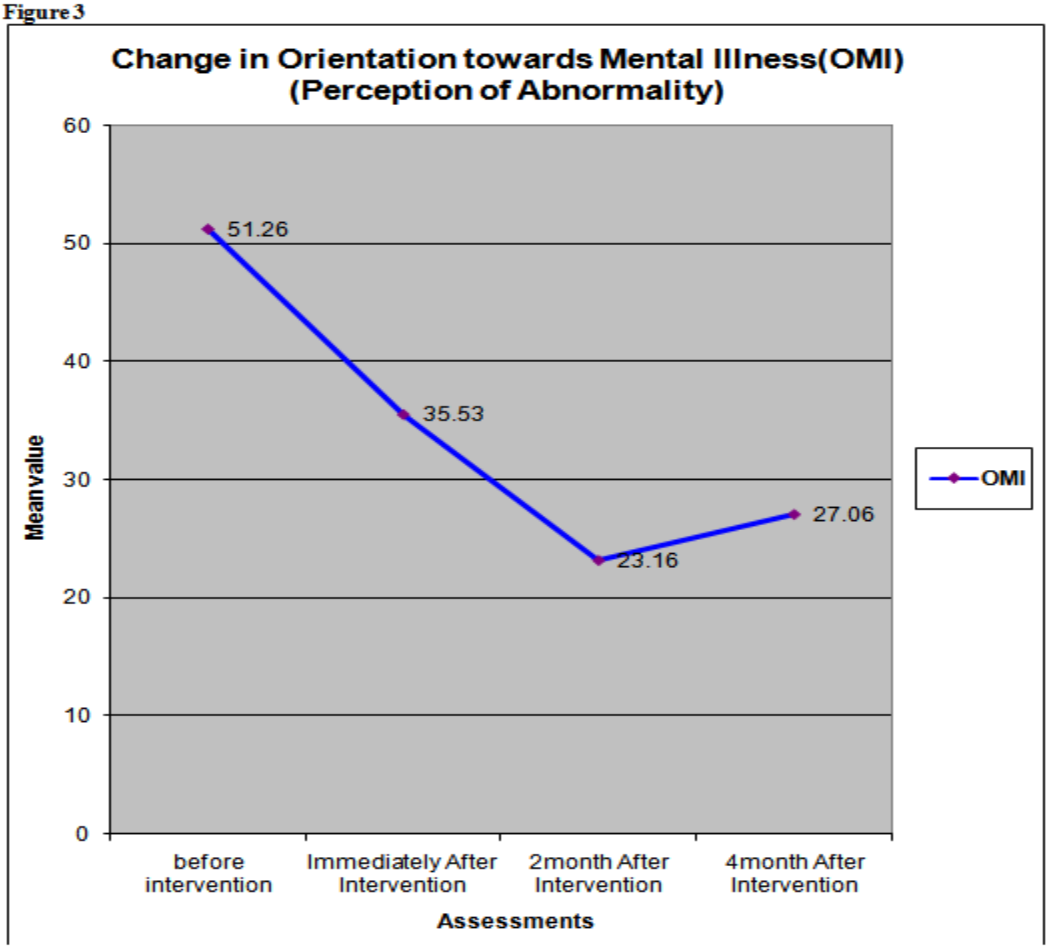
Figure 2



IV.2. Extent of Changes in Orientation towards Mentally Illness (OMI) Domain *(Perception of Abnormality)* over different time periods among Rural Persons with Schizophrenia: (1=Before intervention, 2=Immediately After intervention, 3=Second month After intervention, 4=Fourth month After intervention)

The results of Repeated Measure ANOVA conducted on Perception of Abnormality to see the differences in the means scores at the four time intervals (1 – 2, 1 – 3, 1 – 4, 2 – 3, 2 – 4, 3 – 4 assessments). The mean score was significantly (P<0.001) reduced on this domain of OMI during this period. It also indicates that the improvement in the Perception of Abnormality was sustained during the subsequent assessments followed by the Psychiatric Social Work Intervention. The overall change in mean value of this domain is shown in figure: 3.

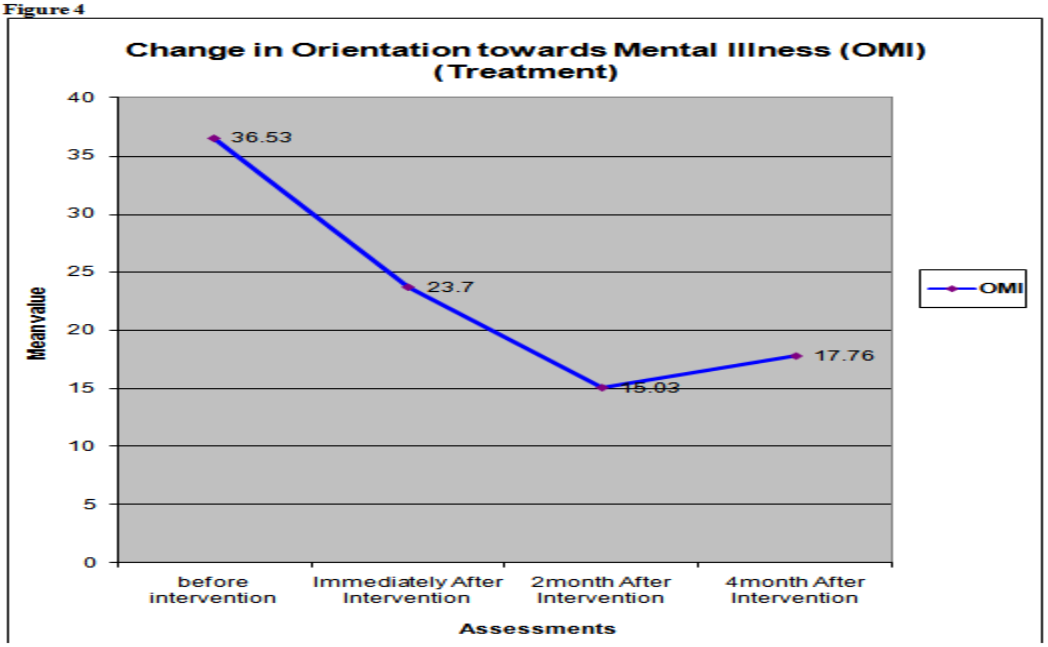
Figure 3



IV.3. Extent of Changes in Orientation towards Mentally Illness (OMI) Domain *(Treatment)* over different time periods among Rural Persons with Schizophrenia: (1=Before intervention, 2=Immediately After intervention, 3=Second month After intervention, 4=Fourth month After intervention)

The results of Repeated Measure ANOVA conducted on Treatment to verify the differences in the mean score at the four time intervals (1 – 2, 1 – 3, 1 – 4, 2 – 3, 2 – 4, 3 – 4 assessments). It shows that there was a significant (P<0.001) reduction in the mean score on this domain of OMI during this period. Moreover it also displays that the improvement in the Treatment was prolonged during the subsequent assessments followed by the Psychiatric Social Work Intervention. The overall change in mean value of this domain is shown in figure: 4.

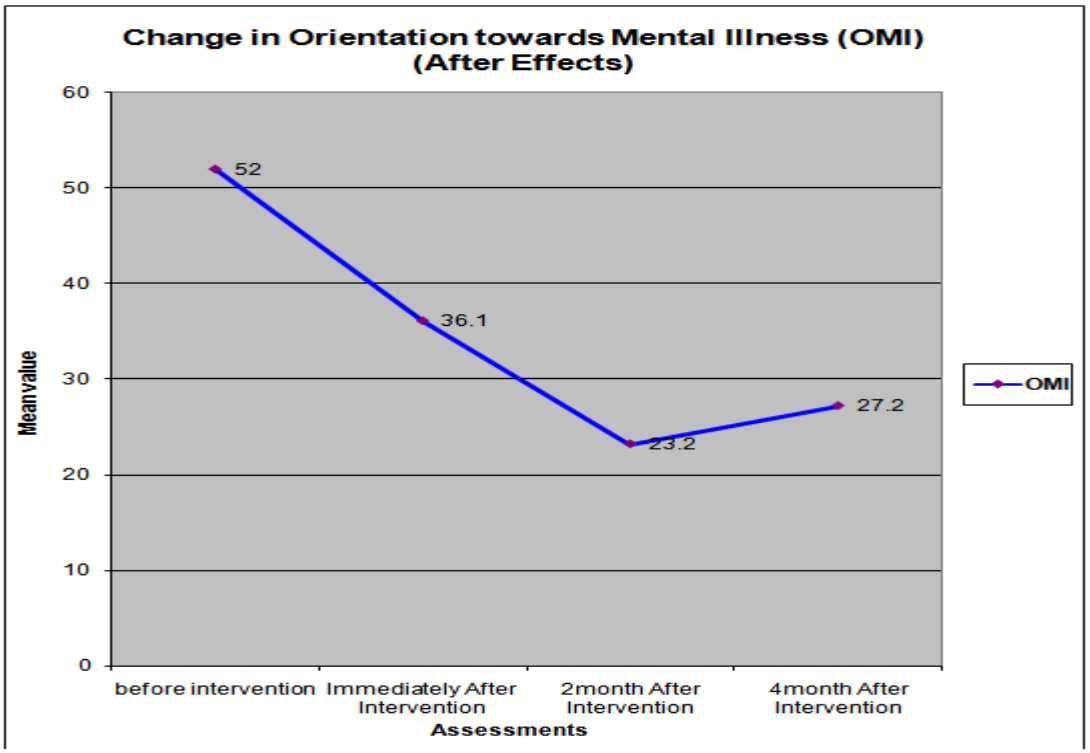
Figure 4



IV.4. Extent of Changes in Orientation towards Mentally Illness (OMI) Domain (*After Effects)* over different time periods among Rural Persons with Schizophrenia: (1=Before intervention, 2=Immediately After intervention, 3=Second month After intervention, 4=Fourth month After intervention)

The results of Repeated Measure ANOVA conducted After Effects to see the differences in the means scores across the four time intervals (1 – 2, 1 – 3, 1 – 4, 2 – 3, 2 – 4, 3 – 4 assessments). It shows that there was a significant (P<0.001) reduction in the mean score on this domain of OMI during this period. Moreover it also indicates that the improvement in the after effects was prolonged during the subsequent assessments followed by the Psychiatric Social Work Intervention. The overall change in mean value of this domain is shown in figure: 5.

Figure 5



IV. DISCUSSION

I. Socio-demographic Characteristics of Rural Persons with Schizophrenia:

Majority (72 %) of the samples were in the age range of 18 – 40 years. Among these samples 36% of them were in the age group of 21 – 30 years and highlighting the fact that most individuals affected by the schizophrenia were in the economically productive age group. The gender wise distribution of the sample indicated that sixty two percent of the samples in the study were male patients. Several studies have documented the reason for the under utilization of health services by women in India was lack of access to health care (Ramalingaswami, 1987; Khan et al., 1982). With regard to marriage, 53% of the samples in the study were married while 30% were never married. A majority of the patients were Hindu (86.7%) and Muslim contributed 13.3% of the sample. The unequal representation of the sample is due to national characteristics. Majority (30%) of the subjects in the samples were primary school educated. On the whole the highest educational qualification among the respondents was higher secondary which was done by 6% of sample. Majority of the respondents 46% were illiterate. Educational impairment was well documented in literature on Quality of Life in patients with schizophrenia (Calvocoressi et al, 1998).

The occupational status of the respondents is also an indicator of disability related issues. Around 60% of the sample in the study was unemployed due to schizophrenia and 26.7% of the samples were coolies. Many of the respondents who employed are performing poorly and may be in danger of losing their jobs. As far as the income of the respondents is concerned 60% of the respondents did not have any income of their own, 30% percent of them had a monthly income of below Rs.500 and only 6.7% had a monthly income of Rs. 1001 – 2000. The group was characterized by low educational levels, poor occupational status and low income levels. These findings reflect the low per capita income of unorganized sector in our country. Lower income can also intensify the problems in the family following the diagnosis of Schizophrenia. With regard to duration of illness 46% of the samples had illness for 2-4 years, 16% of them had illness between 6-8 years and 23% of the subjects had illness more than 10 years. Majority (80%) of the respondents had the diagnosis of paranoid Schizophrenia.

II. Socio-demographic Characteristics of Family Members of Rural Persons with Schizophrenia:

In this study, majority (56.7%) of the caregivers belong to nuclear family, reflecting the changing structure of families in the Indian society and changes in the social support system networks that can result to this. Indian families are in a state of transition and the joint family structure is undergoing radical changes resulting in the nuclear households as a means of adaption. This shrinkage of the family size also results in narrowing down the supportive networks that is essential in the coping process with schizophrenia more during the symptomatic stage.

With regard to the age distribution of care givers of the respondents, majority (36.7%) of the family members were between 51 – 60 years, and about 53.3% of the care givers were female and majority (66.7%) of them were working as coolies. Care giving is a complex and challenging phenomenon and women often face the dual challenge of care giving and dealing with their own vulnerability. As Bharat (1995) pointed out, in countries like India, care givers would either be the elderly parents, often physically and financially weaker, or wives or partners who mainly occupy position of dependency. Thus, on the whole the subjects in the study are heterogeneous in nature covering several background variables.

III. Effects on Patient Rejection among persons with Schizophrenia in Rural Areas:

The feeling of rejection of family members towards persons with severe mental illness is high in the community. Due to chronicity and prognosis of the illness, family members of patients with schizophrenia may develop criticality, hostility and over involvement towards the patient (Brown, et al., 1966).

The present study revealed that the mean score of social rejection was high before psychiatric social work intervention. This finding suggests that the family members of persons with schizophrenia in rural areas would have had high degree of rejection of patients, understand about them and expectation from the patients. This finding consistent with result reported by Bailer, et al., (1994), who reported that attitude of rejection towards the patients had risk of psychiatric rehospitalization and had more social disability. After psychiatric social work intervention, there was a significant reduction in the mean score of this domain. This result was sustained in the subsequent assessments such as second month after intervention and fourth month after intervention.

IV. Effects on Orientation towards Mental Illness (OMI) among persons with Schizophrenia in Rural Areas:

It has only recently become apparent to clinicians that for the families of persons afflicted with schizophrenia disorder; life is drastically different-more stressful and more demoralizing than for those dealing with most psychiatric disorders and non-psychotic family dysfunction. There has been a distressing trend in the field to

ignore the devastating impact of watching one's child or sibling deteriorate into someone who is all but a stranger, and a most incapacitated one. Many clinicians have ignored the fact that families have become the de facto caretakers of individuals with Schizophrenia, without the required knowledge, training, resources and support. Family psychoeducation can be most simply understood as an attempt to deal with both these realities; the disappointing record of antipsychotic drugs and the complex burden imposed on families by the illness.

Psychoeducation is method for training families and other natural social groups to create an interactional environmental that compensates and may partially correct functional disability in one of its members. Despite widespread use of antipsychotic medication, progressive deinstitutionalization reform of the last decade, expanding treatment, residential, and rehabilitation services, the prognosis of patients with schizophrenia has not changed remarkably. 25% of first-episode patients recover, while the rest often are consigned to a life of increasing mental dysfunction, emotional deadness, social isolation, rejection and disabilities (Anderson, et al., 1980). Patients who take medication regularly can still expect a 40% chance of relapse during the first year after any given episode. Thus, for many patients life consists of two altering state and contexts: one is psychosis and hospitalization, another one is marginal stability and dependent living with the support of other, especially the family of origin (Hogarty, et al., 1979).

The present study has also focused on Orientation towards Mental Illness through psychiatric social work intervention for persons with schizophrenia in rural areas. There are four domains in the scale like Area of Causation, Perception of Abnormality, Treatment and After Effects. Till the intervention the family members of persons with schizophrenia used to believe that mental illness affects the human being due to superstitious believes, stress in the life and many other organic problems. After the psychiatric social work intervention, there was a significant reduction in the extent of this Area of Causation. It shows the patients and the significant family members gained the knowledge about mental illness. It was sustained even at second month after intervention and fourth month after intervention assessments. This finding is consistent with the findings of Smith and Birchwood (1987), who have reported that intervention led to knowledge gain significantly and even at the six month follow up.

There was a significant reduction in the extent of the domain namely After Effects following the psychiatric social work intervention. It shows that the patients and the significant family members gained the knowledge about mental illness. It was sustained at the second month after intervention and fourth month after intervention assessments. This finding is consistent with the findings of Barrowclough, et al., (1987), who have reported that in the post test assessment the family members gained information significantly.

After the psychiatric social work intervention, there was a significant reduction in the mean score of the area of Perception of Abnormality. It shows the patients and the significant family members gained the knowledge about mental illness. It was sustained at the second month after intervention and fourth month after intervention assessments. This finding is consistent with the findings of Moson, et al., (1990), who reported that in the post test assessment the family members gained information significantly.

After the psychiatric social work intervention, there was a significant reduction in the mean score of the area of Treatment. It shows the patients and the significant family members gained the knowledge about mental illness. It was sustained even at the second month after intervention and fourth month after intervention assessments. This finding is consistent with the findings of Leff, et al., (1982), who reported that in the post test assessment the family members gained information significantly about the treatment modalities for persons with mental illness.

V. CONCLUSION

The purpose of this research work was to establish Psychiatric Social Work Intervention model for persons with schizophrenia in the rural areas. In doing this, factors that are associated with the development of the intervention model and the outcome in terms of social rejection and orientation towards mentally ill were specifically studied. The limitations of the present study are as follows: The sample size for the intervention group was only 30. This size is not big enough for generalization of the findings. The inclusion criteria of the sample ensured that only patients who were not actively symptomatic included in the study. This excludes a number of patients who have serious symptomatology. Whether psychiatric social work iintervention is useful for them or not, cannot be gauged from the study. Owing to time constrains, the assessment after intervention was restricted to 2nd month and 4th month assessments only. Though there are some limitation, tt is evident from the findings that Psychiatric Social Work Intervention is effective in helping the persons with schizophrenia in reducing their feeling of social rejection and improving their knowledge and skills on orientation towards mental illness. The study established the usefulness of a Group Work Approach in dealing with patients suffering from schizophrenia in rural areas. Conducting similar studies in different settings, would contribute the Social Work knowledge so as to make this profession more meaningful in future.

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