PREVENTION IN ACTION

Rehabilitation Promotes Recovery in Schizophrenia

PERSPECTIVE

Schizophrenia 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 brain's capacity for insight.

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.

BY CARL C. BELL, M.D.

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 relapse prevention should 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 so doing progress along a normal path in their lives.

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Psychiatric rehabilitation is an important but often overlooked component of managing—and sometimes preventing—prodromal schizophrenia symptoms.

However, symptom control and relapse prevention should not be confused with recovery. Studies have shown that, even with optimal drug therapy and remission of symptoms, functional recovery in early psychosis is poor.

For example, in a 2004 study involving 118 patients in their first episode of schizophrenia or schizoaffective disorder who were treated based on a standard medication algorithm, about 47% achieved remission of symptoms after 5 years, but less than 14% met full recovery criteria—defined as symptom remission and adequate social/vocational functioning—for 2 years or longer (Am. J. Psychiatry 2004;161:473-9).

Similar results were observed in the McLean-Harvard First Episode Project, which recruited 257 patients with affective and nonaffective psychosis at their first lifetime psychiatric hospitalization, conducted baseline and 6-month follow-up evaluations, and assessed syndromal and functional status at follow-up.

Recovery outcomes were syndromal status, defined as the absence of DSM-IV criteria for a current episode, and functional status, as measured by vocational and residential functioning. Although syndromal recovery was achieved by nearly half of patients within 3 months of hospitalization, functional recovery was not achieved by 6 months in nearly two-thirds of patients who had attained syndromal recovery, according to the authors (Biol. Psychiatry 2000;48:467-76).

The available literature overwhelmingly suggests that a pure symptomatic remission does not predict functional recovery, and that failing to pay due attention to social and occupational considerations in early psychosis can contribute to a worse long-term prognosis.

"A remission is a necessity but not a sufficient prerequisite for recovery," according to Dr. Georg Juckel of Ruhr University Bochum (Germany) and Dr. Pier Luigi Morosini of the Italian National Institute of Health in Rome, who stressed in a recent review article that psychosocial functioning should be the treatment outcome criterion in schizophrenia.

"The improvement of symptoms is not sufficient to reach this difficult treatment goal. The deciding factor is how well the patient is able to fulfill private and professional requirements. Ideally, the treatment has to improve the social functioning in such a way that the patient is able to achieve reintegration and a major improvement in the quality of life" (Curr. Opin. Psychiatry 2008; 21:630-9).

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 minimize 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," 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" (Psychiatr. Serv. 2009;60:3).

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. John K. Hsiao of the organization's division of services and interventions research. The specific aims of the initiative include these:

- The development of a comprehensive, integrated treatment intervention for promoting symptom recovery, minimizing disability, and maximizing social, academic, and vocational functioning.
- The evaluation of the intervention's feasibility and practical implementation in the community.
- The assessment of the intervention's overall clinical impact and cost-effectiveness relative to current treatment standards.

Since antipsychotic drugs "are not able to restore skills and abilities lost to the illness," said Dr. Hsiao, "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).

The objective of the program, which is delivered by a multidisciplinary treatment team and comprises four phases focusing on engagement and wellness management, substance use, persistent symptoms, and functional recovery, "is to improve occupational functioning and promote goal pursuit and effective illness self-management," the authors reported (Community Mental Health J. 2008;44:443-55).

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, personal goal attainment, 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 and uncontrolled design limit 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, and his colleagues. Although 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, they wrote (Schizophr. Bull. 2009 Jan. 6 [doi:10.1093/schbul/sbn171]). "We see functional remission as a separate domain of functioning from clinical remission and subjective response and argue that the process of recovery includes all of these domains." ■

By Diana Mahoney, New England Bureau. Share your thoughts and suggestions at cpnews@elsevier.com.

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