Vol. 14, No. 17 • August 24, 1994

Directions in Psychiatry

VOLUME • 14

LESSON • 17

SELF-MANAGEMENT APPROACHES FOR SERIOUSLY MENTALLY ILL PERSONS

Alex Kopelowicz, MD, and Robert Paul Liberman, MD

Dr. Kopelowicz, a Postdoctoral Fellow in Community & Rehabilitative Psychiatry at UCLA, is Medical Director of the San Fernando Mental Health Service.

Dr. Liberman is Professor of Psychiatry at UCLA School of Medicine; Director of the Clinical Research Center for Schizophrenia & Psychiatric Rehabilitation; and Director of the Clinical Research Unit at Camarillo State Hospital.

EDITOR'S NOTE

It has been clearly shown that integrated programs of treatment and rehabilitation—which incorporate case management, psychopharmacology, rehabilitation, family involvement, and social-skills training—produce vastly better outcomes than other, more restricted approaches to the care of chronic schizophrenic patients. In this lesson, the authors focus on ways to enhance patient (and family) knowledge and participation in the recovery process. Within this context, noncompliance is seen not so much as a patient's failure to comply with a physician's orders but rather a lack of collaboration between patient and clinician or a deficiency in the accessibility of the mental health delivery system.

Skills training includes education about schizophrenia and its care, as well as the development of communication and problem-solving skills. The authors illustrate skills training approaches and present strong experimental evidence in support of their effectiveness.

Although this lesson primarily focuses on patients with chronic schizophrenia, it seems to me that psychoeducation should and will play a much greater role in the treatment of all seriously mentally ill patients—especially considering that as mental health delivery systems continue to change, patients will become increasingly responsible for recovering from illness and staying well *on their own.*

Introduction

Although advances in the neurosciences and the prospect of new and more effective psychotropic drugs have captured the attention of psychiatrists and psychiatric training programs, these developments have also inadvertently promoted a biological perspective on schizophrenia and other serious mental disorders, thereby ignoring contributions from psychosocial research and practice. Clearly, judicious use of pharmacotherapy remains the sine qua non for building a foundation for treatment and rehabilitation. **By employing the biopsychosocial approach to comprehensive care—with social and independent living-skills training, family psychoeducation, self-management of medication and symptoms, assertive clinical case management, and supported housing and employment—psychiatric rehabilitation often can amplify the impact of medication in fostering higher functioning and even symptomatic and social recovery from schizophrenia and other disabling mental disorders.**

The biopsychosocial approach to treatment and rehabilitation offers opportunities to patients, clients, or consumers who wish to be active participants in their own treatment. **Being a responsible consumer of maintenance antipsychotic medication requires lengthy, repeated education of patients about the effectiveness, value, side effects, and self-administration of medication, as well as learning the negotiation skills necessary to effectively communicate with a physician.** The technology for training patients to assume self-management of their mental disabilities is in its infancy, but already progress has been made that needs to be disseminated to and used by other practitioners.[1]

The Zeitgeist is Changing

Patients with major mental disorders no longer are content to remain in a passive role with their physicians and other service providers. They prefer to see themselves as clients, survivors, or consumers with an active interest in learning about their disorders, setting their goals, and selecting their treatments. **From a role of passive compliance with treatments prescribed for them, more patients now insist upon an informed collaboration** with their professional treaters. The growing consumerism movement has converged with other developments to make the potential for illness self-management feasible and successful. Aside from the high rate of symptomatic remission among cases of recent onset, these developments include: **destigmatization** of mental illness; **improved symptom relief** from newer antipsychotic drugs; **optimistic follow-up data** regarding the course of schizophrenia; the **emergence of skills training technology** that overcomes the cognitive deficits associated with schizophrenia; the **active coping role that helps limit the intrusion of symptoms into everyday life**; and the **demonstrated effectiveness of integrated, comprehensive, and coordinated systems of mental health delivery**. The additive benefits that accrue from interweaving these factors have led us to question whether, *together with our patients*, we can improve the course and outcome of schizophrenia and enhance the potential for recovery to many more people who have a serious mental disorder.

Consumerism and the Self-Help Movement

Unlike other mutual aid self-help groups (such as Alcoholics Anonymous) that emphasize individual reform and cooperation with the medical profession, the mental patient self-help or consumerism movement originated in the early 1970s with a distinctly antipsychiatry focus.[2] The emphasis of these early "grass roots" self-help groups was to challenge or reject social norms and values, to question the need for medications and involuntary admissions, and, generally, to serve as an alternative to the mental health system.[3]

Several recent developments have improved rapport between consumer activists and professionals. In 1987, the U.S. Surgeon General-sponsored Workshop on Self-Help and Public Health recommended establishment of formal systems of care to build egalitarian links with member-governed voluntary associations.[4] This led to the formation of a National Council on Self-Help and Public Health, which **encouraged numerous public health agencies to interact with ongoing and fledgling self-help groups.**[5] One recent example has been the establishment of an Office of Consumer Affairs in the California Department of Mental Health.

A parallel event has been the rise of **self-help organizations and clearinghouses that provide information and referral services to individuals and groups.**[6] The broad dissemination of material made possible by these clearinghouses has contributed to the development of a **"self-help ethos,"[7] a value system that includes empowerment and self-determination but does not promote a radical antipsychiatry philosophy**. The self-help ethos encourages clinicians to provide more active educational services in an interactive, respectful fashion. Consumers also educate each other and organize group activities and advocacy efforts, such as the Project Return Clubs in California and Florida, The Recovery Inc. nationwide, and the Network of Mental Health Clients. The shift of the mental health consumer movement from radicalism to a more constructive partnership with professionals—combined with clinicians' recognition that hierarchical, authoritarian relationships with patients are frequently destructive to the therapeutic alliance[8–10]—has created a window of opportunity for galvanizing truly cooperative working relationships.

The Growth of Collaboration in Treatment

A key goal of the self-help movement is to supplant the passive recipient of mental health services with an active participant in the treatment endeavor. **Thus, instead of being viewed as the patient's failure to comply, noncompliance is seen as a lack of collaboration between patient and clinician or a deficiency in the accessibility (or outreach efforts) of the mental health delivery system.** For example, a patient's failure to continue on maintenance antipsychotic medication does not necessarily derive from a lack of motivation by the patient but from inadequate education of the patient about medication benefits and side effects, a rupture in the therapeutic alliance, or failures in the mental health service delivery system. The task for the treater becomes **mobilization of the**

patient's assets and resources (including the family) to cooperate in a treatment partnership, sharing responsibilities for adherence to mutually agreed upon treatment prescriptions.

Because of the chronic and relapsing nature of schizophrenia, **the patient and his or her family members must understand the stress-related, neurobiological nature of the disorder and must develop a close working alliance or collaborative empiricism with the treaters**. Failure to educate and engage patients and their caregivers in a long-term collaborative and informed therapeutic alliance results in noncompliance with essential antipsychotic medication, psychosocial treatments, and supportive services.[11,12]

Noncompliance is a serious problem, and the clinician must be sensitive to the obstacles or barriers that lie in the pathway of a therapeutic partnership. **The most common barriers to this alliance in treatment can be divided into five domains** (Table 1, *supplement*).[13] An example of a "patient characteristic" barrier is cognitive disorganization—deficits in short-term memory and sustained attention. Circumventing this problem might require minimizing the complexity of treatment regimens; using telephone calls, compartmentalized pill boxes, and reminders for patients to take their medications; using cognitive rehabilitation techniques to improve the patient's memory and attention[14]; teaching the patient self-monitoring techniques; and enlisting caregivers' assistance in monitoring compliance. When the clinician assumes responsibility for improving collaboration with the patient by imparting needed information and skills, patients become more satisfied, more responsible, and more reliable consumers of services.[15]

Positive Outcomes for Those with a Serious Mental Illness

Most mental health professionals have viewed the treatment of the seriously mentally ill as an unrewarding and often frustrating experience.[16] However, **several long-term outcome studies from the United States, Europe, and Japan demonstrate that when people with severe forms of schizophrenia are interviewed 20–40 years after the most disabling period of their illness, more than half are functioning in a reasonably normal way**.[17–20] In their study of patients with serious symptoms of schizophrenia, Harding and colleagues[21] found that 30 years after deinstitutionalization, **82% of these patients had not been hospitalized in the previous year; two thirds were functioning in the normal range of the Global Assessment Scale, had close friends, and reported living full lives**. Furthermore, **only 25% required daily maintenance antipsychotic medication to keep them well**.

Considering these data, the outlook for people diagnosed with schizophrenia is not bleak; rather, it illustrates that **recovery from the illness is possible if continuous access to treatment and rehabilitation is provided**. This hopeful attitude has contributed to the growth of biobehavioral technology that uses new and better medications as well as improved psychosocial and behavioral treatments for schizophrenia to accelerate remission of symptoms, recovery of social and vocational functioning, and improvement in quality of life.

Integrated and Comprehensive Assertive Community Treatment

During the late 1960s and early 1970s, mental health experts realized that office- or clinic-based treatments based on psychotherapeutic models had little relevance for persons with persisting mental disabilities. As a result, they designed a variety of experimental, creative methods of service delivery for community-based treatment of persons with schizophrenia and other chronic disorders.[22–26]

These innovative programs restored optimism that chronically mentally disabled patients could be rehabilitated and reintegrated into community life without having to wait 20–40 years for symptoms to "burn out." Despite differences in orientation, structure, and organization, these programs succeeded because they shared basic strategies for effective intervention with the seriously mentally ill. Bachrach[27] identified **nine common principles** (Table 2, *supplement*) **that are credited with the success of these model programs.** Pre-eminent among them are **administrative endorsement for a rehabilitation philosophy** and the use of **practical, learning-based, educational methods** that transformed the traditional therapeutic relationships between staff and patients into "teacher-student" roles.

Skills Training

Specific learning-based techniques that facilitate collaboration in treatment and focus on the capacity for adaptation, coping, and wellness of the individual have been developed and experimentally validated.[28] **Skills training provides a technology for galvanizing patients and their families (or significant other caregivers), into both responsible consumers of mental health services and active advocates for their needs in the realm of community support services**. Moreover, skills training can equip patients and caregivers with the capacity to cope with ambient biopsychosocial stressors, such as drugs of abuse, family stress and burden, and major life events.

Educating the Family:

One of the most important areas for skills training involves educating the family. Most patients either return to live with their families or continue to have substantial contact with them.[29] **Families are the main source of enduring financial and social support for patients with schizophrenia**. In times of crisis, most often it is the family that offers assistance, so it is not surprising that **a high level of stress exists in families of psychiatric persons**. Nor is it surprising that **patients who live with families who exhibit high "expressed emotion" (which can be defined as excessively critical, hostile, or emotionally overinvolved attitudes and behavior) are three to four times more likely to relapse within a year following discharge from the hospital than patients in low expressed emotion families**.[31] These internationally replicated findings have led to the development of training techniques and educational programs designed to teach patients and families about schizophrenia and its management.

Behavioral Family Management:

Another skills-training method, **behavioral family management, is based on behavioral skills training.**[32,33] **Training occurs in five stages, with considerable recycling of each stage throughout the therapy: (1) Behavioral assessment; (2) education about schizophrenia and its care; (3) communication skills training; (4) problem solving; and (5) coping with special problems.**

The clinical efficacy of this model has been systematically evaluated and replicated both in Los Angeles at the Clinical Research Center for Schizophrenia as well as in England.[34–36] Results showed that **patients who received the family treatment had fewer hospitalization episodes, spent less time in the hospital, experienced fewer major exacerbations in psychotic symptoms, had more sustained remissions, and required fewer emergency crisis sessions than patients who received supportive individual therapy. Patients who received the family intervention also improved more in their social and vocational adjustment** and were actually prescribed ***lower*** **doses of neuroleptics to control their symptoms** than their counterparts who received individual supportive therapy. Through provision of behavioral family therapy in an educational format, families can be trained to detect and resolve stresses that arise from the persisting vulnerability associated with schizophrenia.

Multidimensional Approach:

In another effort to equip patients and their relatives with knowledge and skills for dealing with schizophrenia, Hogarty and colleagues[37] developed a **psychoeducational family treatment program for patients and their families**; patients also received individually oriented social skills training in conjunction with pharmacotherapy. Acutely hospitalized patients with schizophrenia who had been living with high expressed emotion relatives were randomly assigned to one of four treatment protocols: medication only; medication with either of the two modalities alone; and medication with both social-skills training and family treatment. At 1-year follow-up, the medication-only group had a relapse rate of 41%, whereas **the group receiving medication, social-skills training, and family therapy had no relapses. The group receiving medication combined with family therapy alone or social-skills training alone had relapse rates of 19% and 20%, respectively**. Most significantly, this study demonstrates that the **effects of these therapies are additive**, suggesting that a multidimensional approach is most likely to be translated into greater resilience against stress-induced relapse.

These practical, educational, and family management approaches have been replicated in London,[38] Manchester,[39] and New York.[40] A recent meta-analysis of 27 studies incorporating social-skills training on patients with schizophrenia found significant effect-sizes for this modality's impact on discharge rates from hospitals; relapse rates; acquisition, durability, and generalization of skills; and social adjustment.[41]

Modules for Social and Independent Living Skills Training

Unfortunately, techniques for teaching social skills are not easily learned by professionals. At least 3–6 months of apprenticeship are required to prepare a psychologist, nurse, social worker, or psychiatrist to use these methods confidently and competently. To overcome this obstacle, **a step-by-step multimedia program for training social and independent living skills was designed for easier use by a wider array of mental health professionals and paraprofessionals.**[42] Several "user friendly" modules are now available in the UCLA Social and Independent Living Skills Program. Together, the modules form a comprehensive rehabilitation program, but they also can be used selectively in combination with existing programs in a wide variety of hospital and community settings.

The techniques described in the trainer's manual for each component include all of the behavioral learning principles known to help people with schizophrenia overcome their learning disabilities: **behavioral rehearsal, repetition and overlearning, coaching, shaping and fading, modeling, video feedback, and positive reinforcement**. Each module is divided into separate skill areas that have specific educational objectives. **The patients proceed through each skill area by employing eight learning activities**. (Table 3, *supplement*).

Module Specifics:

The Medication Management Module of the multimedia program has **five skill areas: obtaining information about antipsychotic medication**; correctly **self-administering and evaluating the medication**; **identifying the side effects** of the medication and distinguishing between benign and serious side effects; **negotiating medication issues with health care providers**; and **understanding the value and benefits of using long-acting neuroleptics**.

In the **Symptom Management Module**, patients learn: how to **identify the warning signs of relapse**; how to **intervene early to prevent relapse** once these signs appear; how to **cope with the persistent psychotic symptoms that continue despite medications**; and how to **avoid alcohol and other drugs of abuse**. Each skill area can be further divided into target behaviors. **For example, in the skill area of "Identifying Warning Signs of Relapse," patients learn how to discuss warning signs with their relatives and physician** so that there is agreement on the symptoms that predict relapse (e.g., insomnia, irritability, social withdrawal, ideas of reference). Patients are also taught to **keep a checklist of warning signs to monitor themselves** over time. This is designed to help patients understand the benefits of early intervention and realize when to request help.

These modules were designed to compensate for the cognitive and symptomatic obstacles to learning that are regularly experienced by many patients with schizophrenia. The two modules outlined above, Symptom Management and Medication Management, have been used to train patients in illness self-management.[42,43,44] In one controlled study, 41 patients with schizophrenia who received constant maintenance neuroleptic therapy were randomly assigned either to supportive group therapy or to structured, modularized skills training. The skills training comprised training in medication and symptom self-management using the UCLA modules. Patients in group therapy engaged in an insight-oriented and supportive

group process that included less-formally structured education about schizophrenia as an illness and the importance of medication. Both treatment conditions involved twice-weekly, 90-minute sessions over the course of 6 months.

After 6 months, the patients who received skills training made significant gains in each of the areas taught, whereas those in group therapy did not. As shown in Figure 1 (*supplement*), **these skills were largely retained 1 year after training was completed.** Even patients with moderately severe levels of psychopathology showed significant learning effects. **Although the data used to compare groups for improvements in psychopathology and relapse were inconclusive, nearly all of the patients who participated in the skills modules systematically and regularly monitored their warning signs throughout the 6-month training period, indicating an increase in the collaborative relationship with the prescribing clinician.** Moreover, the patients who received skills training showed significantly improved utilization of their illness self-management skills and social adjustment 2 years after they entered the study.

Evaluating Skills Training

Controlled studies have tested for the efficacy and replicability of skills training for patients with schizophrenia. One study[45] randomly assigned patients at seven facilities (one state hospital, five residential care homes, and one day treatment program) to a control group, which consisted of customary social rehabilitation therapy, or to a modular program, in which they received specific training on how to develop independent recreational activities, improve their grooming skills, and learn medication self-management. Patients and trainers were evaluated on their ability to learn and teach these skills, respectively. **Over a period of 30–40 hours of training per module, the patients who received skills training acquired and retained significantly more than the patients who received the customary form of social rehabilitation across all facilities.** Some of these results are depicted in Figure 2 (*supplement*). More germane to the question of disseminability, **the effectiveness of the intervention depended on the trainers' adherence to the instructional techniques specified in the modules—not on their level of education or professional degree.** Thus, the techniques showed great utility in the hands of professional and nonprofessional trainers alike.

First Person Accounts

It has become increasingly clear that many persons with schizophrenia have learned coping strategies to deal effectively with their illness. The *Schizophrenia Bulletin* has published the "First Person Accounts" section continuously since 1979. Besides letting patients and families know that they are not alone in confronting the problems associated with schizophrenia, this section has frequently included anecdotes that provide insight into the coping techniques people have used to combat their illness successfully.

More recently, individuals have come forward to tell their stories of relapse and recovery. Fred Frese,[46] a practicing psychologist from Ohio, described the personal coping techniques he developed for dealing with his symptoms of schizophrenia in a series of articles, lectures, and a videocassette. The autobiography *Welcome, Silence* documents one woman's odyssey from acute schizophrenia to practicing psychiatrist.[47] **Many others, unfortunately, fear "coming out of the closet," believing that the stigma of mental illness endangers their jobs, social positions, and families.**[46]

Many case reports confirm the **benefit of cognitive and behavioral coping methods.** A retrospective study of 10 fully recovered persons with schizophrenia identified various "curing elements" critical to effective management of the disorder.[48] Another report focused on how mental health consumers who have learned to cope with symptoms have been trained and employed as case management aides.[49] It was found that **coping techniques not only benefited the consumer but also the "prosumer"** (i.e., the one who both performs and consumes mental health services).

In the past decade, researchers have used semistructured interviews with open-ended probes to learn patients' techniques for controlling their symptoms of psychosis. One study found that **patients' self-monitoring of internal states and their evaluation of such states** were prerequisites for effective self-control of symptoms.[50] In another study, many patients with schizophrenia were found to monitor symptoms of incipient decompensation and alter their behavior effectively when symptoms of decompensation were present.[51] A third investigation revealed that the formation of a **"disease consciousness"—that is, an awareness of the existence of psychotic behavior**—was the most crucial step in attaining self-control.[52] These studies, along with the Symptom Management Module (in which patients are successfully taught coping strategies for dealing with psychotic symptoms)[14,53] demonstrate that the key question is not whether it is time yet for cognitive remediation in the treatment of schizophrenia,[54] but rather, **"When will clinicians use the patient's own adaptive strivings or coping strategies as an essential part of treatment?"**

Case Example

Mr. S is 27 years old and has suffered from paranoid schizophrenia since age 17. His first psychotic break occurred at a rock concert, and use of lysergic acid diethylamide (LSD) was suspected as the triggering event. He was hospitalized for treatment of delusions and hallucinations 2 weeks later and three more times before graduating from high school.

During the first few years of his illness, he had the good fortune of being **treated by a psychiatrist who believed in the value of patient education.** Using the Medication Management Module, the psychiatrist and Mr. S spent 45 minutes weekly for 3 months exploring the learning activities of this module. At many of the sessions, the psychiatrist and Mr. S invited his parents to attend so that they would be able to reinforce and support his self-management and use of medication without being overly involved or nagging. Mr. S learned about schizophrenia, the medications used to treat the disorder, and their side effects. He learned and applied effective coping mechanisms for dealing with dry mouth and supersensitivity to sun exposure.

He was engaged in a social-skills training group of outpatients that featured an individualized approach to learning how to achieve one's needs.[55] Led by a behaviorally oriented psychologist, **the group enabled Mr. S to learn relationship-building skills (i.e., the correct response to social cues such as facial expression, tone of voice, and body language)**. This enabled him to **judge other people's responses to his actions** and helped him **make subtle behavioral adjustments to mask his sometimes-severe thought disorder**. He was accepted to a prestigious university to which he applied while an inpatient in a psychiatric hospital.

Feeling overconfident because he was attending a university and was clinically stable, he discontinued his medication. Within 3 months, he suffered another psychotic break, necessitating a psychiatric hospitalization and retitration of his neuroleptic medication. He recovered several weeks later but felt the need to enroll in a different university "where people don't know me" back in his home state. At this time, he resumed treatment with his original psychiatrist, who persuaded Mr. S to participate in the Symptom Management Module, which taught Mr. S how to identify his prodromal symptoms of impending relapse. For Mr. S, **psychotic decompensation was heralded on each occasion by several weeks of ideas of reference, suspiciousness, difficulty concentrating, and arduousness in expressing himself.** With Mr. S's permission, the psychiatrist invited his parents to participate in the framing of Mr. S's "relapse prevention plan," which involved asking his parents for assistance with making a phone call to the psychiatrist and driving him to the psychiatrist's office.

Mr. S and his therapist worked together to develop a self-monitoring system that identified early warning signs of stress and relapse. Each night, Mr. S would rate his daily symptoms and adjust his medication accordingly. **For example, if Mr. S felt he had no problems concentrating, no difficulty expressing his thoughts, or no feelings of suspiciousness, he would take the baseline level of 5 mg of fluphenazine (Prolixin). If he had experienced ideas of reference but no speaking problems that day, he would take 10 mg. The presence of both cognitive and loose associations when speaking to others would warrant 15 mg.**

Another crucial factor in Mr. S's self-management was his ability to form trusting relationships. His several close and loyal friends **allowed him to gather feedback on his cognitive and behavioral processes** as well as empirically validate his perception of symptoms. This was an important element in building self-esteem that increased his confidence in his capacity for self-assessment.

Mr. S's psychiatrist, with help from a social worker, engaged Mr. S, his parents, and his girlfriend in 25 sessions of behavioral family management,[56] during which they learned **basic communication skills (e.g., giving positive feedback to each other, making a positive request instead of a "demand" from others, and expressing angry or frustrated feelings directly and non-accusatively)**. After 10 sessions of systematic training in communication skills, Mr. S and his parents were taught how to use these skills in coping with and solving day-to-day problems. The problems could arise in the family relationships (e.g., Mr. S secluding himself for long periods of time in his room) or in the community (e.g., Mr. S experiencing difficulty using the new computerized index catalogue at the local library).

Mr. S continued successfully in college and graduated with honors in psychology. He applied and was accepted for graduate school in clinical psychology in another state. One year later, he married his girlfriend of 3 years.

Graduate school went very well for nearly 2 years. He had been on the same medication regimen; but for practical reasons, **he switched to a local psychiatrist who did not concur with the diagnosis of schizophrenia**, principally because Mr. S was functioning at such a high level. **Soon thereafter, the psychiatrist thought he saw early signs of tardive dyskinesia, and persuaded Mr. S to stop his medication and begin taking lithium (Eskalith, Lithane). Within 6 weeks, he decompensated and was admitted to a psychiatric facility. He was restarted on fluphenazine, and although his psychotic symptoms abated rapidly, his return to baseline functioning was delayed by the heavy-handed and stressful work load of his graduate program.** He was forced to resign from the program; he was allowed to finish his master's degree but was not permitted to pursue a doctorate or a clinical certificate.

Despondent but not defeated, he returned to his home state and began **working as an administrator in a mental health advocacy program**. He has been successfully employed for the past several years; at the time of this writing, he is the assistant director of the program. Although his original goal was to be a clinician, he has channeled his desire to help others avoid the torment he experienced by becoming active in the political arena, believing that by working to influence the attitudes of legislators, he can most effectively fight discrimination against the mentally ill.

Although he acknowledges the importance of medication, social support, his own intelligence, and good premorbid adjustment as protective factors in his ongoing efforts to cope with schizophrenia, **he believes the key to his wellness is self-discipline**. His ability to sacrifice comfort for psychiatric stability is partially a result of his stoic personality, but he ascribes most of his self-management ability to the skills training he had received. It is this inner strength that is tested daily: at home, by taking extra fluphenazine; at work, by trying to appear objective when supervising coworkers who talk disparagingly about clients; at political gatherings, where he tries to remain the professional advocate but wishes to scream out his personal anguish. **His biggest disappointment is that he cannot tell his story for fear of losing his job, social position, and credibility**. He says there are many people with schizophrenia like him in the community. If so, these people have much to teach us about self-management of schizophrenia.

From Illness Self-Management to Recovery

What are the prospects for broadening symptomatic and social recovery to a larger number of persons with schizophrenia? **The key to succeeding in this endeavor lies in early intervention that engages the patient and**

family in a comprehensive program of treatment and rehabilitation within the first years of the illness. When persons who have a recent onset of schizophrenia are involved in an integrated biobehavioral treatment program, they show rapid and substantial remission of their positive and negative symptoms.[1]

For example, at the UCLA Aftercare Clinic, persons with recent-onset schizophrenia who received 12.5 mg of fluphenazine for 2 weeks, family education, individual case management, and psychoeducational group treatment were in complete remission of clinically significant levels of positive psychotic symptoms for 82% of their first year in treatment and in remission of clinically significant levels of negative symptoms for 78% of the first year.[57] These lengthy periods of remission of psychopathology offer clinicians a window of opportunity to intervene with psychosocial services and skills training when patients have the cognitive capacity to benefit from learning experiences. If treatment and rehabilitation is sustained and flexibly linked to the phase and type of an individual's schizophrenic disorder for many years, then the prospects rise considerably for sustained symptomatic remission and normal psychosocial functioning (e.g., living independently, working or studying, having friendships, and pursuing recreational activities).

The elements of service described herein are not "pie in the sky"—they have been assembled and delivered in real programs. For example, a community mental health system in the County of Buckingham in England implemented an integrated system of care for the seriously mentally ill in the mid-1980s. Services such as those cited in this lesson were delivered in vivo, especially in the patients' homes and workplaces, by a team of specialized psychiatrists, psychologists, social workers, and psychiatric nurses. Epidemiologic surveys in this county indicate that the incidence of new cases of chronic schizophrenia decreased 10-fold during a 5-year period.[58]

Scientist-practitioners working at the UCLA Clinical Research Center for Schizophrenia & Psychiatric Rehabilitation have applied and adapted the findings from research in their clinical work with young patients suffering from schizophrenia. Working with a private agency of specially trained case managers, the "life adjustment team," psychiatrists and psychologists from the Clinical Research Center are integrating many of these principles to accelerate the process of symptomatic and social recovery in these patients, who range in age from 17 to 40.

Case managers, under the supervision of psychologists and psychiatrists, **teach clients medication and symptom self-management skills, basic conversational skills, and recreational skills. Behavioral family management is employed for achieving a partnership with family members** who, along with the client, become educated and empowered to participate as full members of the "team." **Personalized goals are formulated by each client** with the astute assistance and coaching by the case managers, and **these goals are monitored weekly and reported monthly and quarterly to the client, family, and treating psychiatrist.**

Vocational rehabilitation, in the form of transitional and supported work, is facilitated by the case managers when clients' symptoms have stabilized and their goal setting reaches the domain of work. The therapeutic alliance between the clients and their case managers is developed and strengthened through frequent interactions in natural, community-based recreational and social settings, as well as through home visits. Even though a formal research study is still being planned to evaluate this integrated mental health treatment and rehabilitation program, 10 clients already have achieved stable and prolonged remission of psychotic symptoms and reintegration into full-time work or university study.

Summary

Community-based care of persons with serious mental disorders has become infused with greater optimism in recent years because efforts increasingly are guided by empirically validated and treatment-specific interventions. These treatments include **a new generation of antipsychotic and antidepressant medications, use of existing and customary antipsychotic drugs with higher benefit/risk ratios, social-skills training, supported employment, assertive case management, and psychoeducational family management.** The clinical and economic effectiveness of treatment systems marked by comprehensiveness, accessibility, and coordination of services is now generally recognized.

Psychopharmacologic and psychosocial treatments appear to be additive in their efficacy. For example, adding psychoeducational or behavioral family management to maintenance antipsychotic medication reduces relapse rates by half. **Combining social-skills training with maintenance pharmacotherapy yields better social functioning while minimizing relapse.** If comprehensive and coordinated treatment and rehabilitation services are accessible on a continuous basis for those in the early phases of their psychotic disorders, the goal of recovery (i.e., sustained remission of psychotic symptoms and normal instrumental role functioning) is a legitimate aim of any clinical program.

As an organization accredited for continuing medical education, St. Vincent's Hospital and Medical Center of New York certifies that when these continuing medical education materials (Directions in Psychiatry) are used as directed, they meet the criteria for 30 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

QUESTIONS BASED ON THIS LESSON

These questions must be answered for CME credit. Please mark your answers on the response form.

49. In the study by Hogarty and colleagues, which therapeutic modality decreased relapse rates the most?

A. Family psychoeducation
B. Individual social-skills training
C. Psychopharmacology
D. A, B, and C combined

50. Which of these factors has contributed to the feasibility of illness self-management?

A. Emergence of skills-training technology
B. Optimistic long-term outcome data
C. Both of the above
D. None of the above

51. The main source of enduring financial and social support of patients with schizophrenia is:

A. The family
B. The state hospital
C. The federal government
D. None of the above

QUESTION BASED ON A PREVIOUS LESSON

These questions are for self-assessment only. Answers appear below.

Predictors of a positive outcome for treatment of acutely ill patients with valproate include:

A. A designation of bipolar I disorder
B. An absence of a family history of mood disorder
C. Increasing severity of mania over the natural history of the illness
D. Mixed states

Answer: D

QUESTION BASED ON A FUTURE LESSON

Antidepressant medication usually should be started early, often as soon as possible, when:

A. Improvement is likely to occur with psychotherapy alone
B. There is a strong family history of mood disorder
C. Suicidal risk is absent
D. The diagnosis of major depression is unclear

Answer: B

Directions in Psychiatry (ISSN #0891-3870) is published biweekly with a year-end index issue (27 issues per year) for $357 per year by The Hatherleigh Company, Ltd., 420 East 51 Street, New York NY 10022-8095.

Second-class postage paid at New York, NY, and additional mailing offices.

POSTMASTER: Send address changes to *Directions in Psychiatry*, 420 East 51 Street, New York NY 10022-8095.

© 1994, The Hatherleigh Co, Ltd.

EDITORIAL BOARD OF CONSULTANTS
Frederic Flach, MD, **Program Director/Editor-in-Chief**

E. James Anthony, MD
Ross J. Baldessarini, MD
Joel Elkes, MD
Joseph T. English, MD
Shervert H. Frazier, MD
Hugh Freeman, FRCPsych
Jimmie C. Holland, MD
Hideo Hosaki, MD
Carl P. Malmquist, MD
Timothy B. Moritz, MD
Malkah T. Notman, MD
Michael A. Schwartz, MD
Louis Jolyon West, MD
Peter C. Whybrow, MD
Robert L. Williams, MD

For information, please call toll-free 1-800-367-2550.

Directions in Psychiatry

Lesson Supplement

Vol. 14, No. 17 • August 24, 1994

Self-Management Approaches for Seriously Mentally Ill Persons

Alex Kopelowicz, MD, and Robert Paul Liberman, MD

Figure 1

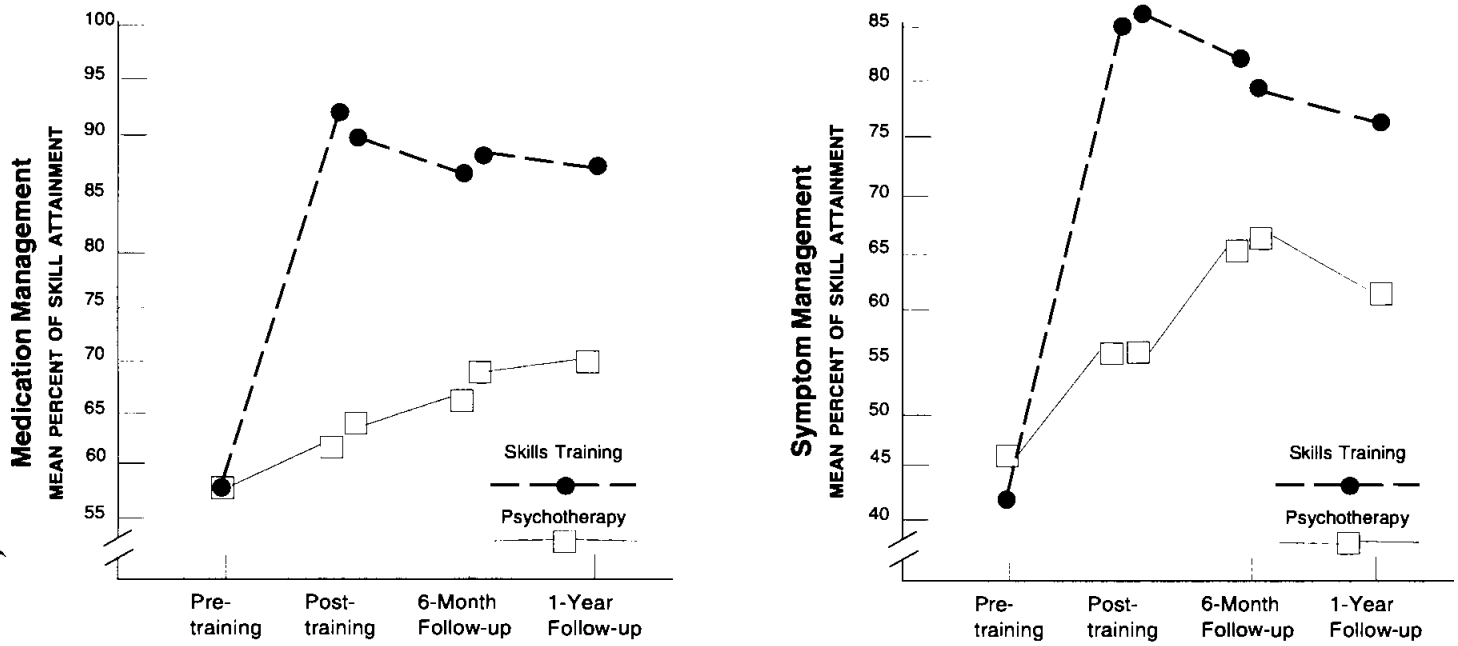

Figure 1. Durability of skills learned in two modules, Symptom Management and Medication Management. The contrast group is Supportive Group Therapy.

Figure 2

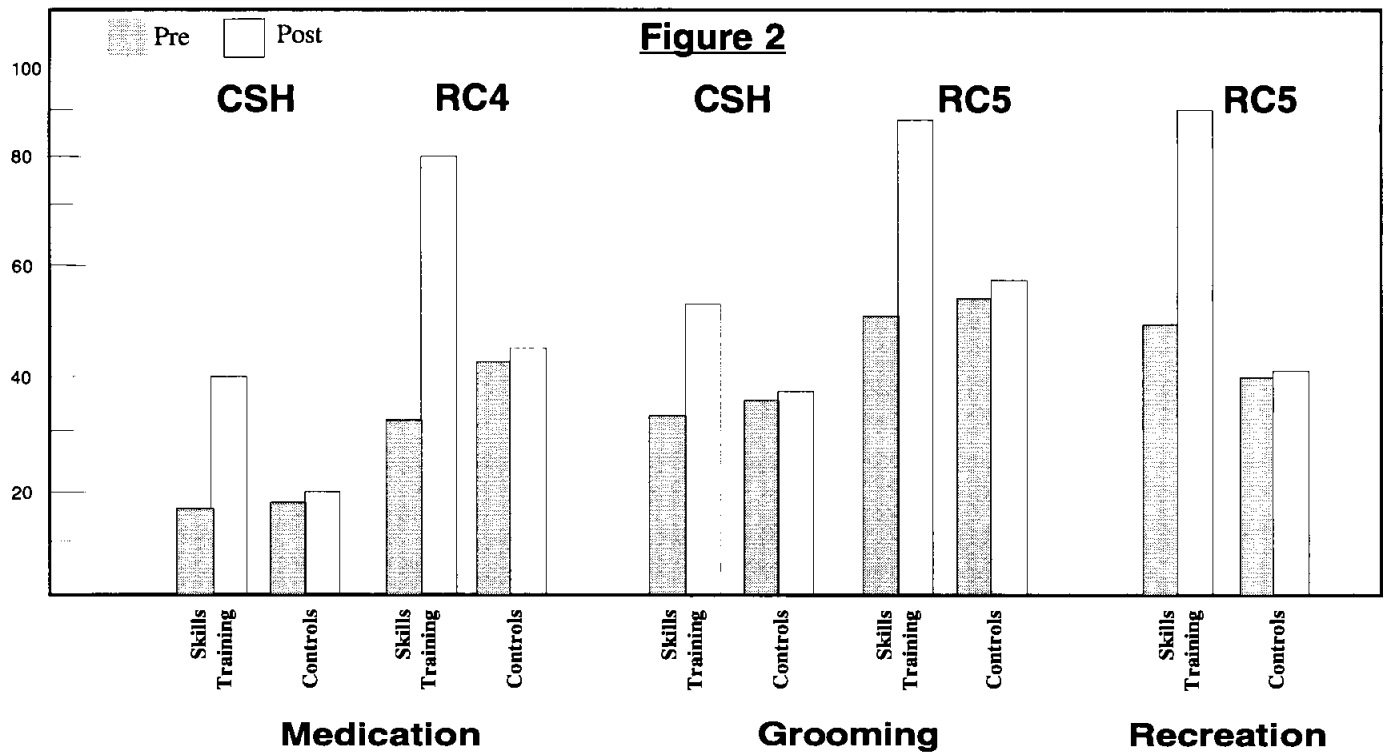

Figure 2. The acquisition of knowledge and skill in persons with serious mental disorders who participated in the Medication Management Module or in a control group. The open bars represent the post-test means and the shaded bars the pre-test means. CSH=Camarillo State Hospital long term wards. RC4=Residential treatment facility. RC5=Residential treatment facility.

Table 1
BARRIERS TO PATIENT COLLABORATION IN TREATMENT AND EXAMPLES OF CORRECTIVE MEASURES

Barrier	*Corrective Measure*
Treatment techniques (side effects)	*Educate patients about side effects and their management*
Patient characteristics (cognitive disorganization)	*Teach self-monitoring techniques to patient*
Family characteristics (unrealistic expectations)	*Encourage family participation in psychoeducation and support groups*
Clinician-patient relationship (clinician's nihilism)	*Help patient and family members to set and attain realistic, incremental goals; offer lavish reinforcement when they are achieved and even for effort*
Treatment delivery system (lack of coordination)	*Use case managers and continuous treatment teams with capability for assertive outreach to coordinate services*

Table 2
PRINCIPLES FOR SUCCESSFUL COMPREHENSIVE ASSERTIVE COMMUNITY TREATMENT

1. Priority given to the persistently mentally disabled population with an optimistic, "can-do" rehabilitation philosophy
2. Linkage with other resources in the community, including liaison with partial hospitalization and inpatient care when indicated
3. Functional integrity in which provision is made for patients to receive the full range of services formerly associated with institutional care (e.g., medical, psychiatric, housing, financial, recreational, vocational)
4. Individually tailored treatment with outreach as needed and least amount of supervision and restrictiveness to encourage empowerment, autonomy, and illness self-management by patients
5. Cultural relevance and specificity
6. Staff trained to engage difficult clients, conduct symptomatic and functional assessment, and provide empirically validated biobehavioral treatment (e.g., social-skills training) and rehabilitation modalities
7. Systematic, written set of policies and procedures, including treatment manuals
8. Educational thrust with patients viewed as "students," "members," or "clients" who can acquire greater self-help and self-reliance through learning-based procedures.
9. Ongoing internal assessment and quality assurance mechanisms that permit the program to monitor itself continually and improve its functions, processes, goals, and outcomes

Table 3
LEARNING ACTIVITIES FOR EACH SKILL AREA IN SKILLS TRAINING MODULES

Learning Activity	*Role of Trainer*
1. Introduction to skill area	Tell participants the skills that will be taught and the benefits of learning them
2. Videotape, questions/answers	Show participants a videotaped demonstration of the skills, and ask questions to be sure the material is understood
3. Roleplay	Help participants practice the skills
4. Resource management	Teach participants to identify the resources needed to perform the skills and methods of obtaining these resources
5. Outcome problems	Teach participants to solve problems that might occur when the skills are used in new situations
6. In vivo exercises	Supervise participants as they perform the skills in new situations
7. Homework assignments	Encourage participants to perform the skills independently in new situations
8. Booster sessions	Provide participants with "refresher" courses on an as-needed basis

REFERENCES

1. Liberman RP, Wallace CJ, Blackwell G, Eckman TA, Vaccaro JV, Kuehnel TG. Innovations in skills training for the seriously mentally ill: The UCLA Social & Independent Living Skills Modules. *Innovations Res.* 1993;2:43–60.
2. Zinman S, Budd SU, Harp H. *Reaching Across: Mental Health Clients Helping Each Other.* Riverside, Calif: California Network of Mental Health Clients; 1987.
3. Emerick RE. Group demographics in the mental patient movement: group location, age and size as structural factors. *Community Ment Health.* 1989;25(Winter):277–300.
4. Surgeon General's Workshop on Self-Help and Public Health. *DHHS Public Health Service, HRSA, Bureau of Maternal and Child Health and Resource Development Publication No. 224-250.* Washington, DC: US Government Printing Office; 1988.
5. Borkman T. Self-help groups at the turning point: emerging egalitarian alliances with the formal health care system? *Am J Community Psychol.* 1990;18:321–332.
6. Wollert R. A survey of self-help clearinghouses in North America: special report for the U.S. Surgeon General's Workshop on Self-Help and Public Health. Washington, DC: US Government Printing Office' 1987. DHHS publication No. 224-250.
7. Riessman F, Gartner A. The surgeon general and the self-help ethos. *Soc Policy.* 1987;18(Fall):23–25.
8. Frank AF, Gunderson JG. The role of the therapeutic alliance in the treatment of schizophrenia: relationship to course and outcome. *Arch Gen Psychiatry.* 1990;47:228–236.
9. Stark M, Corrigan PW, Liberman RP. Schizophrenic patients' attitudes to therapists using behavioral and humanistic techniques. *J Psychother Pract Res.* 1992;1:80–85.
10. Stein LI, Test MA. *Alternatives to Mental Hospital Treatment.* New York, NY: Plenum Press; 1978.
11. Morrison RL, Bellack AS. Social skills training. In: Bellack AS, ed. *Schizophrenia: Treatment, Management, and Rehabilitation.* New York, NY: Grune & Stratton Inc; 1984.
12. Van Putten T. Why do schizophrenic patients refuse to take their drugs? *Arch Gen Psychiatry.* 1974;31:67–72.
13. Corrigan PW, Liberman RP, Engel J. From noncompliance to adherence in psychiatric treatment: strategies that facilitate collaboration between practitioner and patient. *Hosp Community Psychiatry.* 1990;41:1203–1211.
14. Green MF, Kinsbourne M. Subvocal activity and auditory hallucinations. *Schizophr Bull.* 1990;16:617–626.
15. Hall JA, Roter DL, Katz NR. Meta-analysis of correlates of provider behavior in medical encounters. *Med Care.* 1988;26:657-675.
16. Meyerson AT. What are the barriers or obstacles to treatment and care of the chronically disabled mentally ill? In: Talbott JA, ed. *The Chronic Mental Patient: Problems, Solutions, and Recommendations for Public Policy.* Washington, DC: American Psychiatric Press Inc; 1978.
17. Bleuler M. A 23-year longitudinal study of 208 schizophrenics and impressions in regard to the nature of schizophrenia. In: Rosenthal D, Kety SS, eds. *The Transmission of Schizophrenia.* New York, NY: Oxford University Press; 1968.

18. Ciompi L. Catamnestic long-term study on the course of life and aging of schizophrenics. *Schizophr Bull.* 1980;6:606–618.

19. Harding CM. Course types in schizophrenia. *Schizophr Bull.* 1988;14:633–644.

20. Huber G. *Verlauf und Ausgang Schizophrener Erkrankungen.* Stuttgard, Ger: Schattauer; 1973.

21. Harding C, Brooks G, Ashikaga T, Strauss JS, Breier A. The Vermont longitudinal study of schizophrenia. *Am J Psychiatry.* 1987;144:949–955.

22. Falloon IRH, Boyd J, McGill C. *Family Care of Schizophrenia.* New York, NY: Guilford Press; 1984.

23. Beard JH, Malamud TJ, Rossman E. Psychiatric rehabilitation and long-term rehospitalization rates. *Schizophr Bull.* 1978;4:622–635.

24. Liberman, Bryan. Behavior therapy in a community mental health center. *Am J Psychiatry.* 1977;134:401–406.

25. Paul GL, Lentz R. *Psychosocial Treatment of Chronic Mental Patients.* Cambridge, Mass: Harvard University Press; 1977.

26. Fairweather GW, Sanders DH, Cressler DL, Maynard H. *Community Life for the Mentally Ill.* Chicago, Ill: Aldine; 1969.

27. Bachrach LL. Overview: model programs for chronic mental patients. *Am J Psychiatry.* 1980;137:1023–1031.

28. Lieberman J, Jody D, Geisler S, et al. Time course and biological correlates of treatment response in first episode schizophrenia. *Arch Gen Psychiatry.* 1993;50:369–376.

29. Carpentier N, Lesage A, Goulet J, Lalonde P, Renaud M. Burden of care of families not living with young schizophrenic relatives. *Hosp Community Psychiatry.* 1992;43:38–43.

30. Fadden G, Bebbington P, Kuipers L. Caring and its burdens: a study of spouses of depressed patients. *Br J Psychiatry.* 1987;151:660–667.

31. Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. *Br J Psychiatry.* 1992;160:601–620.

32. Falloon IRH, Liberman RP. Interactions between drug and psychosocial therapy in schizophrenia. *Schizophr Bull.* 1983;9:44–55.

33. Mueser KT, Glynn SM, Liberman RP. Behavioral family management for serious psychiatric illness. In: Hatfield AB, Lefley H, eds. *Models of Interventions with Families of Mentally Ill Relatives--New Directions For Mental Health Services.* San Francisco, Calif: Jossey-Bass; 1994.

34. Falloon IRH, Boyd JL, McGill CW, et al. Family management in the prevention of morbidity of schizophrenia. *Arch Gen Psychiatry.* 1985;42:887–896.

35. Randolph E, Eth S, Glynn S, et al. Efficacy of behavioral family management in reducing relapse in veteran schizophrenics. *Br J Psychiatry*; in press.

36. Strachan A. Family management. In: Liberman RP, ed. *Handbook of Psychiatric Rehabilitation.* New York, NY: Macmillan Publishing Co; 1992.

37. Hogarty GE, Anderson CM, Reiss DJ, et al. Family psychoeducation, social skills training and maintenance chemotherapy in the aftercare treatment of schizophrenia. *Arch General Psychiatry.* 1986;43:633–642.

38. Leff J, Kuipers L, Berkowitz R, Eberlein-Vries R, Sturgeon D. A controlled trial of social intervention in the families of schizophrenic patients: two-year follow-up. *Br J Psychiatry.* 1982;146:594–600.

39. Tarrier N, Barrowclough C, Vaughn CE, et al. Community management of schizophrenia: a controlled trial of behavioral intervention with families to reduce relapse. *Br J Psychiatry.* 1988;153:532–542.

40. MacFarlane WR, Stastny P, Deakins S: Family-aided assertive community treatment. In: Liberman RP, ed. *Effective Psychiatric Rehabilitation: New Directions for Mental Health Services.* San Francisco, Calif: Jossey-Bass; 1992.

41. Benton MK, Schroeder HE. Social skills training with schizophrenics: a meta-analytic evaluation. *J Consult Clin Psychol.* 1990;58:741–747.

42. Wallace CJ, Boone SE, Donahoe CP, Foy DW. Psychosocial rehabilitation for the chronic mentally disabled: social and independent living skills training. In: Barlow D, ed. *Behavioral Treatment of Adult Disorders.* New York, NY: Guilford Press; 1985.

43. Eckman TA, Liberman RP, Phipps CC, Blair K. Teaching medication management skills to schizophrenic patients. *J Clin Psychopharmacol.* 1990;10:33–38.

44. Eckman TA, Wirshing WC, Marder SR, Liberman RP, et al. Technique for training schizophrenic patients in illness self-management: a controlled trial. *Am J Psychiatry.* 1992;149:1549–1555.

45. Wallace CJ, Liberman RP, MacKain SJ, Blackwell G, Eckman TA. Effectiveness and replicability of modules for teaching social and instrumental skills to the severely mentally ill. *Am J Psychiatry.* 1992;149:654–658.

46. Frese FJ. *Schizophrenia: Surviving in the World of Normals.* Videocassette produced by Wellness Reproductions Inc, 23945 Mercantile Road, Beachwood, Ohio 44122; 1991.

47. North CS. *Welcome, Silence.* New York, NY: Simon & Schuster; 1987.

48. Rund BR. Fully recovered schizophrenics: a retrospective study of some premorbid and treatment factors. *Psychiatry.* 1990;53:127–139.

49. Sherman PS, Porter R. Mental health consumers as case management aides. *Hosp Community Psychiatry.* 1991;42:494–498.

50. Breier A, Strauss JS. Self-control in psychotic disorders. *Arch Gen Psychiatry.* 1982;40:1141–1145.

51. McCandless-Glimcher L, McKnight S, Hamera E, Smith BL, Peterson KA, Plumlee AA. Use of symptoms by schizophrenics to monitor and regulate their illness. *Hosp Community Psychiatry.* 1986;37:929–933.

52. Dittmann J, Schuttler R. Disease consciousness and coping strategies of patients with schizophrenic psychosis. *Acta Psychiatr Scand.* 1990;82:318–322.

53. Falloon IRH, Talbott RE: Persistent auditory hallucinations: coping mechanisms and implications for management. *Psychol Med.* 1981;11:329–339.

54. Green MF. Cognitive remediation in schizophrenia: is it time yet? *Am J Psychiatry.* 1993;150:178–187.

55. Liberman RP, Mueser K, DeRisi WJ. *Social Skills Training for Psychiatric Patients.* New York, NY: Pergamon Press; 1989.

56. Falloon IRH, Boyd JL, McGill CW. *Family Care of Schizophrenia.* New York, NY: Guilford Press; 1984.

57. Nuechterlein KH, Ventura J, Liberman RP, et al. Symptomatic recovery in recent onset persons with schizophrenia. Paper presented at Annual Institute on Hospital & Community Psychiatry of the American Psychiatric Association; Oct 1993; Baltimore, Md.

58. Falloon IRH, Fadden G. *Integrated Mental Health Care.* London, UK: Cambridge University Press; 1993.