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Psychoeducation and Work Practices in Chronic Mental Disorders

Kronik Ruhsal Bozukluklarda Ruhsal Eğitim ve İş Uygulamaları

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Abstract

The unemployment, one of the difficulties faced by individuals with the chronic mental disorder who are stigmatized and marginalized by the society in terms of social identity, is an important problem. Providing occupation and a regular job for individuals with chronic mental disorders has a great importance in terms of increasing their functionality in the society. In this context, patients with chronic mental disorder, who are stigmatized and identified by the society, are examined in this review, in terms of "social identity theory".

Keywords: Chronic mental disorders, psychoeducation, work practices.

Öz

Toplumun, sosyal kimlik açısından damgaladığı, ötekileştirdiği kronik ruhsal bozukluğa sahip bireyle-rin yaşadıkları güçlükler arasında yer alan işsizlik önemli bir sorundur. Kronik ruhsal bozukluğu olan bireylerin hayatlarında bir uğraşın ve düzenli bir işin olması ise, toplumdaki işlevsellikklerinin artması açısından son derece önemlidir. Bu bağlamda bu derlemede, toplum tarafından damgalanarak, giydirilmiş bir kimliğe sahip olan kronik ruhsal bozukluğu olan hastalar "sosyal kimlik kuramı" açısından irdelenmiştir.

Anahtar sözcükler*:* Kronik ruhsal bozukluklar, ruhsal eğitim, iş uygulamaları.

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CONCEPTS of mental health and mental disorders differ from culture to culture. Black and Andreasen (2010) defined mental health as an uncertain relative condition and Townsend (2014) defined it as a successful adaptation to internal and external stress sources, evidenced by age-appropriate thoughts, emotions, and behavior consistent with cultural norms. Defining the concept of mental disorder is difficult because of the cultural factors that affect the concept. However, regardless of their cultural origins, mental disorders are considered to be related to the individual's perception (Horwitz 2002).

Although in some cultures, behaviors deviating from cultural norms are not welcomed, they are considered as acceptable behaviors and traditionally seen as different cyclical and categorical conditions. This view has been questioned by evidence of consecutive/chronic coexistence of many disorders and, while determining what mental health and mental disorders are, it was pointed out that traditional dualism of body-mind relations should be overcome and biological, psychological and social factors at all ages should be considered in interaction and chronic mental disorders have been noted (Horwitz 2002).

Chronic mental disorders are obligatory diseases that need to be addressed as a priority because of their widespread appearance in the society, their causes of loss of competence and labor. Among these diseases, schizophrenia and mood disorders are top-ranked due to the fact that they are chronic and cause severe disruption in psychosocial functioning (Horwitz 2002, Black and Andreasen 2010). Individuals with these illnesses experience a decrease in their awareness (Amador et al. 1991), due to their drug-dependent and passive lifestyles; unemployment problems are seen and their quality of life gradually decreases as a result of stigma caused by the disease and the negative impact of stigma on personal and social identity (Boardman et al. 2007). In this context, in this review, patients with a chronic mental disorder, who are stigmatized by society and clothed in this context, have been examined in terms of "social identity theory". The aim of this study is to contribute to the literature by emphasizing the importance of psychoeducation, which is accepted as evidence-based in the treatment and improvement of individuals with chronic mental disorder, in terms of social identity, especially in terms of work and work practices.

Social Identity and Work in Chronic Mental Disorders

The first studies in the field of social identity began with the experiences of Henri Tajfel (1970), who lived in prison camps in France and Germany during World War II. Working on religion and racial discrimination, Tajyel merged his scientific experience he had with Turner, who worked in the same field as himself and developed "social identity theory" in the mid-1970s. This constitutes the center of the theory of the effects of being a group member on the individual. According to the theorists, people often act not as individuals but as members of certain social groups/classes, and act according to their membership in social classes, while they define themselves. For example, when an individual who is a doctor introduces himself to the outside environment by adding a doctor in front of his/her name in relations outside the hospital, he/she introduces himself/herself with his/her social identity as a member of a particular group, not with his/her personal identity. Because people have a tendency to 'feel themselves a member of a group' as a requirement of being a social entity (Mlicki 1997,

Tajfel 1997), in the sense of needing a positive self-evaluation and self-respect.

Being a member of a group has an important influence on the individual's motivation, on the determination of his / her feelings, thoughts and behaviors about others, and on the formation of social identity (Tajfel 1997). Because social identity is the part of the concept of self-arising from group membership. Individuals define and evaluate themselves based on the social group they are members of. This evaluation involves identifying themselves with the group they perceive themselves as members, and at the end of the identification process, their "social identities" are formed (Turner 1978).

An individual with social identity should consider social group membership as not a formal concept but as a psychological concept that involves belonging to a group within the concept of "we" and behave accordingly. However, when individuals act within stereotypes, they may begin to classify themselves and others as belonging to a social group, alienating others, especially individuals with chronic mental disorders. As a result of this classification, the individual expresses his / her social identity as "I am a woman", "I am a teacher", and on the other hand, he/she can characterize, alienate individuals with chronic mental disorder as "he/she is schizophrenic", "he /she has bipolar" (Bilgin 1996).

The most sensitive group members against positive and negative influences on existential and social identity are individuals with chronic mental disorders. Considering that social isolation is the most important problem for these individuals, their alienation in terms of social group membership, underestimating the capacity and skills of patients may cause the risks that may arise for employers to be exaggerated, especially in terms of membership in the professional social group. Whereas, working and having a job play a very important role in the lives of individuals with chronic mental disorder (Becker et al. 2011).

Among the first questions, we ask when we meet someone are the name, the country and the work they do (Soygür 2013). Individuals with chronic or severe mental disorders are introduced to others by their stigmatised social identities that they have acquired from the society. Thus, when they are a candidate or owner of a job, their work experience can turn into an experience of isolation from the work environment. Individuals who do not want to face such negative work experience and whose social identity is damaged by the society can resort to conceal their current illness in order not to lose their jobs, try to do their own treatment with their limited sources or even go for miles to get treatment (Becker et al. 2011).

According to Boardman et al. (2007), only one-fifth of the 30–40% of individuals with chronic mental disorders who have the ability and desire to work in a job actually works. London's national statistics show that the unemployment rate of individuals with chronic mental disorder rose from 88% in 1990 to 96% in 1999 (Office for National Statistics 2000). In a study by Yıldız et al. (2010) examining the registry data of 720 schizophrenic patients, 56% of individuals with chronic mental disorders were found to have unemployment problems. Therefore, with the lack of regular employment seen in chronic mental disorders, the high rate of unemployment may increase even further and the quality of life may decrease at that rate (Becker et al. 2011).

A regular work life contributes to the restoration of the cognitive functions and allows the individual to gain self-confidence, responsibility and social sense of belonging. It also contributes to achieving satisfaction from life, increasing quality of life and inc-

reasing problem-solving skills (Becker et al. 2011). However, it is inevitable that disabled individuals with chronic mental disorders have difficulties in their work life due to difficulties in social skills and interpersonal relationships. In this context, evidence-based and structured psychoeducation programs that contribute to improvement in insight, decrease in stigmatization, increase in functioning, social skills, and interpersonal relationships can be used as an important supportive treatment method (Pekkale and Merinder 2002, Yıldız et al. 2010).

Psychoeducation

Although there is no consensus to define the concept of psychoeducation, it is defined as a psychosocial initiative aimed at behavioral change, including self-care skills along with problem-solving and social skills training (Xia et al 2011). It has become a part of medical service in the 1960s, when common sense prevailed, along with the socialization movements in psychiatry. By the eighties, the patient education was seen as an indispensable part of the service delivery due to the focus on the concept of individual welfare in social, political and economic terms. In particular, reducing the degree of disability caused by chronic mental disorder and the loss of competence of the person, and the necessity of increasing his/her social, occupational functioning, have gained importance. The prerequisite for achieving these goals was that the individual and his family knew well how to deal with the disease (Bauml and Pitschel 2003, Cummings and Cumming 2008, Bhattacharjee et al. 2011, Xia et al. 2011). In this regard, psychoeducation was first applied in schizophrenia groups and in subsequent periods in systematic education programs and treatment programs of patients with mood disorders (Xia et al. 2011).

As mentioned above, psychoeducation is a method used in the treatment of chronic mental disorders. It serves three main objectives within the framework of the basic philosophy of ensuring that the hidden patient and the individual who is expelled from the society is brought to the forefront allowing him/her to participate in the society. (Yıldız and Danacı 2013). The first is to provide the patient with the control over the disease by strengthening the knowledge of the disease and creating a crisis plan that they can apply in case of emergency. The second is the ratification of stereotypes about the disease, alleviation of internalized stigmatization of alienation and discrimination components, and the third is to raise the level of insight associated with treatment incompatibility, high relapse rate, and deterioration. 2011, Bisbee et al. 2012).

Psychoeducation planned for the stated goals can be applied at individual and group level by professional members of different disciplines such as psychiatrists, nurses, psychologists, and psychological consultants (Pekkala and Merinder 2001). However, psychoeducation focuses on the individual because the requirements, cognitive status, and priorities of each patient are different from each other within the principle of "a jacket does not fit any body" of psychiatric rehabilitation even applied at the group level (Baskak and Özgüven Revolutionary 2013).

Practitioner Attitudes in Psychoeducation

The main expectations of patients for psychoeducation are that they are informed by a specialist and that their quality of life is improved in the light of the information provi-

ded. For this reason, the information presented to them is given in such a way so that they will have dominion over the disease (Pekka 2002, Sibitz et al. 2009), and in order to achieve the healing effect of psychoeducation, the main objectives of psychoeducation, its structuring, and the practitioners' attitudes are important and given in Table 1.

Table 1. Structuring in psychoeducation, main objective, practitioner attitude (Baskak and Özgüven 2013)

Structuring of Psychoeducation	Main Objective in Psychoeducation	Practitioner Attitude
Planned, systematic and applied in the same environment,	Developing a sense of dominance,	Vigorous, vibrant, dynamic,
Time-limited but flexible,	Increasing knowledge base,	Constantly striving to give positive feedback,
Applicable in individual or group level,	Increasing insight,	Self-confident and reliable,
Interactive and individual focused	Preventing internalization of the stigma.	Showing emotion, sincere,
		Not emphasizing uncertainty,
		Monitoring insight and motivation constantly for each individual.

An important indicator of the healing effect of psychoeducation is that patients feel more vigorous and energetic after their education. Therefore, psychoeducation should be as active and dynamic as possible. In order to achieve this, the practitioner should be lively, vigorous and stimulating behavioral activation during psychoeducation (Sibitz et al. 2007). On the other hand, since verbal memory disorders are frequently encountered in chronic mental disorders, the information given to overcome this problem should be repeated frequently and patients should be assured that they understood correctly by making them repeat it (Heinrichs 2001, Green et al. 2008). On the other hand, in schizophrenia from chronic mental disorders, the ability to recognize their emotions and insight is very low (Johnston et al. 2010). Therefore, the gestures and mimics used should be coherent, sincere, and unambiguous enough not to overshadow the given information (Xia et al 2011, Revelation 2013). Raising the insight can be achieved by the practitioner by improving the motivation of the patient. Therefore, the practitioner should be in an ongoing manner of observing the initiatives to increase motivation (Pekkala 2002, Bauml et al. 2003, Xia et al. 2011).

Each psychoeducation program can be carried out for 60 to 90 minutes, with one or two sessions per week, with attendance of 6 to 12 participants, within the framework of the main objectives of increasing knowledge and insight on the disorder, attaining command over it (Furr 2008). The location of the application should be a fixed environment, the date and time of the sessions should be hung on the places seen in the service. During psychoeducation, members should be allowed to interact with each other and it is necessary to give information about the previous session in each session and to make a brief summary of the session at the end of each session. While correct feedback from members is approved during the sessions, if inappropriate feedback is received, minor interventions could be done to make the member say the right suggestion (Furr 2008, Gürçay et al. 2009, Corey et al. 2010).

Individual Placement/Support Programs in Psychoeducation

The importance of work in people with chronic mental disorder has been known from the "Moral Treatment and Occupation" approach with the initiatives of French physician Pinel, who was known as the founder of Contemporary Psychiatry in the 1975s. With this approach, Pinel defined work as the use of time, energy, interest, and attention according to one's goals (Paterson 2008). The British physician William Tuke, who is uncomfortable with the mistreatment that psychiatric patients are exposed to developed principles that define occupational and occupational therapy (Bewley 2008), considering work and engagement, would improve the functionality of religion and purposeful activities, and reduce symptoms. In the following years, with the studies of Dorothy Linda Dix, the first professional psychiatric nurse to care for psychiatric patients, work and occupation were evaluated as a treatment in psychiatric hospitals and numerous occupation and work opportunities were provided for the patients (Kum 1996).

Looking at the world as a whole, the supportive employment practices that enable people with chronic mental disorders to participate in social life and gain economic independence is the common goal to be achieved (Erkoç et al. 2011). However, in traditional non-competitive occupational models, individuals seem to be ineffective in acquiring work and achieving occupational goals and not able to benefit from this approach (Becker et al. 2011). For this reason, the supportive employment model of vocational rehabilitation, focusing on the rapid realization of competitive employment, is viewed as an alternative to traditional models (Liberman 2011) to meet the need for effective work services. Therefore, individual placement and supported work practices, which are part of the evidence-based medical practice, and are key to the employment of individuals with chronic mental disorders, are included in the pre-program and the principles of the program are given in the Table.

Table 2. Principles of individual placement and support programs in work life (Boardman and Robinson 2007)

The disabled individual should state his / her wish to work in a competitive work environment.
Many patients may think that if they work in a job, they will be deprived of their rights and benefits, such as healthcare. Therefore, these people should be given a comprehensive counseling service.
Patients do not undergo any training before they are recruited. They are trained after they start to work.
Support to the patient should be provided by staff who can work in coordination with the mental health team, such as a work coach or employment specialist.
Patients' jobs are determined in accordance with their skills and past experiences.
Support for a patient who starts work in accordance with the program is provided as long as the patient wants and needs it.
The work coach or employment specialist should review the patient's condition and update the plans at least once a week.

The most orderly, most widely used and empirically validated form of supported employment is called individual placement and support (Liberman 2011). Individual placement and support were introduced in the 1980s and in the following years was referred to as individual placement and support program in the workplace of individuals with chronic mental disorders and disabilities (Becker et al. 2011). These programs, which are included in psychoeducation applications, are used as a component of the work program together with social skills training (Becker et al. 1998). However, the

most distinctive feature of these programs is that psychoeducation begins after placement and contributes to the increase in the employment rate (Boardman and Robinson, 2007, Bercer et al. 2011 page 175). In fact, in the study conducted by Drake et al. (1994), the employment rates of patients in daytime treatment programs and rehabilitation services and individual placement and supported work programs were compared and it was determined that individual and supported work programs increased the employment rate. In addition, it was stated that supported employment achieved very good results in terms of a number of employed individuals, hours, month/year worked, and job income (Liberman 2011). The main objective of individual placement and supported work programs is to ensure that the individual has a job that will generate regular income by providing adaptation and orientation to the work environment (Becker et al. 2011). Liberman (2011) states that vocational rehabilitation plays an extremely important role in the recovery of schizophrenic individuals. It is reported that vocational rehabilitation enables them to join among non-disabled citizens in the society, by working in a job and earning the "working" identity, irrespective of the current position in the job or the salary received, and brings positive expectations for the future with planned and programmed routines instead of depression and dispiritedness by bringing money, socialization and friendship opportunities that can increase the quality of life of the individual to work life with self-respect and self-sufficiency (Liberman 2011).

In Salyers et al. (2006) ten-year monitoring study and Becker et al. (2007) eight-year monitoring study conducted for the same purpose, individual placement and supported work practices in mental illnesses were discussed. As a result of both studies, it was concluded that these programs can achieve the goal of having a career in the profession beyond a short-term work. Little et al. (2011) emphasized the importance of providing practical training programs for employers in order to ensure that people with chronic mental illnesses adapt to their work life and avoid negative attitudes they may encounter in work life (Little et al. 2011). Because one of the biggest obstacles in preventing people with mental illness from having jobs is underestimating the capacity of patients and stigmatizing their social identities by exaggerating the risks that people with mental health problems can put on their employers. (Cicekoğlu 2017). It is also seen that social skills training is used as a supporting practice for work-life considering the greatest difficulties in the work life of the unemployed individuals are thought to be difficulties in interpersonal relationships (Marhawa and Johnson 2004, Soygur 2013). In the research results, it is emphasized that in case of providing employment, social skills and self-esteem will improve and a social identity will be obtained in society (Bell et al 2005, Krupa 2004). However, studies conducted by Drake et al. (1996a, 1996b) concluded that social skills training, which was applied before the supported work programs, was ineffective.

The first and only practical example of supported work practices and psychoeducation in our country is the "Mavi At Café / Culture Living Environment" founded in 2009 by schizophrenic patients, patient relatives, and mental health workers. The aim of the organization is to provide job and psychoeducation opportunities for individuals diagnosed with schizophrenia which is one of the chronic mental disorders that can exhibit severe loss of competence, as well as stand against the stigmatization by allowing people to get to know schizophrenic patients through the service offered to the

community. Thanks to individual placement and support practices, such as the Blue Horse Café, where patients serve four hours of short-term shifts, it has been determined that compliance with working hours and rules, self-care, ability to solve interpersonal problems, increase in quality of life and reduced cost of community mental health care were observed (Soygur 2010).

Conclusion

Unemployment is an important problem among the difficulties faced by individuals with chronic mental disorder, who are stigmatized and alienated by society in terms of social identity. The fact that individuals with mental disabilities have an occupation and a regular job in their lives is of great importance in terms of increasing their functionality in society. In this respect, the inclusion of psychoeducation programs in the mental health system through work practices, application of individual supported placement programs, and the importance given to works done in this direction will guide the development of correct approaches. It is believed that psychoeducation programs prepared in this direction will contribute to the improvement of patients' problem-solving skills and self-esteem, to contribute to a more productive, quality life and regular income in the society, to reduce the frequency and duration of hospitalization for patients and also the economic cost for health institutions.

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