# Psychiatric rehabilitation and its present role in developing countries

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Psychiatric rehabilitation, or psychosocial rehabilitation as is nowadays more often termed, is a science in psychiatry that has had a limited role in the actual practice of managing mental illnesses. Even in developing countries the emphasis on rehabilitation as a component of managing severe mental illness is often neglected in favour of instituting newer generations of medicines with the premise that these will produce dramatic improvements in symptoms and subsequently in the level of functioning of the patient. This is borne out by the surprisingly limited role of psychiatric rehabilitation in the training programmes for psychiatric residents. With this lack of understanding, emphasis and training in the field of rehabilitation in psychiatry, the World Health Organization came out in 1996 with a consensus statement on psychosocial rehabilitation (1). This statement defines psychosocial rehabilitation as a process that facilitates for individuals who are impaired, disabled or handicapped by a mental disorder to reach an optimal level of independent functioning in the community. This core statement is further elaborated with objectives through steps that reduce symptomatology by pharmacological and psychosocial means, reduce iatrogeny, improve social competence, reduce discrimination and stigma, and improve family and social support and consumer empowerment.

The aims of psychosocial rehabilitation in developing countries, while largely similar to those in developed countries, have several other important additions (2). The economic problems that affect non-mentally ill persons in developing countries are often made worse by mental illness, which, in the

absence of any national insurance system, unemployment benefits or social security, places a heavy burden on the patient and his or her family. The social stigma of mental illness too is high, as the individual and his or her family become stigmatized in many ways, including the reduced chances of marriage for children or siblings of the ill person. To make matters worse, the opportunities for rehabilitation in developing countries are very much lower, as institutionalized mentally ill patients lack staff trained in basic principles of psychosocial rehabilitation. Even where rehabilitation is practiced, the aims are seldom the same as those described above. Repeated making of baskets or rugs with little incentive or psychological and social measures to improve the quality of life does little to rehabilitate the mentally ill in the true sense of the concept of psychosocial rehabilitation.

In many developing countries, training is rarely available for occupational therapists, psychologists or social workers. Psychiatrists are few, with many countries having 1 psychiatrist for 300,000 to 1 per one million of population. In these circumstances, the psychiatrist is most often occupied by numerous medical, administrative and leadership duties that leave him or her little time to work with rehabilitation units, even if there is one.

There are also other conceptual differences between psychosocial rehabilitation in developed and developing countries. These include the emphasis on housing in developed countries, where individualism, availability of public housing and social insurance help the need for provision of houses for the mentally ill. In developing countries, that of housing is usually not a question, as the mentally ill person's family is expected to look after him or her. It is only the destitute or the abjectly poor or those totally rejected by kith and kin who present as those with housing problems. The focus on recreation, leisure time activities and recreational therapy is also not as acute as is seen in developed countries. The strong family ties and strong sense of religion and culture in many developing countries contribute to fill up spare time when participation in family centered daily activities is over.

In many developing countries the aim of rehabilitation is not fully understood. This may result in the most difficult and sometimes misdiagnosed mental patients being sent for rehabilitation, in the mistaken impression that somehow the process of rehabilitation by non-doctors will solve the problem. The high cost of the newer medicines with fewer side effects poses major problems in the less well-to-do countries, where all medicines have to be bought without subsidy or through out-of-pocket expenses. Relapses due to poor compliance, because the patient is unable to afford the medicines, contribute to negation of rehabilitative efforts.

While much has been said and written about milieu therapy in psychiatry, the process of rehabilitation is not dependent on the atmosphere or milieu alone. The rehabilitation unit has to be both conducive as well as structured to make the activities help the individual overcome his or her inhibitions and social problems. Mentally ill and particularly severely mentally ill often have had premorbid difficulties with social skills and have psychological conflicts which remain unresolved despite treatment with medicines. The cost-effective way to address these psychological difficulties is to introduce group therapies that offer opportunities to bring about personal growth and change. But skills in conducting group therapy are not easily available in many developing countries whose psychiatrists have had limited training in psychotherapeutic skills in their post-graduate training.

The return of the mentally ill to a functioning and productive state is a crucial goal. In most developing countries, any person who has truly recovered from any illness is expected by his or her family to be productive and fully or at least partly functional. Thus, recovery followed by unemployment or being poorly functional is not only frowned upon but in some may contribute to rejection and additional stigma even within the family. Thus, an important aim of any psychosocial rehabilitation is to get the recovering patient back to employment or at least assume a functional and productive role. Any other outcome can be a source of stress to patient and family. In developed countries which expect the state to support the mentally ill through social security arrangements or safety nets, the return to work may not take the same role as in developing countries. Therefore, many rehabilitation programmes in developing countries focus a lot of their energies in getting the mentally ill involved in income generation activities. These include selling of craft work made by patients undergoing rehabilitation, selling of cooked food made by patients, and where possible sale of products from farms run by patients. In the more industrializing countries, simple subcontract work, such as assembly of electrical components or packing of goods from factories, adds to the occupational rehabilitation work. The profits from these sales or industrial work are shared with the patients, which adds to the sense of achievement that rehabilitation activities bring about.

The efforts at rehabilitation of the chronically mentally ill will obviously come to naught if the prevention of relapses is not a part of the rehabilitation process. To this end family and patient education sessions are conducted in many countries now. These include taking family and patient as allies in detection and early prevention of relapses, medication education, discussion on the side effects, and provision of a "hotline".

While psychosocial rehabilitation is an important part of the overall process of successful management of chronic mental illnesses, its importance has not been recognized in many developing countries, and its practice is still rare compared to the use of medicines to "cure" illnesses.

## References


1. World Health Organization. Psychosocial rehabilitation: a consensus statement. Geneva: World Health Organization,1996.
2. Deva P. Psychosocial rehabilitation in the developing world. Psychiatr Rehabil J 1990;4:21-8.