Chapter 12

The relevance and use of life skills assessments

DUŠAN HADŽI-PAVLOVIĆ, ALAN ROSEN and GORDON PARKER

The schizophrenic has grown weary of internal and external pressure; he lives out everything that is on his mind, regardless of any benefits to his existence. He cannot exist in a conventional adaptation to the real world, but struggles for the concept of a world that would adapt to him. Or, in a somewhat loose, oversimplified statement it might be said that schizophrenia is the extreme rejection of established convention. (E. Bleuler, 1978, p. 487).

12.1 OVERVIEW

The effective treatment of those with schizophrenia asks that we find for them a place in the world — one in which they are comfortable, and which in turn is comfortable with them. Whatever their relative merits, the choice of hospital or community, and more specifically, where in the community?, where in the hospital?, need to be formed by the knowledge of the patient’s capacity to survive and to achieve a satisfactory quality of life in each of these settings. We suggest that this capacity can be summarized by assessing a particular range of behaviours and abilities — so-called ‘life skills’ — whose scope, description and measurement occupy a middle ground between that of ‘living skills’ and ‘social skills’. For individuals with schizophrenia and their carers such assessments are intended to help them in thinking about how the individual might fare in each of the available treatment and living options; while for the community it is meant to help by identifying the range of treatment and living options that it needs to provide or support. In describing our way of thinking about life skills we have tried to look not only at the theory, but at the nitty-gritty of making such a measure part of the clinical practice of a wide range of professionals.

12.2 DISABILITY AND DYSFUNCTION

Using the terminology of Anthony and Liberman (1986), it is convenient to see schizophrenia as a pathology (or pathological process) leading to various forms of impairment which might produce disabilities that might result in handicap. For example, the brain pathology may lead to a paranoid process and accompanying delusions, which produce behaviours in the workplace which cause friction and then result in unemployment. The way in which disability manifests as handicap is intimately related to the individual’s society; in rough terms, to what that society will tolerate and the types of health services which it will fund. In a society that gracefully accepts from each according to his means, becoming
unemployed would have few consequences. If it were a sufficiently benign society, then the friction would be put aside or not even occur. The work of Warner (1988) is interesting, in this regard, for the way in which he incorporates social factors; asserting a strong association between the economy — especially unemployment — and the detected rates of occurrence of schizophrenia and apparent recovery from it. However, there are no hard and fast causes, no inevitable sequels — the potential for various positive symptoms might be primed in brain chemistry, but the likelihood of their emergence appears to be related to an additional component, as is asserted for instance by the EE research (e.g. Kuipers and Bebbington, 1988).

12.3 SURVIVAL AND ADAPTATION

The thrust of current thought is that the prognosis for schizophrenia is a more optimistic one than previously held and that as much of its course as possible should be lived in the community and not in institutions. (This optimism has encouraged many to speak of ‘the person with schizophrenia’ rather than, like Bleuler (1978) of ‘the schizophrenic’.) While the community management of the acute stage is feasible and effective (e.g. Hoult et al. 1984; Chapter 25), the bulk of life with schizophrenia and the accompanying normal life, usually occurs in a less intensely managed environment. Even so, our expectation is that a large percentage of schizophrenics can, for example, have an acute episode whilst remaining in the community; retain a job; find decent stable accommodation; and receive adequate service from health professionals. This is not an expectation of survival by the skin of their teeth, but survival in the fullest sense when she or he is attempting to live in some form of community. Clearly then a life skills measure will need to focus around those forms of disability which may be associated with the large range of handicaps that affect survival in the community or the institution. Conversely, we can think of this as a focus on those strengths and abilities essential to satisfactory life in the community. These handicaps are essentially those that restrict the person’s access to the interpersonal, social and physical supports provided by society. Life skills, as exemplified in Rosen et al. (1989), are a mixture of questions about the performance of an ability A: ‘Can the person do A?’ and ‘Does the person do A?’, with the latter being more important. We are ultimately interested in the actual — ‘Does the person survive?’ — and not in the potential — ‘In theory, could the person survive?’ Many of the life skills are intertwined with each other and it is part of management to decide which deficit to address. Cooperation with medication, for example, is an item in the assessment scale of Rosen et al. (1989), but it will also influence the level who is not surviving can only begin to do so by adapting, which means either changing his or her habits and skills, or finding a niche in which they can survive. The main purpose of a life skills assessment is to enable carers to assist in that adaptation. A second purpose is to tell society which kinds of niches it ought to be creating, what bits of the world it ought to be adapting to fit the individual with schizophrenia who, in Bleuler’s words, ‘lives out everything that is on his mind’.

12.4 DEFINITION OF LIFE SKILLS

Life skills can be defined as those abilities which are components of essential functional roles; which are expressed in terms of self-care, work, leisure and relationships; and which contribute to an individual’s survival in the fullest sense when she or he is attempting to live in some form of community.

Clearly then a life skills measure will need to focus around those forms of disability which may be associated with the large range of handicaps that affect survival in the community or the institution. Conversely, we can think of this as a focus on those strengths and abilities essential to satisfactory life in the community. These handicaps are essentially those that restrict the person’s access to the interpersonal, social and physical supports provided by society. Life skills, as exemplified in Rosen et al. (1989), are a mixture of questions about the performance of an ability A: ‘Can the person do A?’ and ‘Does the person do A?’, with the latter being more important. 

We are ultimately interested in the actual — ‘Does the person survive?’ — and not in the potential — ‘In theory, could the person survive?’ Many of the life skills are intertwined with each other and it is part of management to decide which deficit to address. Cooperation with medication, for example, is an item in the assessment scale of Rosen et al. (1989), but it will also influence the level