Rehabilitation Promotes Recovery in Schizophrenia

By Carl C. Bell, M.D.

S chizophrenia is a devastating illness, and one of its hallmarks is also one of the most stubborn obstacles to effective management: a structural deficit that limits the ability of the brain to function. Without insight into the illness, individuals with schizophrenia often deny they have a disease, which in turn leads to an unwillingness to buy into treatment, whether medication or behavioral therapy. This is especially true with a first episode. Without multiple psychotic breaks, these individuals cannot see the patterns that might be suggestive of the disease.

Another challenge is the difficulty of determining the exact nature of a first break: Was it a first schizophrenic episode? Was it a drug-induced episode? To some extent, this has been solved with the identification of the unique nature of prodromal schizophrenia symptoms: magical thinking, anxiety, delusions, and hallucinations—although such symptoms can occur in many different illnesses.

Fortunately, you don’t need to know how a fire started before you can put it out. The first step toward putting out the schizophrenia fire—after convincing the patient that he or she has a major psychiatric disorder—is medication, because without it, there almost certainly will be a relapse. But order—is medication, because without it, the patient is able to achieve remission of symptoms: magical thinking, anxiety, delusions, and hallucinations—although such symptoms can occur in many different illnesses. The hope is that with these self-observations and emulated clear expectations, the individual will not be confused with recovery. The individual still has an active form of schizophrenia. So, while medication is a necessary component to treatment management, it might not be the most important, as behavior is multidetermined and treatment is interdependent.

Successful management requires family support to provide external compensation for the lack of insight; a structured, individual intervention that the patient can understand and practice; and assertive case management to oversee all elements of care and compliance.

Cognitive-behavioral approaches are beneficial in that they are structured and manualized with clear expectations. Another benefit is the capacity to develop the ability to identify when a symptom begins, which puts patients in a better position to respond to the symptom vs. reacting to it. The hope is that with these self-observations and empowering techniques, patients will be more willing to continue therapy, and by doing so progress along a normal path in their lives.

Dr. Bell is chief executive officer and president of Community Mental Health Council Inc. in Chicago and serves as director of public and community psychiatry at the University of Illinois at Chicago.

Toward this end, psychiatric rehabilitation, in addition to medication, should be a major player in the field of schizophrenia management. By definition, psychiatric rehabilitation in schizophrenia involves the use of psychosocial interventions to identify symptoms and the possibility of relapse while maximizing social and vocational functioning.

Without the inclusion of psychiatric rehabilitation interventions, according to William Anthony, Ph.D., of the Center for Psychiatric Rehabilitation at Boston University, “people who are at risk of developing long-term, severe mental illnesses will not receive the critical help they need to remain in, resume, or improve their living, learning, working, and social roles.”

In a recent editorial, Dr. Anthony advocated for “the integration of contributions of psychiatric rehabilitation into current research and practice in the area of severe mental illness,” suggesting that people should learn over again in the field of prevention what has taken us so long to learn in the treatment field—that medications and therapies designed to ameliorate symptoms do not routinely or singularly help people achieve their residential, educational, vocational, or social goals.”

A 2008 initiative from the National Institute of Mental Health (NIMH) provides a step in this direction. Recovery After an Initial Schizophrenic Episode (RAISE) seeks to “fundamentally change the trajectory and prognosis of schizophrenia through coordinated and aggressive treatment in the earliest stages of illness,” said Dr. Anthony, stressing that “we should not have to learn over again in the field of prevention what has taken us so long to learn in the treatment field—that medications and therapies designed to ameliorate symptoms do not routinely or singularly help people achieve their residential, educational, vocational, or social goals.”

In an open feasibility trial, 10 individuals recovering from an initial psychotic episode were assigned to receive treatment as usual plus GRIP for up to 36 weeks, and completed baseline and post-treatment assessments. Social functioning was the primary clinical outcome of the study, and symptoms, psychosocial functioning, and attitudes toward antipsychotic medication, and substance use were secondary outcomes.

Overall, study participants attended a mean of 15 sessions. Among participants who attended at least 12 sessions, “GRIP was associated with improvements in almost all measured domains, especially social functioning, positive and general symptoms, and goal attainment,” the authors wrote.

Early treatment termination, on the other hand, “was associated with deterioration in almost all domains.” In terms of qualitative feedback, “both therapists and participants reported positive experiences,” they said.

Although the study’s small sample size limits definitive conclusions, “the preliminary results suggest that GRIP may be associated with clinical benefits, can assist clients in pursuing their personal goals, and is generally well received by clients and therapists,” according to the authors.

Taken together, the available data support the inclusion of functional recovery as a goal of schizophrenia management, according to Philip D. Harvey, Ph.D., of Emory University, Atlanta, Georgia. Even though the primary focus for the management of schizophrenia has historically been on clinical symptoms and their consequences, this does not address most of the problems faced by schizophrenia patients. "The important unanswered question is whether function could be preserved and disability forestalled after an initial schizophrenic episode by intense and sustained pharmacological, psychosocial, and rehabilitative intervention."

Preliminary findings from a study by Evan J. Waldheter and colleagues at the University of North Carolina at Chapel Hill suggest the answer to that question might be yes. The investigators have developed a manualized, comprehensive cognitive-behavioral therapy program for people recovering from an initial episode of nonaffective psychosis called the Graduated Recovery Intervention Program (GRIP).

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