Phase-Specific Recovery from Schizophrenia

Robert Paul Liberman, MD

Recovery from schizophrenia is a realistic outcome for many individuals who have been disabled by this disorder. To dispel the stigma of schizophrenia, recovery must be defined by improvements in both functional and symptomatic impairments so they no longer intrude on the social and instrumental activities of daily life. The advent of evidence-based, recovery-oriented and person-centered treatments has demonstrated that persons with schizophrenia can experience satisfying and meaningful lives as citizens in their communities – being employed, attending college, voting and enjoying social and recreational activities in normative settings. To sustain their capacity for independent living, individuals with schizophrenia need continued treatment with maintenance medication and psychosocial services for equipping them with coping skills and resilience to buffer the omnipresent noxious effects of stressors and neurodevelopmental vulnerability. With functional and symptomatic improvement, individuals begin to experience the personal qualities that are concomitants of recovery: empowerment; hope for the future; self-esteem and self-efficacy; responsibility for oneself; and dignity. The keys to demonstrably effective and normalizing psychosocial interventions are teaching relevant skills and providing collaborative supports that can override the cognitive and symptomatic impairments of schizophrenia. Both pharmacotherapy and psychosocial treatments must be linked to an individual’s phase of illness.

Robert Paul Liberman, MD, is Distinguished Professor of Psychiatry Emeritus, UCLA Department of Psychiatry & Biobehavioral Sciences; and Director, UCLA Psychiatric Rehabilitation Program, Semel Institute of Neuroscience & Human Behavior.

Address correspondence to: Robert Paul Liberman, MD, 760 Westwood Plaza, Los Angeles, CA 90024; fax: 310-825-7508; email: rpl@ucla.edu.

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Increasing numbers of studies have documented that symptom remission and functional recovery can occur in persons with even severe and longstanding forms of schizophrenia. A variety of evidence-based, person-centered psychosocial rehabilitation practices can improve the functional capacities of persons with schizophrenia and, by so doing, enhance their possibilities for recovery. These psychosocial practices include social skills training, psycho-educational family therapy, illness management, assertive community treatment, supported employment, cognitive-behavior therapy (CBT) and cognitive remediation. One of the critical elements of each of these psychosocial interventions is the active teaching of skills for community adaptation through the use of behavioral learning principles.

**RECOVERY-ORIENTED PSYCHOSOCIAL PRACTICES**

While the term “psychoeducation” has gained widespread use in the psychiatric community, the consequence has been that the term refers to programs that are so general and varied as to be a mélange of activities with questionable value in promoting the skills essential for recovery. Psychoeducation is offered in wellness programs that offer discursive and unfocused discussions of whatever group members may want to talk about. It is also offered in Family-to-Family and Peer-to-Peer seminars developed and offered by the National Alliance on Mental Illness (NAMI), which inculcate information but not the impetus or training to apply it for improving functional skills of families and patients.

Employing family members and peers with mental illness to convey some of the basic facts of symptoms, diagnosis, medications, and modes of coping with problems outsources the responsibility for educating patients and their relatives from mental health professionals but has the adverse effect of permitting clinicians to carry on “business as usual” without engaging patients and relatives as active and informed partners in the treatment process.

In contrast, psychosocial practices that are collaborative offer systematic training and supportive interventions for patients and their relatives to develop the knowledge, attitudes, and skills that are necessary to navigate in society so that successful participation in community life becomes possible. Effective teaching of persons with serious mental disorders must employ the basic, behavioral principles of learning. Simply talking about how to improve medication adherence, cope with persistent symptoms, or communicate more effectively within the family will not produce reliable changes in adherence, coping, or communication because of information processing deficits that plague most persons with schizophrenia.

Effective teaching requires the use of the full range of instructional methods that can compensate for cognitive deficits and yield behavioral change in the individual’s everyday life. Some of the principles of learning and instructional methods that have been shown to translate into functional and pro-social behavior in the real life experiences of persons with schizophrenia are listed in Sidebar 1. The Figure (see page 213) shows the various phases of schizophrenia from the prodromal period to the acute, psychotic episode, and then on the route to recovery through the stabilizing, stable and recovery phases.

At each phase, education is combined with the capacity to form and maintain a longitudinal therapeutic relationship.
The therapeutic relationship that promotes recovery is not paternalistic or time-limited but rather a long-term commitment, infused with continuity of care, collaboration with the patient and family, with optimism for progress even when the patient has lost all hope and appears to be sinking beneath the turbulence of relapses, re-hospitalizations, and loss of self.

**TREATMENT PHASE**

Even when a patient voluntarily enters the clinic, hospital, or consulting office with the recent onset of schizophrenia, or when experiencing the prodromal signs and symptoms of this disorder, the clinician faces the challenge of engaging the patient in a diagnostic evaluation followed by treatment recommendations and relevant services.

Given the cognitive deficits, stigma, and lack of insight, it is understandable why patients are often reluctant to seek or accept professional intervention. It is almost always advantageous to involve the family at this critical juncture for several reasons, including that the family is more likely to grasp the presence and serious significance of the disorder and so can help educate and motivate the patient to cooperate. The family also can participate in psychoeducation and illness management with the patient, thereby helping to reduce their anxiety and gain similar knowledge about and a positive attitude toward treatment; this aids in creating a hopeful prognosis conjointly with the patient.

In multi-family group therapy for persons with schizophrenia, making salient the positive attitudes, norms, and beliefs of family members regarding treatment has favorable effects on the acceptance and participation by the patient in the treatment process. Because of the influence of the family on patients' health-seeking behavior, one study of multi-
family group therapy for Hispanics with schizophrenia found significantly improved adherence to treatment and reduced hospitalizations through the motivating effect of family members’ perceptions, positive attitudes, and beliefs on the patient’s attitudes and willingness to pursue treatment. Involvement of families from the start of treatment has been shown to improve continuity of treatment and social functioning, reduce relapse, and lighten family burden.

Eliciting and validating the patient’s personally-relevant goals in life is just as important as family collaboration for engaging the patient’s active involvement in treatment. This is usually the very first focus of conversation with a new and often reluctant patient. Rather than conducting a clinical interview, the psychiatrist or other mental health practitioner inquires, “How do you want your life to be different than the way it is now?”; “What would you like to be able to do in your everyday life in 3 to 6 months that you are not able to do now?”; “What are your desires or dreams for your future?” These questions usually provide enough information for the clinician and personal interest of the patient to gain the latter’s cooperation in some initial treatment intervention that is likely to reduce symptoms and suffering while, at the same time, prove to the patient that desired change in the direction of his or her personal wishes can be attained.

This approach has been termed “motivational interviewing” and has been documented as effective with a variety of populations, including persons with substance dependence and schizophrenia. A critical challenge to psychiatrists and allied mental health professionals is to focus on the uniqueness of the individual with the disorder, realizing that in proceeding with treatment, “one size does not fit all.” If recovery is to become a reality for a greater number of persons with schizophrenia, it is imperative to view patients in the dynamic, human ways in which their families see them, not as clones of the diagnostic manual.

**ACUTE PHASE**

While antipsychotic medication is the primary treatment for acute episodes of psychosis, the first experience that patients have with medication is almost invariably an adverse side effect. Because dysphoric responses to medication presage poor adherence, it is essential to integrate psychoeducational interventions with pharmacotherapy. To compensate for the symptomatic and cognitive impairments posed by acute episodes of schizophrenia, psychoeducation intended to promote positive and informed attitudes in patients toward their medication as well as self-responsibility for consistent adherence to their drug regimen must draw upon basic principles of human learning.

The educational process needs to be infused with well-validated learning principles such as: specification of educational objectives in behavioral terms; modeling or imitative learning by observing role models demonstrate the skills; behavioral rehearsal or role playing the skills to be learned; abundant, contingent positive feedback for demonstrating the skills in role playing; problem solving through generating alternatives to overcome obstacles in gaining benefits from medication; and using homework assignments to encourage in vivo performance of the illness management skills in the patient’s natural environment.

These effective learning principles have been incorporated by the UCLA Social & Independent Living Skills Program into four psychoeducational modules for illness self-management: Medication Management; Symptom Management; Substance Abuse Management for Dually Diagnosed Patients; and Community Re-entry. Sidebar 2 indicates the skill areas of two of these modules plus the learning activities that incorporate basic principles of learning. Combined pharmacotherapy and skills training in illness self-management hastens reconstitution, discharge from hospital with assured continuity of care, and empowerment of the patient to become an informed, shared decision-maker with his or her psychiatrist.

In one study of acute patients in a Los Angeles county hospital, the use of the Community Re-entry module during hospitalizations lasting 1 week or less, successful connections to comu-

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**SIDEBAR 2.**

**Medication and Symptom Management Modules**

**Medication Management Module**
- Identify the benefits of antipsychotics
- Self-administration and evaluation of medication
- Differentiate serious from minor side effects
- Communicate effectively with psychiatrists
- Consider benefits of long-acting, injectable medication

**Symptom Management Module**
- Identify warning signs of relapse
- Develop a relapse prevention plan
- Cope with persistent symptoms
- Avoid alcohol and drugs of abuse

**Learning Activities for Each Skill Area and Module**
- Orientation and motivational enhancement
- Video record questions and answers
- Role play
- Resource management for using the skills
- Outcome problem solving
- In vivo exercises
- Homework assignment for autonomous functioning

Source: Liberman RP. Used with permission.
nity mental health centers were made by 85% of patients vs. 37% of patients who were provided with conventional, discharge planning services.9

STABILIZATION PHASE

Once the acute phase has passed, and psychoeducation has begun to destigmatize the illness to the patient, while providing the knowledge and skills necessary to progress along the road to recovery, patients with schizophrenia need to continue self-directed management of their illness and maintain adherence to their medication.

Simultaneous to advancing through the medication management and symptom management modules, patients may need their medication regimen modified. Collaborating with family members or other caregivers in “behavioral tailoring” such as making sure the medication is located in places that are consistent with the patient’s routine in the home (eg, on the kitchen table or next to the toothbrush and toothpaste), can help ensure medication compliance in the patient, despite any memory and learning deficits prevalent in schizophrenia.10,11

By actively engaging family members in modular learning, psychoeducation can be most effective because both patient and family are acquiring the same knowledge and skills in synchrony. This generates a “team approach” where family members become collaborators in the recovery process along with the patient, psychiatrist, and other members of the community-based treatment team.12 Flexible levels of assertive community treatment provided by a community mental health center, a psychosocial rehabilitation program, or a personal support specialist can assure that the patient will continue to pursue his or her personal goals for recovery.13

At this point in the individual’s goal-orientation, the person who is eager to participate in social and recreational activities, and to establish or revive peer relationships can benefit from the systematic learning principles inherent in social skills training (Sidebar 3). Shown to be the single most effective means of enabling individuals with schizophrenia to improve their social functioning in community life,14 “skills training approaches are the most powerful rehabilitation technology currently available for addressing the stubborn social impairments that are so prominent in schizophrenia.”15 The technique used in this highly structured and systematic psychosocial approach is described in Sidebar 4.

SIDEBAR 3.

Criteria for Symptomatic and Functional Recovery from Schizophrenia

- Reduction of psychiatric symptoms to a moderate or mild level on the Brief Psychiatric Rating Scale with no significant interference in everyday life activities.
- Illness self-management including: identifying warning signs of relapse; having a relapse prevention plan; reliable self-administration of medication; knowledge of benefits and side effects of medication and monitoring them for feedback to the psychiatrist.
- Participating in recreational activities in the community with a peer at least once every 2 weeks.
- Independent living skills that include successful budgeting and money management; food purchase and preparation; personal hygiene; care of personal possessions; clean and appropriate clothing; ability to wash and maintain clothes.
- Reasonably cordial relations with family.
- Working or going to school on a half-time or greater basis.

Source: Liberman RP. Used with permission.

SIDEBAR 4.

Steps of Social Skills Training

- Identify long-term, personally-relevant goals.
- For the next week, what interpersonal situation will arise that would be one step toward achieving your personal goal?
- Observe a role model – either a group member or one of the group leaders – demonstrate how to interact and converse effectively in your chosen interpersonal situation.
- Practice engaging in that interaction with a person in the group who may resemble the individual in your life, adopting some of the effective verbal and nonverbal skills that you observed used by the role model.
- Give yourself and get positive reinforcement from others in the group for using specific, adaptive verbal and nonverbal social skills and communicating effectively in the role play.
- Repeat the role play until you have learned to use sufficient skills and gain enough confidence so you are ready to take on the situation in a homework assignment.
- Carry out the interaction you have practiced in real life situations as homework and report back next week how it went. Positive feedback for even partial success will be given for reporting your homework.

Source: Liberman RP. Used with permission.
STABLE PHASE

Since each person with schizophrenia or other disabling mental disorders progresses along the road to recovery at different rates, negotiating “detours” and “potholes” that are often unanticipated, the stable phase of illness may come early or late in the course of treatment. Because of the continuity required in recovery, it is important to recognize that individuals may need periods of time for consolidating their gains, both symptomatically and psychosocially. Sometimes, gains may more likely occur when the individual is proceeding slowly and with considerable practice and generalization in a variety of community settings.

It is important to continue having the family and patient involved in the movement toward more socially demanding relationships and problem-solving. Stress-related relapse can occur when a person with schizophrenia attempts to engage in more demanding community roles and friendships, which can often be fraught with high levels of social and emotional challenges. Thus, preparation for this step toward a more normal life can be aided by learning interpersonal problem-solving, a skills training approach that teaches the individual to identify a problem as a personal goal that is being stymied by some obstacle – personal or environmental. Training in problem-solving progresses from identification of the obstacle to brainstorming ways to remove or ameliorate the obstacle, choosing an alternative solution that is feasible and realistic, and then applying it to the situation. The process is iterative since any one alternative that is chosen to remove or circumvent the obstacle may or may not succeed.

Depending upon the individual’s personal goals, the stable phase may be an appropriate time to consider employment, school or independent living. Fortunately, there are evidence-based practices for achieving these goals. They are: supported employment; supported education; and supported housing. In each of these modalities, the individual’s unique background, values, interests, abilities and deficits are taken into account while the nature, frequency and type of supports are designed to match the individual’s needs.14,16

REFRACTORY PHASE

Approximately 15% of individuals with schizophrenia will continue to be buffeted by psychotic symptoms, cognitive impairments and severe disability that do not respond to medication or conventional psychosocial modalities that have been described thus far.17 For these individuals, highly specialized pharmacotherapy17 and psychosocial interventions are needed. The most effective psychosocial approaches for treatment refractory patients are social learning programs that utilize contingencies of reinforcement, antecedent control, shaping, positive practice, time out from reinforcement, and planned and scheduled pro-social activities. To overcome the substantial learning disabilities of persons with persistent, treatment-refractory schizophrenia, a conglomeration of behavioral therapies and well-organized, learning environments must be in place. In many controlled trials, employing these prescriptive and individualized learning principles has enabled a large number of individuals to leave locked or otherwise controlled institutions for semi-independent life in the community.18,19 More recently, CBT procedures have been adapted to meet the needs of persons with schizophrenia whose delusions and hallucinations have failed to respond optimally to medication.20 Both interventions are now considered evidence-based and person-centered for the most refractory forms of schizophrenia.21

RECOVERY PHASE

Maintaining recovery requires continued monitoring, enhancing and reinforcing wellness behaviors, and teaching patients to recognize the early warning signs of relapse so they can engage in more intensive intervention to forestall decompensation and disability. Therefore, we never say “goodbye” to our patients who need our consultation and occasional intervention to sustain the protective factors in their lives, such as long-term medication adherence, supportive families that are well-schooled in the nature of mental disorders, services provided by NAMI, such as peer-to-peer educational and support groups and programs for achieving self-support sponsored by the Social Security Administration. Psychiatrists who choose to employ evidence-based and person-centered services in the long-term quest to keep hopes of recovery for persons with schizophrenia know that success is largely a matter of hanging on after others have let go.

CONCLUSION

As new treatments and rehabilitation services are developed and empirically validated, more and more patients with serious mental disorders are able to enjoy lives that can be considered within the normal range. Of course, sustained recovery and integration into their communities will depend upon services that are comprehensive, continuous, coordinated, collaborative, consumer-oriented, consistent with the phase of the disorder, competency-based with empirically validated techniques, connected with the patient’s skills and deficits, compassionate, and cooperative. While treatment and rehabilitation programs of excellence that meet these criteria are still not standard, persistent advocacy of stakeholder organizations, consumers, and family members can help them proliferate. Two other requirements must be in place before we see the transformation of psychiatry into a reliably effective discipline that will promote recovery in patients who heretofore were considered
to be chronically disabled: the mental health disciplines must look to themselves to banish stigmatizing, therapeutic pessimism from their views of persons with schizophrenia; and systems of delivering psychiatric services must shift from paying practitioners for the generic type of services that they deliver to their use of evidence-based, recovery-oriented practices that yield demonstrably favorable results.

REFERENCES


