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Psychosocial Assessment for Community Based Psychiatric Rehabilitation: A Practice Oriented Approach

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Abstract

Community Based Rehabilitation has been recognized worldwide as a best method of rehabilitation for individuals with various Psychiatric problems. It aims to restore the wellbeing and quality of life of the individuals with Psychiatric disorders at its maximum possible level with the active participation of his/her living community. A comprehensive assessment of all psychosocial factors is very crucial to plan an effective management plan for any of such interventions. This article aims to give basic technical and practical information to the fresh professionals and volunteers in the field of Community Based Psychiatric Rehabilitation. The article

attempts to combine the theoretical knowledge and author's practical experiences from the field.

Keywords: Community Based Rehabilitation, community volunteers, Psychiatric problems, psychosocial assessment, psychosocial interventions

Introduction:

Psychiatric rehabilitation is a systematic and strategic approach to restore the psychosocial functioning of an individual with mental illness through continuous strategic services targeted on symptom management, prevention of relapses, and maximizing the level of functioning and wellbeing. Although not restricted to particular mental disorders by definition, traditionally such interventions are focused on chronic psychotic illnesses like Schizophrenia, mood disorders and at times Obsessive Compulsive Disorders. Community based psychiatric rehabilitation aims to provide psychiatric rehabilitation services with the assistance of individuals and resources available in patient's living environment. Placing or treating the patient in his/her community itself with the support of community volunteers, has received lot of appreciation in recent time. A detailed psychosocial assessment which is often carried out by a social worker or any mental health professional is very essential for initiating and for ensuring success of rehabilitation. A careful psychosocial assessment gives detailed idea about the individuals living conditions, past and present experiences, risks and protective factors, culture and beliefs, available and lacking resources etc., and such information helps to develop clearer view about illness, an appropriate treatment plan based on individual circumstances, diagnosis, define immediate and future goals and planning to achieve them systematically and realistically. Although there are many structured and semi structured instruments for psychosocial assessments, they do carry number of limitations when practiced in community such as it is not possible to go with scales or interview schedules every time as such way of measurement does not ensures the sensitivity to the patient's situations as well as a single measurement is unable to cover all the areas of psychosocial functioning. Each family and community differs in terms of culture, beliefs, attitude and approaches.

The quantitative data received through the structured measurement may not have a direct applicability in practical context. Whereas a qualitative approach provides situational related descriptive idea based upon patients circumstances which can be used effectively for the management. In such situation it is often not clear for many of the mental health professionals about how to go ahead and what all areas should be covered under the psychosocial assessment for the community based rehabilitation of an individual with mental illness. Present article attempts to combine the theoretical knowledge with practical experiences for assessment in community based rehabilitation focusing on family dynamics. Undermentioned components are significant in evaluations of psychosocial rehabilitation.

SOCIO-DEMOGRAPHIC DETAILS

Age, sex, marital status, details of family members, socio-economic status, place and type of residence, religion, geographic features etc., has its own significance in community based rehabilitation under the cover of socio demographics. It helps to have a clearer and individualized understanding based on their circumstances, which is a part and parcel of an emic view. Researches also state that socio- economic status is related with mental illnesses in different ways (Bradley & Corwyn, 2002; Goldberg& Morrison, 1963). All such information's need to be incorporated carefully under various phases of psychosocial rehabilitation. For example, the implications of socio-demographic factors for the rehabilitation plan for an aged person living in a hill area and costal area has to be different.

BRIEF DEVELOPMENTAL AND SCHOOL HISTORY

A brief developmental history about the patient's childhood and family backgrounds, social situations, friends, various likes and dislikes, life events etc., are also important. The negative life experiences, especially associ-

ated with parents and key caregivers are found to increase the vulnerability of the individual to develop various psychiatric disorders (Bifulco et al, 1994; Bowlby, 1973). It caters following advantages. Firstly it supports to have more empathetic understanding towards the patient by being realistic towards their situations. Secondly it helps in tailoring specific individualized interventions. For example identifying some specific interest areas like playing chess or badminton can be effectively utilized for managing negative symptoms of a person with chronic schizophrenia.

SEXUAL AND MARITAL HISTORY

Sexual orientation, attitude towards own and opposite sex, knowledge about sex and sexuality, sources of information, masturbation history, menstrual history, deviant behaviors etc. are the key elements. If the individual is married, the information about the type of marriage (i.e., arranged, forced, love marriage), duration, history of divorces, quality of current relation, number of children etc., should be collected. Considering spouse as primary care taker for most of the married individuals it is essential to understand the marital relationship for incorporating those details in the management plan.

VOCATIONAL HISTORY

If the person was employed earlier the details of the job, job adjustment, ability to take care of responsibilities, changes in job or job pattern, satisfaction with job, history of promotion or increments etc., should be collected in detail. Such information will be effectively useful for planning the vocational rehabilitation for the person.

PREMORBID PERSONALITY

Understanding the premorbid factors are important for planning and implementing an effective strategy for the individual's psychosocial rehabilitation. Premorbid personality refers to the individual's overall functioning at various levels prior to the onset of illness. Premorbid personality found to be associated with development of different mental illnesses and also associated with differences in psychopathology and prognosis (e.g., Hirschfeld et al, 1989; Erlenmeyer-Kimling et al, 1995; Peralta et al, 1991). It is also important to frame realistic treatment goals as the primary objective of psychosocial rehabilitations would be to restore the premorbid functioning of the individuals. Addressing personality issues may become additional or secondary goals in the rehabilitation process as it progress. Possibility for dilemma may exist in distinguishing personality traits with presentation of current psychopathology such as schizoid traits can be interpreted as negative symptoms of schizophrenia, or as anhedonia in depressive disorders etc. The assessment in this domain can be done by collecting the information about, their predominant mood before the onset of illness, interests in social and interpersonal relationships, hobbies and interests, vocational adjustments, religious and moral practices, problem solving and coping skills, recreational activities etc.

CURRENT MENTAL STATUS

It will not be reasonable and realistic to plan a psychosocial rehabilitation without assessing the current mental status. One must thoroughly assess the individual for ongoing psychopathology, their abilities and limitations because of psychopathology, progress (improving, stable, and worsening) etc., to make set of achievable goals. The interventions should be designed in such a way which helps to deal with the ongoing psychopathology, if present.

FAMILY TYPE

Traditionally families have been classified into nuclear, extended and joint families. Nuclear families consist with members from two generations such as father, mother and children. In extended family there may be three or more generations present such as grandparents or one more unit of family may live together such as two brothers and their family living together. Joint family consists of multiple family units living together under same shelter with defined power structure. Understanding family type is important to define the systems and

subsystems and related dynamics in the family.

FAMILY BOUNDARIES

Family is conceptualized as a small social system consists of individuals who are related to each other by sharing reciprocal affections and loyalties (Terkelsen, 1980). It has been viewed as a system of interacting parts having many subsystems (Minuchin, 1974). The common subsystems in a family are parent subsystem, child subsystem, and grandparent subsystem and so on. Boundaries can be any of such factors which separate or limit the interaction between two systems or subsystems. In family factors like age, sex, generation, religion, geography, education, socio-economic status etc. are major determinants of boundaries. As because of such boundaries the communication process between different systems are restricted and regulated. For example, communication between parents will be different from their communication to the children as some content of communication may vary depending upon the factors cited above. Likewise all the information shared between siblings may not be shared with parents. Boundaries have been classified into three such as open, closed and semi-open or partially open (Holman, 1983). An open boundary is where anyone from the outside system or subsystem can enter in the system without any interference and a closed boundary where no outsider is permitted to enter in the system or subsystem are considered as dysfunctional (Holman, 1983). Sharing 'all' or 'not at all' between any system results unfavorable outcomes. Maintaining equilibrium between 'what ought to share' and 'what not to' results in semi-open boundaries where a healthy exchange of information takes place. Boundary dysfunctions are found to be associated with the onset of psychopathology and problems in different functional domains of life (Carlson et al, 1995; Fullinwider-Bush & Jacobvitz, 1993; Sroufe et al, 1993; Tienari et al, 2004). One can easily assess the existence and functions of boundaries by gaining the relevant information in the areas like; what are the subsystems in the family? Are there proper communications between subsystems? Are they sensitive about what to share and not to share with others? Is there someone left out from other peoples? Is the family open or closed for outside members? Do they accept suggestions and advices from others? Are there any kinds of restrictions or how easy for an outsider to come and interfere with family matters? An open boundary increases the chance of different kind of abuses and external influences, which hinders the management and may interfere negatively. Whereas the closed boundary reduces receptiveness to the new persons and information. Management issues need speculation to cater such elements, for example if a family maintains very rigid boundaries in terms of religion a volunteer from the same religion may be easily accepted and may be in future they can work on changing such attitude of the families.

POWER STRUCTURE

It refers to the kind of distribution of power among the family members and leadership patterns. It can be democratic, laissez fair, authoritarian or autocratic. A defined power structure such as who is first and who is next is important for a family to maintain healthy functioning. Family structure denotes the relationship pattern within and between the family by its members, way of participation and influence on other members (Levy, 2006), and the family power structure defines the actual influence of each member on day to day functioning and decision making process of the family (Gladding, 2007). It defines the hierarchy distribution of power in the family which serves as base for family's decision making in day to day functioning, and change is based upon the generational changes such as death, acquiring maturity through age and by taking up new responsibilities such as marriage and procreation. It will be helpful in problem solving and resolving different kind of conflicts when it flows with a set of norms in family. The leadership styles like autocratic and laissez fair may not be healthy for a family. A democratic style and an authoritarian style with the readiness of the leader to consider others opinions before taking decisions may be healthier. Problems in power structure occur when a family fails to define their power structure or fail to maintain it or to execute the authority on children by its senior members. Dysfunction in the family power structure is associated with a number of problems in children and adolescents including delinquent behaviors (Moitra, 2012; Zimmermann, 2006). It is important to understand these factors for a successful strategic intervention in community based rehabilitation. It gives clear idea for the professionals to approach the right person or to work on such deficits. One can understand the power

structure by clarifying factors like; how the family takes decisions usually? How they resolve conflicts when there are differences of opinions? Is there any person whose decision is ultimate in the family? Is there any person who is considered as the head of the family? Are the family members obeying the decisions of the family head? Is there someone who get over importance or less importance in family?

PROBLEM SOLVING AND DECISION MAKING

It refers to the activities of the family for resolving conflicts and taking appropriate decisions. A democratic approach where a collective brainstorming takes place along with most suited and acceptable decision is taken is considered as appropriate. Most often families are unknown about such strategies and the decision making ends up with everyone taking their own decisions when it is concerned about them, or the head of the family takes decision in autocratic manner. The dysfunction in family problem solving and decision making is found to be associate with the onset and maintenance of different psychiatric disorders and delinquencies (e.g.,Heru, & Ryan, 2004; Mathew et al, 2009; Trangkasombat, 2006; Unal et al, 2004). In presence of unhealthy problem solving strategies, teaching family about the alternative becomes important in order to include the one who is left out or may underperforming the role that is the one with mental health issues. A healthy inclusion promotes feeling of accepted and boost the self-esteem. Following information may be required to address the issue of problem solving like; what do they do in face of problem? Do they share it with other members? If it is a concern to whole family, who takes the decisions? In such circumstances whether family members' opinion considered? Do all members express happiness with the process or how do they react? Do such decisions result in resolving the conflicts or accelerate to another problem?

COMMUNICATION PATTERNS

It is an important area containing various concerns within. It can be explained as an exchange of information between two or more individuals, families, systems or community. Communication with and between other members may affect the individuals. Studies suggest that the faulty communication between family members may affect the mental health of children and a proper management of such problem gives desirable outcomes (Dwyer et al, 2003). Problems in communication and communication deviances have been observed in a greater level among the families of individuals with various psychiatric disorders including schizophrenia and bipolar disorders (e.g., Miklowitz et al, 1991; Goldstein, 1987; Heru, & Ryan, 2004; Mathew et al, 2009; Trangkasombat, 2006). To have an understanding in this area, communicational engagement between all the systems in family needs to be explored, and in case of dysfunction reasons need further exploration. Factors known for the communication dysfunction are rigid boundaries where one or other members of the family keep restrictions from another member due to certain reasons like age, sex, generation gaps, technology, level of education, lack of interest, psychopathology and personality. Possibility of separation and feeling cornered by family members because of ongoing psychopathology needs attention. Sensing out someone at the initial part of assessment who can be a resource person in healing such dysfunction in relationship is advisable. Need based communication in present era is known; however patients with mental illness face it in even harsher and at times in punitive manner. Families may limit their communication with mentally ill persons because of different reasons like ongoing psychopathology, feeling of incompetency, prejudices towards them, family burden and so on. These peripheral issues need to be addressed. The quality of communication lies in clear meaning in message, conveyed through appropriate emotional tone and audibility along with positive attitude and congruence between verbal and non-verbal expressions. Double bind communication, confusion, argument, strained emotional attachments, lack of volume and audibility, half completed messages, lack or excess of nonverbal expression are all ingredients of poor quality of communication. A careful observation during home visits and clinical interviews helps the practitioner to understand these factors. Locating sources and severity of such unhealthy communication helps to work on underlying issues in the management.

ROLE FUNCTIONING

Roles can be understood as the socially expected and appropriate performances of behavior and action from

each individual in the family or society (Biddle & Thomas, 1966 cited in Holman, 1983). Each of the identity expects a specific set of responsible behavior functioning from the individual and appropriate performances of such responsibilities which is important to maintain a healthy functioning of families, communities and nations. Not performing or deviations from such duties may result different kinds of dysfunctions in family. A gross dysfunction in role functioning have been reported by different studies in different psychiatric conditions (e.g., Heru, & Ryan, 2004; Mathew et al, 2009; Trangkasombat, 2006). Mental illnesses are known to cause dysfunction in role functioning which requires productive compensation from family, in terms of financial, social and emotional aspects. Families failing to compensate need speculation by focusing upon individual strength and weakness of each family member. Undue compensation result in many role dysfunctions within families such as role confusion, role diffusion, role conflict and so on. People with mental illness face difficulties to resume their roles after recovering from illnesses and at times their roles are taken over by the other members. Often such circumstances raise question to their competency to perform any duties or responsibilities which further pushes them back to perform as a passive member in the family without any specific roles. Bringing the person from passive to active role in family requires careful assessment about his current level of functioning which covers his current status of psychopathology and related cognitive and physical abilities which helps the team to develop an appropriate plan of management. It could be started at basic level of scheduling activities with very simple tasks such as pouring water in the garden, taking care of poultry, simple purchases from shops etc., depending upon individual's capacity and backgrounds.

BEHAVIOR CONTROL

Behavior control in family refers to the kind of strategies adopted by the family to maintain and control the behaviors of each individual member. Disorders such as schizophrenia, depression and anxiety disorders are found to be associated with low levels of parental care and high levels of parental control (Parker, 1983; Silove et al, 1991). Dysfunctional parenting strategies are found to be associated with various risks in the children's life under various stages including increased vulnerability to develop different psychiatric illnesses and affecting prognosis and recovery (e.g., Arrindell et al, 1983; Bryce et al, 2007; Johnson et al, 2006; Mathew et al, 2015). It is important for the family to have a clear understanding about acceptable and non-acceptable behaviors and their consequences. The rules should be common to all and in case of restriction to a particular group, it should have a rationale. For example "you are a child so you should not smoke cigarette" is not a rational explanation in a family's context, but "you are a minor so you should not drive a car" is having a rationale. There should be consequences for all the behaviors based on good or bad. Most of the families are not aware about reinforcement strategies and even if they know they fail to follow it consistently, contingently and with clarity and hence yield unhealthy outcomes. Approach of the families may become ignorant or over protective and at times even hostile depending upon their attribution towards patient's behavior. Before formulating a management plan it is important to recognize the following points. Does the family have any kind of common understanding about the acceptable and non-acceptable or good or bad behaviors? If yes, do such rules are common to all? Do they share clarity about the consequences of their good or bad behaviors? Does the family have someone who looks after and monitor the behaviors of other family members and if yes whether it happen every time properly? Is family aware about the positive and negative reinforcements?

COHESION

Cohesion is one of the necessary characteristic for family, which comprises the healthy attachments and bonding between members of the family. At the same time it permits space for developing individuality and independence. Ideal position requires a healthy attachment and healthy separation between all the family members. All the members should be mutually supportive with an emotional bond. Lack of emotional bonding and insecure attachment may lead to different kind of mental health problem mostly in developing years (Ginsburg et al, 2004; Rosenstein & Horowitz, 1996). An excessive involvement in terms of control or overprotection is known to yield unhealthy outcome and may create vulnerability for problems like anxiety disorders (Bowlby, 1973; Frey & Oppenheimer, 1990). A detached and strained relationship and conflict between individuals in family

causes negative impact on other members, mostly on children (Cummings & Davies, 2002; Fincham et al, 1994; Fergusson & Horwood, 1998). Dyadic and triadic bonding are known to be most dysfunctional in the families (Gjerde, 1986). Having a person with mental illness in family may lead to gradual strained relation, emotional distancing and at times even over protection. Clarifying such factors need inquisitiveness under following domains like, do they feel loved and supported by the family members? Are they satisfied with the emotional and physical support from their family members? Do they feel separated or isolated from other family members because of the illness or any other reason? Do they think that some of the family members love someone more or dislike someone? Do they think that there is some kind of subgroups in the family such as someone preferred to be with someone than others? Do they think that there are sub-groups who hate one another? Do they think family respect their rights to take decisions and being independent?

EXPRESSED EMOTIONS

It is an important concern for the improvement, remission and recovery of a person with chronic mental illnesses (Brown et al, 1972; Butzlaff & Hooley, 1998). It is found to be associated with recovery, relapse and functional outcome of various disorders like schizophrenia, bipolar disorders, and depressive disorders (e.g., Butzlaff & Hooley, 1998; Hooley & Teasdale, 1989; Miklowitz et al, 1988). Expressed emotions refer to the attitude of the family members towards an individual reflected through their comments and behaviors. George Brown (1985) identified five types of expressed emotions under two different categories of positive or favorable and negative or unfavorable. The negative expressed emotions includes critical comments, hostility and emotional over involvement. Critical comments are the attitude expressed by the family members towards a person with mental illness through verbal comments, mostly projecting them as a continuous burden, disturbance or problem for the family, attributing it to their unproductiveness or laziness etc. Hostility is the attitude of relatives expressed through their emotional expressions and behaviors, such as reflecting frequent anger outburst, irritability towards patient, physical and verbal abuse etc. Emotional over involvement is a kind of undue involvement with the patient by not letting the patient to do any work, being over protective, accepting all the behaviors including problem behaviors as part of the illness etc. The positive expressed emotions are warmth and positive regards. Warmth refers to a comfortable level of expression of positive emotions such as love, affection, kindness and being empathetic to a person with mental illness. Positive regard refers to giving meaningful feedbacks and appreciations to the individual in a way to reinforce their desirable behaviors, confidence and self-esteem. During interaction and assessment understanding factors behind expressed emotions, such as burden, stigma due to mental illness, inability to attribute behavioral change to psychopathology etc., should be evaluated carefully (Scazufca & Kuipers, 1996; Schoonover, 2014). Careful observation during interview reveals expressed emotions in the family from different sources under the content of the speech, verbal and emotional tone, emotional expressions and behavior etc. It is also important to understand the subjective feeling and emotional status of the patient with respect to such events. The intensity and frequency of expressed emotion from different family members needs to be speculated. Sensing the upper hand of negative expressed emotions with respect to positive expressed emotions, requires solution in the subsequent visits. For example addressing the probable reasons for critical comment in form of raising awareness of illness, dealing with obstacles secondary to psychopathology and problem behavior can be of help. Based upon the locus approach of intervention can be changed from psychoeducation to behavior modification and so on.

SOCIAL SUPPORT

It is a broad term which refers to the extent and quality of interpersonal relationships of an individual. It is defined as “verbal and or nonverbal information or advice, tangible aid or action that is proffered by social intimates or inferred by their presence and has beneficial emotional or behavioral effects on the recipient” (Gottlieb, 1978). Social Support is found to have significant influence on the onset, recovery, number of episodes and relapses of various mental disorders (e.g., O’Connell et al, 1985; Mueser and Tarrier 1998; Johnson et al, 2003; Davidson et al. 2004). Studies demonstrate positive effects of social support by helping individual to develop immunity from developing various disorders and also for more desirable outcome for those who are af-

fected (Cobb, 1976; Cohen and Hoberman 1983; Cohen et al. 1985; Brugha, 1990; DiMatteo 2004). The social network includes family, friends, neighbors, social institutions etc., as the major source for social support, which could be positive or negative, supportive or stressful, depending upon the manner of relatedness which is also an important concern during assessment. Over protection or autocratic power structure in family, lack of intimacy in family relationships, antisocial traits in the family, antisocial gangs, substance abuse and communal violence can be seen as the examples of negative social networks (Tracy & Whittaker, 1990). The primary social support which a person receives from his/her immediate relatives is most important. Reid (1989, cited in Costello, Pickens & Fenton, 2001) identifies four kinds of social support as given below;

- Instrumental support: It is a direct support to an individual by fuelling material in the forms of money, food, shelter, healthcare etc.

- Informational support: It includes providing information according to the need of the individual. It is more important during growing ages.

- Affiliative support: It means the physical presence of other individuals who have mutual interests.

- Emotional support: It includes developing and maintaining a good emotional bond between individuals, by expressing concerns, providing space for sharing the feelings, etc.

These functions are interconnected with other areas of family functions as well. For example providing only instrumental support is also an indicator of a failure in the areas of role functioning, communication and cohesion and vice versa. The knowledge about availability and type of support of family members, availability of support from one's community and neighborhood as well as from service sector is also essential to plan an effective psychosocial rehabilitation plan. For example, a youth club with a willingness to help a patient can be utilized effectively for managing the deficits of a patient with chronic schizophrenia in social functioning.

SOCIO-CULTURAL AND RELIGIOUS FACTORS

Each community differs in various aspects related to psychiatry and mental health, based on the cultural, religious and educational background of their belonging. There can be favorable or unfavorable attitudes, beliefs and practices in the community related to mental illnesses directly or indirectly. Understanding, interpreting and adopting socio-cultural and religious factors are vital for community based rehabilitation. A direct confrontation or lack of knowledge about such factors may hinder intervention process. At the same time many of such factors can be utilized in a positive manner. For example advising a morning walk to a women hailing from a remote village of India may not be a good example rather motivating her to visit temple at a distance every day in morning can be fruitfully utilized as it is culturally sanctioned and may even fetch social support. People often try to define or explain the causes, symptomatology, treatment and prognosis of mental illnesses based on their self-experiences or their observations of mental illnesses by using their own understanding mostly developed from the belief systems in which culture, religion and tradition are the basic ingredients and such definitions are called as explanatory models (Kleinman, 1980). It is necessary to understand the explanatory models in context of each culture and patient as the help seekers rely more on these explanations. People from developing countries like India often follow a set of culturally sanctioned models of explanations for the symptoms of mental illness and follow a variety of traditional healing practices including faith healing and approach to the mental health professional mostly at the end. Again the explanatory models colored by culture and superstitious beliefs are more common among individuals belonging to socially backward groups and poorly educated (Schoonover, 2014; Nambi et al, 2002). Community workers during the process of community psychiatric rehabilitation need to remain conscious to the use of such strategies while addressing these issues.

IMPACT OF ILLNESS

Impact of illness is the consequences happened to one's life and their family because of the mental illness. A significant level of stress and burden because of the mental illness in a family member has been observed in several studies and such stress and burden may also be responsible for generating negative attitude and behavior towards persons with mental illness by their family members (Abramowitz & Coursey, 1989; Dore & Romans, 2001; Perlick et al, 1999; Scazufca & Kuipers, 1996). An assessment can be focused and pin pointed on the following areas;

On patient

- Personal & cognitive areas: it includes ability to maintain personal care, activities for daily living, motivation, ability to learn, think and reasoning, decision making, memory etc.

- Family: role functioning in the family, managing relationships, ability to express and maintain emotional attachments, ability to take responsibility, participation in day to day family functions etc.

- Social: level of social relationships, ability to establish and sustain social surroundings, social relationships, social behaviors, adaptability with situations etc.

- Physical: capacity to function appropriately and in healthy way, to meet day to day physical needs, appropriate energy level, stamina, biological functions etc.

- Occupational: ability to concentrate and do simple or complex tasks, goal directedness, sustainability, tolerance with others and situations whether in person or in social setting etc.

- Recreation: motivation to engage and participation in pleasurable activities such as hobbies, gardening, chatting, meeting friends, etc.

On family (it is about the changes and difficulties for individual family members of the person with mental illness).

- Personal & cognitive areas: includes negative effect on one's life because of another person's illness as of insufficient time for maintaining self-care and activities of daily living, perception of stress, changes and problems in studies and jobs, difficulties in getting married secondary to stigma etc.

- Family: changes and inadequacies to perform role functioning in the family appropriately, change in relationships as the families may prefer to remain away from other relatives or separated by other relatives because of mental illness, labelling, family burden, financial resources etc.

- Social: changes and limitations in social relationships, attitude toward other members in the society, and perceived feeling of acceptance in the society and perceived social stigma, changes in friends and relationships, etc.

- Physical: capacity to function and meet day to day physical demands of self and for the patient by any of the family member, physical illnesses and difficulties, changes in biological rhythm etc.

- Occupational: changes and challenges in occupation because of illness such as meeting financial needs and compensating for resources or patient's income, or difficulties in managing job responsibilities and patient care, problems at work place secondary to patient care at home etc.

- Recreation: changes in the availability and preference for activities which give pleasure, changes in habits, etc.

A careful observation in the areas mentioned above provides idea about the changes in the different family system because of illness. Professionals need planning for different strategic interventions for tackling each of these issues with a motive to bring maximum healthy atmosphere in the family by minimizing the negative effects.

CONCLUSION

Mental health issues need multidimensional approaches to bring fruitful outcomes. Finding out areas need attention and strategies to restore the wellbeing of an individual requires knowledge and skill based comprehensive assessment. Community based assessment requires more humanistic approach which provides individual information about socio- demographic details, possible etiological factors, current status of mental illness, psychosocial issues, issues related with psychopathology, protective and risk factors, strength and weaknesses of the individual with mental illness, available and lacking resources etc., in such a way that can guide an attitude of an examiner in tailoring a comprehensive yet approachable plan for psychosocial interventions.

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