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Psychosocial Interventions for Schizophrenia

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Psychosocial Interventions for Schizophrenia

Ann Morrison, MD

INTRODUCTION

Decades after first being described by Kraepelin and Bleuler, schizophrenia continues to challenge psychiatrists. In recent years, the focus of much of the psychiatric literature has been on pharmacologic interventions, especially the second-generation or “atypical” antipsychotics. Overlooked to some degree have been advances in psychosocial treatments, including systems of care that provide support for patients in the community, psychotherapeutic and psychoeducational interventions for affected individuals and their families, and rehabilitative programs targeting vocational abilities, social skills, and cognition. Indeed, while the new antipsychotic medications have offered some hope of improved outcome, many individuals with schizophrenia continue to experience significant symptoms and functional impairments despite pharmacologic treatment. Psychosocial interventions that provide even modest improvement in symptoms or function are important additions to the therapeutic options available for this severely disabling disorder.

A lifetime prevalence of schizophrenia of approximately 1% was found in the Epidemiological Catchment area study.¹ However, prevalence alone fails to impart the true public health impact of this illness. Age of onset of schizophrenia (ie, just as people are entering their productive work years) and the severely disabling nature of the illness itself amplifies the consequences of schizophrenia for individuals, their families, and society. In 1990, direct care costs for schizophrenia in the United States were estimated at \$16 to \$19 billion.² Indirect costs, including lost productivity and family burden, added an estimated \$46 billion to this amount.² Psychosocial interventions that enhance function and allow patients to become more self-sufficient could decrease these costs.

Psychosocial interventions are typically used as adjuvant therapy to enhance medication management or improve adherence to medical management. A detailed review of psychosocial interventions follows, preceded by a brief review of the effectiveness of pharmacotherapy alone.

PHARMACOLOGIC TREATMENT

Since chlorpromazine began to be used for the treatment of psychosis in 1952, antipsychotic medication has gradually become the mainstay of treatment for schizophrenia.³ Adoption of drug treatment was accelerated after the study by May in Camarillo State Hospital comparing antipsychotic medication alone, individual psychotherapy alone, antipsychotic plus psychotherapy, electroconvulsive therapy (ECT), and milieu.⁴ Those who received antipsychotic medication fared the best; those receiving psychotherapy alone and milieu had the lowest rate of successful treatment. Those receiving ECT were intermediate in response to treatment.⁴ This effect of successful drug treatment persisted for up to 3 years after discharge and 4 years from admission.⁵ The work of Hogarty’s group further bolstered the case for antipsychotic medication. In this study, outpatients treated with psychotherapy alone (major role therapy) had higher rates of relapse than those who were prescribed antipsychotic medication alone or with psychotherapy.⁶ However, while antipsychotics seem to decrease relapse rates over nonmedicated or noncompliant patients, Hogarty et al reported the group of drug-only controls still experienced relapse rates of 38% at 1 year and 62% at 2 years.⁷ This confirmed earlier relapse rates of 35% to 40% in the first year after hospital discharge even for those patients taking long-acting injectable antipsychotics and for whom noncompliance was not a factor.⁸ Even though newer antipsychotics appear to offer some advantage in both short-term and long-term side effects, to date there is little evidence that overall adherence, relapse, and response rates will be significantly different from those with the older medications. Indeed, using prescription refill data Vanelli et al recently documented that 48% of patients taking old antipsychotics were continuing therapy at 9 months as compared with 44% of those taking new antipsychotics.⁹

Nonadherence to antipsychotic medication also contributes to residual symptoms and relapse. Reviews of estimates of noncompliance approach 80%, with median