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Snips from the journals

Psychosocial interventions for relapse prevention in schizophrenia: New evidence

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Introduction

Schizophrenia is usually characterized by relapses, alternating with periods of full or partial remission, and generally runs a chronic course (1). Antipsychotic medications are effective in reducing relapse rates in some patients, however, nearly 40% of patients are reported to relapse within one year after hospital discharge, even if they are receiving maintenance medication (2). Combining maintenance antipsychotic medication with psychosocial approaches has been found to be more effective than pharmacotherapy alone in delaying or preventing relapse and/or reducing the number of days stayed in hospitals (3).

Relapse in schizophrenia is both distressing and costly, and can devastate the lives of not only patients, but also their families (4). The debilitating symptoms of schizophrenia also require specialist healthcare interventions and targeted treatment, with high costs (5).

Psychoeducation and related programmes have been shown to reduce medication non-adherence, detect prodromal and early symptoms of relapse and reduce the rate of hospitalization (6). We present updates regarding current psycho-social strategies for relapse prevention in schizophrenia.

Psychosocial interventions for very early and early-onset schizophrenia (7).

While most patients with schizophrenia develop the condition between the ages of 20-24 years, approximately one third of patients develop this condition before the age of 18 years (8). Schizophrenia developing before the age of 18 has been subdivided in to two categories, Early-onset schizophrenia (EOS) and very early-onset schizophrenia (VEOS).

EOS has an onset between 13 and 17 years of age, whereas VEOS has an onset before the age of 13 years. Despite the above two conditions being less prevalent than schizophrenia occurring after the age of 20 years, they are known to be more severe and disabling than schizophrenia occurring after the age of 20 years (9).

Armado et al., reviewed the current knowledge and evidence regarding the efficacy of psychosocial interventions in VEOS/EOS. They had focused on research which looked into four interventions, namely family intervention; psychoeducation; cognitive behavioral therapy (CBT); and cognitive remediation, and report that evidence was strongest for cognitive remediation, rather than psychoeducation, family intervention, and CBT.

In addition, they also report that, supportive counseling appeared to be of greater benefit than CBT or TAU in the younger group, whereas CBT benefited the older group over the other two treatments. In accordance with this evidence, more attention should be paid to motivate young patients to engage in therapy, particularly CBT. The authors conclude that once patients are engaged in therapy, CBT as well as other more structured interventions may be a helpful approach in recovering from schizophrenia.

Family interventions are effective in preventing relapse in first episode psychosis (10)

Previous studies have shown that family interventions are effective in reducing relapses, improving social functioning, mitigating the severity of the psychotic symptoms, and adjusting the level of expressed emotions of family members of patients with psychosis (11).

Gomez -Castellvi in their systematic review and a meta-analysis looked at the effectiveness of family interventions to prevent relapse related outcomes over 24 months, in patients who are within five years of onset of their psychotic illness. Relapse after the family interventions was considered as the primary outcome of this study, and the duration of hospitalization, severity of psychotic symptoms, and functionality were secondary outcomes of interest.

They compared studies that received family interventions with studies that received treatment as usual (TAU) or TAU with other active psychosocial interventions. The

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minimum duration of family intervention was taken as 6 months. They chose 11 RCTs that met the inclusion criterias for the systematic review and meta-analysis.

Family interventions used in the above studies were of the following kinds;

- Multicomponent integrated treatment such as Cognitive Behavioural Therapy (CBT) and Relapse Prevention Therapy (RPT).
- Counselling based repeated sessions of psychoeducation, mutual support, and problem solving in caring for a family member individually as well as in group settings with success (12).
- Manuals which included psychoeducation, communication skills and problem solving (FIp) (13).
- Group based mutual support centered around emotional expression, education, coping skills and problem solving.
- Assertive community treatment and social skills training by the multidisciplinary teams, motivational therapy, and other previously used components such as mutual support and psychoeducation delivered over a period of time.

This meta-analysis reported significant reduction in relapse in the FIp group when compared to TAU or TAU with other psychosocial interventions groups. They also reported a significant mean reduction of days of hospitalization in the FIp group when compared to TAU or TAU with other psychosocial interventions groups. Patients with FEP subjected to FIp showed significant reduction of psychotic symptoms, compared to the group that received TAU.

The authors conclude that the overall 58% reduction of risk of relapse during the follow up period, along with improvement of several other secondary outcomes offers new and useful insights into the effectiveness of FIp in the early years of psychotic illness. The meta-analysis did not find that CBT was helpful in preventing relapse in early psychosis although it has been useful in reducing psychotic symptoms among this group.

The authors hypothesize that FIp bring about the positive outcomes by helping the relatives to understand psychosis and its impact on personal, social and interpersonal functioning, identifying exacerbation better by acquiring problem solving techniques, and understanding the importance of treatment adherence. This meta-analysis also highlights importance of the initial years since the diagnosis of psychotic disorder, in determining the prognosis – as this period is vulnerable to high rate of relapses, critical psychosocial reactions by family, and deterioration from premorbid functional level in the society. Relapse during this period is known to increase chronicity of the illness and suicide risk (14).

Adolescents and young adults who experience first episode psychosis usually live at home, which makes family-based interventions ideal and better prospects for relapse prevention and satisfactory prognosis. Camacho-Gomez and Castellvi recommend the need to explore how FIp can be used to improve long term outcome, as current results only demonstrate effectiveness of FIp in the short to medium term.

These findings are reflected by Bighelli et al., who recently conducted a systematic review and network meta-analysis to evaluate the efficacy, acceptability, and tolerability of psychosocial and psychological interventions in relapse prevention in schizophrenia, and their main findings were as follows (15):

- Family interventions, family psycho education, cognitive behavioral therapy, patient psycho education, integrated interventions, and relapse prevention programmes were superior to standard care alone in preventing relapses at 12 months.
- Family interventions and family psychoeducation were not more efficacious than treatment as usual at 6 months, but only after 1 year. This result is consistent with the Cochrane review by Pharoah and colleagues (16).
- Patient psychoeducation was more effective than was treatment as usual at 12 months, but not at 6 months or more than 12 months. In the Cochrane review by Xia and colleagues, patient psychoeducation was efficacious in preventing relapse after 1 year (17).
- Assertive community treatment was efficacious only at 6 months and cognitive behavioral therapy was efficacious only at 1 year, not in the long term.

Bighelie et al., finally recommended that policy makers and clinicians consider giving priority to family interventions, family psychoeducation, and cognitive behavioural therapy, when allocating resources and planning maintenance treatment for patients with chronic schizophrenia.

The role of cognitive remediation in preventing relapses (18)

This study is based on the findings that cognition is related to treatment adherence and therapeutic alliance, which is ultimately related to relapse rates (19). Integrated neurocognitive therapy [INT] focuses on the therapeutic relationship, group interactions, and other facets of cognition and has previously shown a significant reduction of severe negative symptoms (20).

The authors of this study compared INT against TAU which included a broad array of therapies such as medication, art theory and counseling. They found that only 13.3% of those in the INT group relapsed at the end of the intervention period of 15 weeks, compared to 50% in the TAU group. The INT group also showed benefits with regards to passive social withdrawal, delusions, and unusual thought content, general symptoms and total scores on the Positive And Negative Symptoms Scale (PANSS), and in general functioning as assessed by the Global Assessment of Functioning (GAF) (21, 22).

Based on findings from the correlation analysis, they concluded that reduction of relapse rates is associated with the reduction of negative symptoms, improved functioning and composite cognitive score. Regression analysis indicated that negative symptoms had the greatest influence on relapse. These findings are consistent with a meta-analysis by Bowtell et al., which report negative symptoms are a predictor of relapse in early course of schizophrenia (23).

The authors of the article conclude by highlighting that there is a good evidence base to support that cognitive remediation improves proximal outcomes; but integrated cognitive remediation approaches have been shown to be more successful in improving functional outcome, remission of negative symptoms and better generalizability and transfer effects. Nonspecific therapy factors such as group setting may have had an additional effect.

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