Psychiatric Rehabilitation of Schizophrenia: Editor’s Introduction

by Robert Paul Liberman

Abstract

Well-planned and conceptualized rehabilitation of psychiatric patients who demonstrate persisting impairments, disabilities, and handicaps begins with assessment of symptoms and psychosocial functioning. Rehabilitation interventions—aimed at building skills and providing supportive and prosthetic environments—are linked to initial and ongoing assessment. The refractoriness of large numbers of psychiatric patients to conventional and customary forms of therapy will fuel the development of psychiatric rehabilitation that is efficacious and empirically based.

With the growing appreciation of the chronicity of many major mental disorders and their refractoriness to psychotherapeutic and pharmacotherapeutic treatments, the field of psychiatric rehabilitation has come of age. For patients with persisting and disabling psychopathology, rehabilitation offers training in social and vocational skills, as well as prosthetic environments that are congruent with maximal feasible functioning and adaptation. As research using epidemiological, longitudinal, and reliable diagnostic and assessment instruments has flourished, it has become increasingly clear that rehabilitation is indicated for significant numbers of psychiatric patients.

Treatment outcome and naturalistic studies have documented that many individuals with affective, anxiety, and somatoform disorders have now joined ranks of persons with schizophrenia in suffering from persisting psychopathology and lingering social and occupational disabilities. For example, a substantial minority of depressed patients have been found to suffer from “double depression” where acute episodes of depression are superimposed upon unrelenting dysthymia. Approximately 25 percent of patients with major affective disorders do not respond to the intensive inpatient and outpatient treatments currently available; a like percentage of agoraphobic and obsessive-compulsive patients do not respond adequately to drugs or short-term behavior therapy.

But it is schizophrenia that poses the greatest challenge to the rehabilitation practitioner. The chronicity of this disorder is well known; however, the recidivism and failure of existing methods for promoting community tenure are gaining more attention and concern. In one county using a case register, persons with schizophrenia had two psychiatric hospitalizations per year, far greater than any other mental disorder save alcoholism (Kramer 1977). Increasing since 1979 have been the number of patients with long, continuous stays in mental hospitals (Craig et al. 1984). Even with reasonable state-of-the-art treatment, approximately 40 percent of patients with schizophrenia will relapse within 1 year and 75 percent within 5 years of discharge from inpatient care (Talbott 1981; Hogarty 1984).

A new subgroup refractory to customary treatments—young adult chronic patients—has emerged from the baby boom after World War II and reduction in number of long-term hospital beds. With the advent of civil libertarian codes regulating commitments to psychiatric hospitals, hundreds of thousands of young chronic patients under age 35 are served intermittently and inade-

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quately by community-based agencies. Often entangled with the law and substance abuse, these individuals desperately need longer-term strategies of rehabilitation that address their widespread deficits in social and living skills, and their atrophied social networks (Pepper 1985).

The revolving-door phenomenon of hospital admission-brief treatment-discharge-relapse-readmission points to the insufficiency of current methods of symptomatic treatment and aftercare for the chronically mentally ill. Moreover, the enduring incapacity, burden, and symptoms of chronic illness demoralize patients, relatives, and professionals—generating therapeutic nihilism and fruitless quests for causes and cures that are decades away. While we invest in research that may bring the "magic bullet" closer to reality, there are practical and proven methods of rehabilitation that can give optimism and hope to professionals and consumers alike.

Psychiatric rehabilitation, originally inspired by the enormous successes of physical rehabilitation, has now acquired its own conceptual base from the "vulnerability-stress-coping-competence" model of mental disorder. Advances in conceptualization are described in the articles by Anthony and Liberman and Spaulding et al. in the first two articles of this special issue. Any new applied science requires a data base, and reliable and valid methods of symptom and functional assessment—reviewed by Lukoff et al. and Wallace—provide just that for the field of rehabilitation.

The failures of deinstitutionalization and early efforts at community care of the chronically mentally ill have underlined the fact that changing the locus of care without innovations in the modus operandi yields little of significance in long-term outcomes. But innovative techniques for rehabilitating the severely and chronically mentally ill are now available and have been empirically validated as shown in the brace of articles in this special issue by Liberman et al., Glynn and Mueser, and Strachan. Other methods of rehabilitation, not given major emphasis in this special issue, have been supported with empirical evidence of efficacy and offer the practitioner a spectrum of service models (Beard, Malamud, and Rossman 1978; Bachrach 1980; Bond et al. 1984; Stein and Test 1985). The final articles in this issue indicate the need and strategies for disseminating rehabilitation principles and techniques broadly to professionals and consumers. It would be a tragedy if the promising methods of rehabilitation now available in a few locales and centers are delayed in their dissemination and utilization for the next generation of teachers and students, professionals and patients. This special issue is a small step toward diffusing psychiatric rehabilitation principles throughout the mental health professions, agencies, and institutions.

References


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