Chapter 23

Training life skills

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23.1 HISTORICAL TRENDS IN THE TREATMENT OF SCHIZOPHRENIA

Our conceptualizations of schizophrenia and other major psychiatric disorders have gone through revolutionary changes in the past 40 years. Prior to the advent of anti-psychotic medications in the mid-1950s, patients suffering with schizophrenia were thought to be caught in an unremitting downward spiral, with little hope for recovery or rehabilitation (Kraepelin, 1919, 1921). In light of this poor prognosis, it is not surprising that treatment efforts typically involved trying to keep patients comfortable, calm, and occupied while they were sequestered away from the stresses and strains of everyday living situations. Persons suffering from schizophrenia frequently resided in asylums or institutions for many years, or lived sheltered lives at a relative’s or friend’s home.

The discovery that antipsychotic medications could often reduce or eliminate symptoms such as hallucinations, delusions and formal thought disorder brought a new spirit of hope to mental health professionals working with patients in schizophrenia. This enthusiasm for new treatment innovations and more active interventions for patients with severe mental illness culminated with legislative acts both in the USA and Europe to decentralize care for the mentally ill and to base it in the community. Rather than being considered intractable, schizophrenia was re-conceptualized as a serious, but temporary, disorder which could be controlled and even eradicated by proper care and medication. Massive efforts were made to discharge patients from hospitals and return them to their communities, where they would presumably thrive (Bachrach, 1983).

Thirty years later, the vigour with which mental health professionals embraced the idea that the availability of psychotropic medications would permit most patients to be reintegrated into society seems almost embarrassingly naive. As we now know, while the benefits of neuroleptic medication are very real, they are also limited. Three factors contribute to this less optimistic appraisal of the positive aspects of anti-psychotic agents. First, these medications offer little of no benefit for 20–30% of all patients with schizophrenia (Gardos and Cole, 1976; Chapter 19). Second, even among patients who do obtain relief from their psychotic symptoms with the medications, continued compliance is a problem. Reasons for this non-compliance include denial of the illness and dislike of the particularly noxious side effects resulting from neuroleptic medications (Van Putten, 1974; Chapter 20). Finally, even when these medications are effective in reducing hallucinations and the other positive symptoms
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of schizophrenia, they frequently do little to reduce negative symptoms such as anhedonia, apathy, social isolation, and alogia (Kane and Meyerhoff, 1989). In addition, neuroleptic side effects such as sedation and akinesia may actually make these negative symptoms worse.

The failure of neuroleptic medications to ‘cure’ schizophrenia is beginning to have a profound influence on our newer models of the disorder. As Bellack and Mueser note, the conceptualization of schizophrenia as a circumscribed, short-lived disturbance in functioning which is highly responsive to pharmacological intervention, which was prevalent in the 1960s and 1970s, has not been confirmed by clinical experience (Bellack and Mueser, 1986). Certainly, up to 25% of patients with schizophrenia do have extended periods of high social and vocational functioning interrupted only briefly and very infrequently by psychotic episodes (Stephens, 1978). These patients typically have had high levels of premorbid functioning, and are able to return to these levels; some require anti-psychotic medications, while others do not.

Most patients with schizophrenia have a less benign illness course. A substantial number (approximately 25%) obtain little benefit from anti-psychotic agents and require ongoing supervision in a protected setting such as a psychiatric hospital or locked residential facility. The remaining 50% typically do not require extended hospitalizations, but their overall level of functioning between psychotic episodes is impaired, and they may need supervision and case-management support, in addition to psychiatric intervention. For them, schizophrenia is a chronic incurable illness which is exacerbated by stress, analogous to juvenile diabetes or kidney disease. They require training in coping with the disorder by managing symptoms effectively and instruction in ways to live as full and independent a life as possible.

It is important to note, however, that training and support in successful living is to be distinguished from intensive psychotherapy or excessively demanding psychosocial programmes. Schizophrenia seriously impairs the patient’s ability to tolerate stress, whether it is from intensive introspection or from participation in an over-stimulating, confrontative milieu (Drake and Sederer, 1986). Given their own state of hyperarousal (Dawson and Nuechterlein, 1984), most patients with schizophrenia benefit most from structured programmes with clear, explicit expectations of attainable performance levels. These comprehensible, reasonable expectations help reduce environmental stimulation to manageable levels. Confusing, overstimulating therapy programmes are generally to be avoided for these patients, as they can have toxic effects on participants (Mueser and Berenbaum, 1990).

23.2 THE IMPORTANCE OF LIFE SKILLS IN TEACHING COPING WITH SCHIZOPHRENIA

Living a full and independent life raises many challenges for the person with schizophrenia. Analogous to those for physical illness, rehabilitation approaches to psychiatric illness conceptualize the disorder as proceeding in four stages: (1) pathology; (2) impairment; (3) disability; and (4) handicap (Anthony and Liberman, 1986). The stress-vulnerability model of mental illness embraces these concepts in positing that biological abnormalities, or ‘pathologies’ interact with an increased vulnerability to stress. This interaction results in diverse constellations of symptom ‘impairments’, associated with social and vocational ‘disabilities’ and ‘handicaps’ in role functioning. The goal of psychiatric rehabilitation is to increase the mentally ill individual’s repertoire of social and instrumental skills in order to improve his or her ability to cope with a stressful world.

These coping skills, together with social support and psychotropic medications protect, or serve as a buffer in guarding against relapse.