Psychosocial management issues and treatment approaches for schizophrenia

The major focus of the algorithm is psychopharmacology, yet the optimal treatment of any person with schizophrenia must incorporate a biopsychosocial approach that covers the full range of needs of a person with schizophrenia. The term biopsychosocial, as it was originally defined by Adolf Meyer (Meyer, 1957) and others, in the context of a biologically-based treatment algorithm, refers to the physician's taking seriously the patient's ***individual*** background, psychologic makeup, service needs, and social support network.

In this context, this section has three sections:a) Provision of basic needs and services ; b) recommended treatment approaches; and c)specific evidence-based psychosocial treatments.

Provision of basic needs and services

One of the tacit assumptions for the medication management of schizophrenia is that the person with schizophrenia has access to adequate shelter, (Drake et al. , 1989; Drake *et al*, 1991) food, spiritual, and health care in a safe environment in a manner that is considered appropriate for that individual, (Lehman et al 1982) taking into account the person's country, culture, and health care environment.

Recommended treatment approaches

We assume that the contents of a medication regimen are the same regardless of where the medication is being prescribed. On the other hand, this is not so for psychosocial treatments. Because of this variability, this section covers treatment ***approaches*** that are recommended across ***all*** specific treatment modalities and settings. (Council, 1999)

Respect for the patient

- The physician needs to model respect for the patient despite the "off-putting" nature of the illness or symptoms (Link *et al*, 1987)
- The physician, treatment team, and institution should not tacitly endorse latent societal biases that stigmatize people with serious mental illness (Phelan, *et al*, 2000) (Jacoby, 1994)
- The physician's attitude for all patients with schizophrenia should be one that maintains hope and avoids therapeutic nihilism

Education about the illness

- The patient and family need to be educated about this illness in a way that does not blame either the patient nor the family for causing the illness (Dixon & Lehman, 1995)
- The education needs to be delivered in a timely way, especially for "first-episode" patients, and take into account the cultural and educational background of the patient and family (Addington, Coldham, Jones*, et al*, 2003)

- There is no universally agreed upon model of disease causation, and the clinician has options that include a biomedical model of illness causation, a stress-vulnerability model, or a personal explanation of symptom content. (Kingdon & Turkington, 1994) However, models that include psychodynamic causation or family causation as explanatory are not acceptable. (Dixon & Lehman, 1995)

Partnership with families in treatment planning

- All families should receive a referral to a support/ self-help group. (Weiden, 1999)
- Families should receive ongoing education which covers specific aspects of the illness, including the role of maintenance antipsychotic medication, review of early warning signs of relapse
- For patients who live with their family or significant others, the family should have access to acute crisis services on a 24/7 basis

Partnership with patients in treatment planning

- The patient's significant other and/or involved family members should actively be invited to be part of the overall treatment plan
- The patient (and involved family members) should be educated about the treatment options available to them and the patient should be encouraged to allow family members to play an active role in treatment decisions .
- Patient preference should be a major factor in ultimate treatment decision, with the physician remaining sensitive to the fact that patient's subjective preferences may be significantly different yet still "reasonable" (Revicki et al. 1996)

Complications of schizophrenia

Schizophrenia is further complicated by secondary consequence of the illness itself. For example, the very high rates of co-occurring substance abuse ("dual diagnosis") has sometimes been attributed to self-medication to treat anhedonia. However, in many cases it is the result of the inability of patients with schizophrenia to resist the efforts of drug dealers to extract money from patients with schizophrenia who receive disability payment. Recognizition of this is needed to institute measures such as better housing to protect the patients. It should be recognized that patients with schizophrenia may experience harmful effects or become addicted to street drugs or alcohol from doses that would not lead to harmful effects in the general population.

Access to rehabilitation

The basic premise is that optimal care includes rehabilitation to help with reintegration and meeting life goals Any rehabilitation program needs to consider the cognitive limitations of the illness, but for those interested in increased level of achievement or functioning, opportunities should be available. (Bell et al. 1996)

Specific psychosocial interventions

There is considerable evidence for the value of treatment programs that combine medications with a range of psychosocial services to reduce the need for crisis-oriented care hospitalizations and emergency room visits and to improve functional outcome. Several psychosocial treatments have demonstrated efficacy, including family intervention, supported employment, assertive community treatment (PACT programs), skills training, and cognitive behavioral therapy (CBT). The selection of psychosocial treatments must be tailored individually to the needs and preferences of the patient. All people with schizophrenia and their families should be provided with education about the illness(Lehman et al. 2003). Social clubs, for which there are no empirical studies that we are aware of, nevertheless, play a useful role in providing opportunities for interaction and pleasure to patients with schizophrenia and other serious mental (Bill, 1970; Voges et al. 1994).

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) attempts to link feelings and patterns of thinking which influence subjective well being. The literature on the effects of CBT for those with schizophrenia compared to standard care has been reviewed by the Cochrane Schizophrenia Group' (Jones et al. 2000; updated in 2002) Four small trials were identified. All presented data suggested that there was a difference favouring CBT plus standard care over standard care alone in terms of reducing relapse rates. The CBT interventions appear to be beneficial in reducing overall symptom levels, especially the severity of delusions. The relative efficacy of CBT is more evident when CBT is compared with routine care than when it is compared with other therapies matched for therapist attention (Dickerson, 2000). CBT, however, did not keep more people in care than a standard approach and there is no data relating to the effect of CBT on compliance with medication. Currently, for those with schizophrenia willing to receive CBT, access to this treatment approach is associated with a substantially reduced risk of relapse. However, at present , CBT is a fairly scarce commodity, often provided by highly skilled and experienced therapists. Therefore, its application in day to day practice may be restricted by the availability of suitable practitioners. Similarly, the present data provides little indication of how effective CBT procedures might be when they are applied by less experienced practitioners (Pilling et al. 2002a).

Social Skills Training

Social skills training, intensively studied by Liberman and colleagues, provides a structured means of teaching patients the skills needed for essential aspects of their everyday life, including self-management of medication, compliance, working with case managers, families, etc. Various methods have been empirically tested to determine the best means of teaching these skills. Role playing, coaching, rehearsal, etc. are key components (Liberman et al., 1986) Patients who received skills training showed significantly greater independent living skills during a 2-year follow-up of everyday community functioning than did patients who receive occupational therapy (Liberman et al., 1998, Kopelowicz and Liberman 2003).

PACT

The Program for Assertive Community Treatment (**PACT**) model pioneered in Madison, Wisconsin, calls for around-the-clock, comprehensive treatment and rehabilitation services for persons with serious mental illness. The six basic elements of the **PACT** model include: multiservice teams, 24-hour service availability, small caseloads that do not vary in composition, ongoing and continuous services, assertive outreach, and in vivo rehabilitation. Most agencies lack the resources to provide all of these elements and modify the program to emphasize what they can afford and which appears to be most useful for their clients (Lachance and Santos, 1995).

Family treatment

To enhance the effect of psychotropic drug treatment, it is often valuable to include family members in educational programs, individual or family group therapy, involvement in community mental health programs. It should be recognized that members of the family other than the index patient may have subclinical elements of schizophrenia and occasionally undiagnosed schizophrenia (Pilling et al. 2002a).

Rehabilitation

Programs designed to provide rehabilitation through skills training, job training, coaching, drop-in centers, community participation, volunteer work, etc. are an invaluable adjunct to drug treatment of schizophrenia. It should be recognized that atypical antipsychotic drugs may facilitate participation in rehabilitation programs because of their ability to improve cognition.

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