A Clinical Guide for the Treatment of Schizophrenia

Edited by

ALAN S. BELLACK

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To Barbara, Jonathan, and Adam –

They provide a reason to work, and

pleasure when the work is done.

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Preface

Research on the nature and treatment of schizophrenia has undergone a revival and metamorphosis in the last decade. For a long while, the field had been moribund, weighed down by an unreliable diagnostic system, pessimism about the possibility of new discoveries, and a dearth of research funds. A number of factors have seemingly coalesced to change this situation, with the result that the field is now alive with excitement and optimism.

Four factors seem to have played important roles in the resurgence of interest. First, prior to the publication of DSM-III in 1980 there was no reliable diagnostic system for the disorder. Previous definitions were overly general and imprecise. Consequently, the label "schizophrenia" applied to a very heterogeneous group of severely disturbed patients. It was rarely clear whether two investigators had studied comparable samples, making it impossible to determine if new findings were generalizable or if failures to replicate were due to the unreliability of the results or the fact that the investigators had studied different disorders. DSM-III has not totally resolved this problem, but it has allowed scientists to reliably identify a much more homogeneous group. As a result, it is now possible to integrate the results of different studies, making it much more likely that we can make important advances.

The second important factor was the development of new technologies that promised to help uncover the nature and etiology of the disorder. The field was plagued by pessimism through the early 1970s as research seemed to be at a stalemate. This has changed in the last 10 years with the development and increasing availability of new brain-imaging procedures. Technological advances, such as new-generation CAT scans, PET, and MRI, as well as technology for measuring regional cerebral blood flow, have dramatically increased our ability to understand brain functioning. These procedures are making it possible to directly test previous hypotheses, such as the dopamine theory, as well as facilitating the development of new models.

The ability to "see" inside the brain and to measure its functioning more directly promises to unlock the neurological keys to the disorder.

The third factor was the development of new approaches to psychosocial treatment. The psychoanalytic and family models that had dominated the field in the 1960s had proven to be useless in the treatment of schizophrenia. Coupled with the realization that neuroleptics had only limited effectiveness, there was considerable pessimism about the prospect of treating the disorder. This situation began to change in the late 1970s as evidence began to accumulate on the effectivenss of new strategies, including social-skills training and some innovative forms of family therapy. It became apparent that psychosocial treatment was not sufficient by itself, but that it could play a vital role in the treatment process.

The fourth factor was more economic and political than scientific. Until recently, schizophrenia, and mental illness in general, has been something of a pariah in our society. One result of this negative societal reaction has been substantial underfunding for research and treatment. This situation began to change in the late 1970s, due in large part to the development of the National Alliance for the Mentally Ill (NAMI). Families of mentally retarded citizens have been an effective lobbying force for decades and have done much to generate public and private funds and secure legal rights for their handicapped relatives. The development of NAMI has now set the stage for a similar increase in public attention, acceptance, and financial support for the mentally ill. In just a few years, they have become a powerful force on both the national and the local level. Among the most immediate and important effects of their support is a substantial increase in research funds available for work on schizophrenia. In fact, schizophrenia has become one of the primary priority areas for the National Institute of Mental Health, the major source of research dollars in the United States.

The issues discussed above might not all seem to bear directly on the subject of this book: new developments in the treatment of schizophrenia. But there would not be enough new developments if it were not for that combination of circumstances. For the most part, the treatment strategies described in this volume are based on new information about the nature of the disorder, its etiology, its course, and the special aspects of the disorder that determine treatment needs. Neither the treatment procedures themselves nor the more basic research that stimulated them would have eventuated without a resurgence of enthusiasm and resources. Regrettably, this book does not provide the "final" answers about treatment of schizophrenia. It does not provide any miracle cures or promise definitive help for every patient. However, it does provide a state-of-the-art picture. It outlines programs that can be of help to a great many patients, and it also identifies limitations and misuses of some popular current strategies. The procedures

discussed in this book offer the best that is available until the next major breakthrough.

This book is a product of a great many people. I would like to thank my contributors, who were kind enough to share their expertise. As always, Eliot Werner from Plenum Press made it easy to produce a first-class product. Last, but certainly not least, is Florence Levito. Nothing comes out of my office that does not depend upon her at some level.

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A Comprehensive Model for Treatment of Schizophrenia

ALAN S. BELLACK

SCHIZOPHRENIA AND THE COMMUNITY MENTAL HEALTH REVOLUTION

The treatment of schizophrenia in the United States during the twentieth century has been a national embarrassment. The (approximately) 2 million schizophrenics in the United States have received short shrift from the government, mental health professionals, and the public at large. In contrast to citizens with severe physical illnesses or mental retardation, schizophrenics have generally been segregated and either mistreated or ignored. This situation first attracted significant public and governmental attention in the late 1950s and early 1960s as a function of the community mental health (CMH) movement. Referred to as the "third mental health revolution" (Hobbs, 1964), the CMH movement had as one of its primary goals the development of new and more effective treatment programs and the improvement of the quality of life for schizophrenics and for the chronic mentally ill in general. The culmination of CMH efforts was the 1963 Community Mental Health Centers Act, which funded the development of local facilities to provide a range of needed services in the community. To be sure, the CMH movement has led to dramatic changes in the pattern of mental health care and the structure of the mental health system. But, like most revolutions, it has not worked out precisely as planned. To the contrary, it has been

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argued that in many respects the chronic mentally ill are as victimized and ignored by society today as they were before the erstwhile revolution (Gralnick, 1985).

The designated villain in the treatment of schizophrenics before the advent of community care was the state psychiatric hospital system. In the first half of this century state hospitals were transformed from a series of small, therapeutic asylums to a network of large, unmanageable warehouses in which society imprisoned many of its indigent and distasteful members. By the mid-1950s state hospitals provided nearly 50% of all psychiatric care in the country (Sharfstein, 1984). Close to one-half of these institutions housed over 3,000 patients; several had as many as 20,000. Forty-five percent of the residents had been hospitalized for more than 10 years (Yolles, 1977). Given the low priority afforded these hospitals by the public sector, they were almost all overcrowded, underfunded, and understaffed. As a result, they placed greater emphasis on "management" than on "treatment." The result was often mistreatment, and the so-called institutionalization syndrome of withdrawal, apathy, and infantile behavior (Paul & Lentz, 1977).

The role of the state hospital in the overall mental health service delivery system has changed substantially in the last 30 years. Stimulated by the development of phenothiazines and the 1961 report of the President's Joint Commission on Mental Illness and Health, there has been a dramatic shift from primary reliance on long-term hospitalization in state facilities to short stays and community-based treatment. This process has led to the *ad hoc* policy of "deinstitutionalization," in which large numbers of long-term patients have been discharged to community care, and new admissions have been severely restricted. The number of state hospital beds decreased from a high of 559,000 in 1955 to 138,000 in the late 1970s, and the average length of stay dropped from 6 months to 3 weeks. By 1977 state hospitals provided only 9% of all mental health care in the country (Sharfstein, 1984).

Unfortunately, these dramatic changes reflect differences in how and where treatment is provided, rather than changes in the prevalence or effects of chronic mental illness. In fact, the shift in service delivery is better reflected by the term *transinstitutionalization* than by *deinstitutionalization*. The decline in state hospital beds has been paralleled by an equally dramatic increase in psychiatric beds in local facilities, including general hospitals, Veterans Administration Hospitals, community mental health centers, and private psychiatric hospitals (Goldman, Adams, & Taube, 1983). It has been estimated that as many as 750,000 of the 2 million patients in nursing homes are chronic mentally ill; many were transferred directly from state hospitals, while others were denied admission owing to current admission policies (Goldman, 1984). Overall, there has been a 38% increase in

inpatient episodes since 1955, resulting primarily from a tremendous increase in readmissions. Some 70% of all admissions involve patients with a previous history of hospitalization (Sharfstein, 1984). Whereas patients entering a psychiatric hospital in the 1950s could expect a multiyear stay, they now enter through a "revolving door" and can expect to have multiple admissions of several days to several weeks. Hospital charts detailing two or three admissions per year for 5 to 10 years are regrettably common. It has been suggested that schizophrenics alone account for some 500,000 hospital admissions per year (Goldman, 1984). Were current commitment laws more lenient, these figures would be even higher. There has also been a dramatic rise in emergency room visits that do not lead to hospitalization but that nonetheless reflect frequent acute exacerbations.

A major goal of deinstitutionalization and the CMH system was to provide treatment in patients' home communities, rather than in large, geographically isolated institutions. It was hypothesized that living in the community would allow patients to be reintegrated into family and peer groups, thereby facilitating adjustment, as well as restoring civil liberties and allowing patients to enjoy the many privileges and benefits our society has to offer. While these expectations were fulfilled for a minority of patients, the majority of chronic patients have traded the distressing conditions in state hospitals for marginal lives in the community (Klerman, 1977; Lehman, 1983).

Only a small proportion of ex-patients have been effectively reintegrated into the community. Most are ostracized or actively avoid social contacts. The vast majority are chronically unemployed, with little hope or desire to find work. As a result, they are dependent on the social service system for money, food, and shelter, and have poor nutrition and health. Comparatively few ex-patients are capable of living independently; the majority require supervised living arrangements (Goldstrom & Manderscheid, 1981). Of those living on their own, a great many live in run-down apartments or rooming houses in decaying areas of cities. Many others have no residence whatsoever; as many as one-half of the 2 million homeless people in our country are mentally ill (Cordes, 1984). It is also thought that a significant number of mentally ill individuals find shelter in prisons, having been arrested rather than brought to psychiatric facilities by police.

The NIMH-sponsored Community Support Program (Goldstrom & Manderscheid, 1981) has yielded the most comprehensive data to date on the community adjustment of chronic mental patients. The data document that most chronic patients have a poor quality of life even aside from housing. They are easy prey for street criminals, and thus they are frequent crime victims. The majority are unable to perform the tasks of daily living: Fewer than 60% are able independently to perform household chores, prepare

meals, or maintain an adequate diet; fewer than 50% can manage their own money or take medication as prescribed. They suffer from poor physical health and have shortened life expectancies. Chronic patients also fail to take advantage of social and recreational opportunities, lacking the money, skills, and motivation to participate in society. Less than half engage in recreational activities other than watching television or listening to the radio. Many are socially isolated, spending endless hours sleeping, walking the streets, or sitting in community mental health center day rooms.

While the practice of long-term hospitalization employed through the early 1960s created the institutionalization syndrome, the policy of deinstitutionalization has created a new syndrome, that of the aftercare client. It is characterized by revolving door rehospitalization, poor physical health, social isolation, inadequate housing, dependence on others, chronic unemployment, and poverty. In many respects, this new syndrome is just as pernicious and has an equally poor prognosis.

Factors Contributing to Failure

How could such a well-intentioned policy have led to such disappointing results? With 20/20 hindsight, three factors now seem apparent. First, expectations about the effectiveness of the then newly discovered phenothiazines were overly optimistic. It was assumed that medication not only would control psychotic symptoms in the vast majority of patients but would allow them to take advantage of community programs and develop constructive lives. It is now apparent that as many as 50% of schizophrenics may not benefit from antipsychotics (Gardos & Cole, 1976). A significant minority do not have a notable clinical response to the medication, while others will not take it as prescribed. Of those who do respond, 25% to 30% can be expected to relapse within 1 year and 50% within 2 years (Hogarty et al., 1979).

The overall effect of medication is also more circumscribed than had been thought. Antipsychotics have a demonstrable effect on positive symptoms, such as thought disorder, hallucinations, and delusions. However, they often do not appreciably reduce negative symptoms, such as apathy, anergia, and withdrawal (Carpenter, Heinrichs, & Alphs, 1985). Similarly, they do not develop skills of daily living or enhance quality of life (Diamond, 1985). Moreover, 15% to 50% of patients experience significant side effects, including akinesia, akathisia, and tardive dyskinesia (Johnson, 1985). These side effects can be as disruptive and distressing as core psychotic symptoms (Drake & Ehrlich, 1985; Van Putten & May, 1978). It is now apparent that antipsychotic medication is a necessary part of treatment for the majority of patients, but that it is far from a panacea.

The second factor was unrealistic expectations about the effectiveness of

the community mental health system. It was assumed that CMH centers would be able to provide the diversity of treatment and support functions needed to help patients maintain themselves in the community. Unfortunately, the broad range of needed services was not anticipated, and the centers were never given adequate funding to accomplish this goal. For all their failures, the state hospitals were integrated institutions that provided shelter, food, clothing, and medical care as well as psychiatric treatment. The major needs confronting chronic psychiatric patients in the community include housing, economic support, and medical care, none of which CMH centers are able to provide (Talbott, 1981; Tessler & Manderscheid, 1982).

Yet another problem is that the limited resources available to CMH centers have been disproportionately utilized by the "worried well," rather than by schizophrenics and other chronic patients. One reason state hospitals now provide only 9% of overall psychiatric care is that the CMH program has attracted large numbers of less disturbed individuals who did not previously seek treatment because of the cost or lack of availability (Goldman et al., 1983). State hospitals still account for 64% of all inpatient care.

In a related vein, many CMH staff members have not been adequately trained to deal with schizophrenics, and the services provided by CMH centers often are not suited to the needs of chronic psychiatric patients. There continues to be an overemphasis on group and individual psychotherapy, despite evidence that these interventions are not particularly effective for these patients (Mosher & Keith, 1980). The primary therapeutic modality at most CMH centers is day treatment, yet there are few data to document the efficacy of such treatment or to suggest appropriate content or intensity (Linn, 1988). Moreover, because of severe underfunding, case loads at most CMH centers are so high that staff members cannot provide the individual support and continuity that schizophrenics require. In many cases, no one knows whether a patient is attending treatment programs or receiving medication, and no one is available to do anything about it even if the patient's absence is recognized. Too often, day treatment is a euphemism for day camp, where the primary therapeutic goal seems to be securing *per diem* reimbursement from the county or state.

The third factor leading to the current situation was an unrealistic model of illness. Stimulated by the writings of Freud, the mental health community has subscribed to an infectious disease model of illness, in which treatment is viewed as a short-term process for dealing with a circumscribed, temporary disturbance. This model is not suited to a disease such as schizophrenia, which is characteristically a multiply handicapping, lifelong disorder. Only a minority of patients will have a full recovery with a return to premorbid levels of functioning (Strauss & Carpenter, 1981). The majority

will have residual handicaps even when the primary symptoms are under control. As many as one-third of schizophrenics will have only a minimal recovery and will remain substantially dysfunctional for their entire lives. Most will be dependent on the social service system and mental health establishment for some services throughout their lives. Periodic relapse is a natural part of the illness, rather than a sign of treatment failure.

In some respects, the mental health system has been frustrated by the fact that schizophrenics do not get better and "go away." Yet the "up and out" philosophy of treatment resulting from an infectious disease model not only is ineffective for schizophrenics but may actually increase stress and precipitate relapse (Schooler & Spohn, 1982). Schizophrenia is better represented by a chronic illness model, akin to that employed for individuals suffering from renal disease, juvenile diabetes, and Down syndrome. Treatment for these disorders is multidimensional, mutidisciplinary, and long-term. The goal is management of symptoms, teaching living and coping skills, and enhancing patients' quality of life, rather than "curing" the illness. We must adopt a similar approach for the treatment of schizophrenia if we are to progress beyond the current, unsatisfactory state of affairs.

A COMPREHENSIVE MODEL OF CARE

The chronic illness model implies a dramatically different conception of the needs of the schizophrenic patient. We can no longer think of "treatment" in the traditional manner of the patient coming to the clinic for a brief visit to receive a single intervention for a limited period of time. Treatment *per se* is only one element of a multicomponent system of services, each of which serves an essential role in the overall care or management of the patient (Anthony & Nemec, 1984; Test, 1984). Such a system is presented in Table 1. It is representative of the range and types of services required, but it is not all-inconclusive. We believe that the specific elements subsumed under each category of service are essential, but other elements may also prove to be needed. Many of the elements of the program are discussed in detail in the subsequent chapters of this book. In the following sections we will highlight some of the most important elements.

Treatment

A Model for Understanding Schizophrenia

The elements of our treatment program have been selected on the basis of Zubin and Spring's (1977) stress-vulnerability model of schizophrenia.