REMISSION AND RECOVERY IN SCHIZOPHRENIA – AN ACHIEVABLE GOAL?

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Every Physician aims for recovery in all medical conditions. In chronic disorders, however, recovery and cure is not an easily achievable goal. In these conditions remission provides a platform for achieving recovery. In Psychiatry, we have not been very familiar with the concept of remission and recovery. In chronic disorders like Schizophrenia, perhaps we have been too contented with just achieving symptom stabilisation. This is compounded by the lack of an operational definition of remission in clinical practice.

It would be instrumental to examine what remission means in medical conditions. In physical disorders such as breast cancer the remission means that tests and imaging do not show evidence of the cancer, and that a doctor cannot see signs of the cancer during a clinical examination. It does not mean the same thing as cure, because even one cancer cell in the body means recurrence is possible. In chronic disorders like Rheumatoid arthritis remission is defined differently. Remission in rheumatoid arthritis is defined as the absence of fatigue, as well as negligible morning stiffness, and a lack of joint pain, tenderness, and soft tissue swelling, accompanied by a normal ESR (erythrocyte sedimentation rate)[1]. It is noteworthy that in this definition all criteria (except ESR) are rather subjective.

Based on these concepts and earlier work on remission in other psychiatric disorders, the Remission in Schizophrenia Working Group (RSWG) proposed a definition of remission for this disorder. According to RSWG, the remission in Schizophrenia is defined using an absolute threshold of severity for the core symptoms of the illness. The criteria define remission as at most a mild symptom intensity level, and not influencing an individual's behaviour. With regard to severity, the working group consensus defined a score of mild or less (Positive and Negative Syndrome Scale item scores of <3; BPRS item scores of <3, using the 1–7 range for each item; SAPS and SANS item scores of <2) simultaneously on all items as representative of an impairment level consistent with symptomatic remission of illness. In addition a period of 6 months is required as a minimum time threshold during which the aforementioned symptom severity must be maintained to achieve remission [2].

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Recovery is a much more complex concept. The operational criteria for recovery in Schizophrenia have been proposed but consensus does not exist. For patients and carers, recovery may be different from what Psychiatrists think. For patients, recovery means stopping drugs and the ability to achieve a steady job[3]. Lieberman et al[4], define recovery as full symptom remission with full or part-time involvement in work or school; independent living without supervision by family or surrogate caregivers; not fully dependent on financial support from disability insurance; and having friends with whom activities are shared on a regular basis.

The remission and recovery are achievable goals in Schizophrenia. Studies indicate that between 22% to 62% of patients can achieve remission[5]. The rates vary generally due to varying lengths of follow-up. The rates of recovery are less well known in part because a consensus definition of recovery is lacking. Bobes et al[6] selected a group of 452 patients suffering from Schizophrenia and meeting RSWG criteria for remission. Recovery was defined as RSWG symptomatic remission plus good functioning as assessed by a Global Assessment of Functioning score of greater than 80. They found that at baseline 23% met the criteria for recovery. After one year 90% had maintained remission and the proportion of those who achieved recovery increased to 27%.

How we can achieve remission and recovery in routine clinical practice? The foremost requirement is that we change our pessimistic outlook about Schizophrenia and keep remission and recovery as goals of treatment from the very beginning of treatment. The treatment goals have generally been modest, with clinicians settling for outcomes such as 'control of behaviour'[7], 'symptom control'[8] or 'stability'[2]. Our expectations of maintaining just symptomatic stability lowers the expectations and may be a major hindrance to recovery. Involving the patients and families in setting targets of remission and recovery as soon as symptomatic improvement is achieved, is also essential.

First episode psychosis is effectively our last chance to achieve remission and recovery in significant proportion of cases. The progress of treatment should be closely monitored, preferably using validated measures such as Brief Psychiatric Rating Scale or Global Assessment of Functioning in routine clinical practice. We rarely monitor the progress in treatment using objective measures which is a common practice in other filed of Medicine. Consequently, it is not possible to use

appropriate treatments effectively and promptly. Using evidence based interventions which can augment each other at initial stage of illness effectively can help to achieve the remission on the way to recovery.

A common mistake is to use one ineffective treatment after another or combination of antipsychotics after patients have failed to respond to first drug. Clozapine, the most effective treatment for the patients who fail to respond to the treatment is grossly underutilized. Studies based on prescription patterns in routine practice almost universally show a much lower proportion of individuals with schizophrenia are prescribed clozapine, even after taking into account potential barriers such as inadequate service provision. The rates of prescription are between 1% and 1.8 %. The mean duration between year of first contact with a clinician and starting Clozapine varies between 5 years and 9.7 years[9]. In developing countries this even bigger problem

Physicians in other branches of Medicine rarely use one intervention to achieve recovery. In most chronic and serious disorders multimodal treatments are rule rather than exception. Oncologists rely on both on chemotherapy and radiotherapy while rheumatologists routinely use drugs and physiotherapy to augment the effects of treatment. The evidence based interventions such as family therapy and cognitive behavioural therapy need to be used *routinely* in combination with drug treatment early in the course of illness before the disease becomes chronic and unresponsive to the established treatments. Even brief family interventions can augment the effects of treatment. STOP (Supervised Treatment in Outpatients for Schizophrenia), a brief family intervention that was evaluated in a developing country settings, was significantly more effective in improving symptoms and functioning compared to the treatment as usual[10].

A major impediment to recovery in Schizophrenia is the relapse of illness. Each relapse demoralises the patients and carers, and increases the resistance to treatment further. Two modifiable factors which may help to prevent relapse are; maintaining adherence with medication and preventing substance abuse. Cannabis abuse and dependence, in particular is likely to precipitate relapses and impede remission. Therefore, interventions to prevent and maintain abstinence from cannabis abuse must be used optimally during the course of illness.

A break in adherence to medication of as little as 1-10 days can increase the relapse risk almost two fold[11]. A systematic review of interventions to improve medication adherence in schizophrenia showed that relatively brief interventions (both in terms of duration and frequency) which targeted the behaviours related to medication adherence were more effective than longer interventions[12]. This should not be surprising for a clinician. After all, one of the most powerful agents in achieving and maintaining recovery is the physician. Our patients suffering from the most serious and disabling disorder of the mind require us more than anything.

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