

**BEYOND MEDICATION, TOWARD REHABILITATION: THE
ROLE OF THE PSYCHIATRIST**

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I have to admit that when I started these schizophrenia conferences at Columbia in 1986, I envisioned that by now, twenty years later, we would have developed medications that, if not able to cure schizophrenia, would at least be far superior to the ones we had been using for the prior 40 years. And, indeed, during these twenty years we have seen the introduction of six new medications that we call second generation anti-psychotics. Nevertheless, I believe it is fair to say that the new medications, while better tolerated by patients, and representing an improvement over what we had, have not led to the dramatic breakthrough that all of us were hoping for. As you know, a recent study, the CATIE study, headed by the new chair of our department of psychiatry, Dr. Jeffrey Lieberman, seems to indicate that the new drugs are really not vastly superior to the older drugs.

In 1986, there were many reasons to be hopeful about achieving that dramatic breakthrough. Genetic studies were picking up pace with the promise that we could discover some of the basic faults in the genes of those suffering from schizophrenia. New and improved imaging techniques were burgeoning, so that we were now able to examine the living brain and detect abnormalities in structure and function. We were just four years away from what was to be called “The Decade of the Brain,” which was an acknowledgement that an enormous scientific effort was underway to elucidate the underlying causes of mental illness. The first of the new second generation anti-psychotics, clozapine, was coming into use with the promise of others to come. And

perhaps most importantly, there was a very rapid increase in the number of young psychiatrists, psychologists, neurobiologists and other neuroscientists devoting themselves to the study of schizophrenia.

Indeed, much of what we were hoping for has actually taken place. We know so much more about schizophrenia now than we did twenty years ago and the new drugs have certainly improved the lives of many patients. Nevertheless, we must acknowledge that a majority of people who are taking these new medications still struggle with the devastating symptoms of this illness, unable to lead the kind of lives that we had hoped they would be able to lead.

Interestingly enough, however, very significant improvements have come from quite a different direction. I am referring to the process of rehabilitation which improves the lives of our patients not through the use of medication, although that is still primary, but by helping them return to school, find employment, find housing that offers them some independence, and helping them re-engage in social relationships. In some circles this has been called the “Recovery and Wellness” model, promoting the idea that we must endeavor to help people to live a fulfilling and productive life despite having a mental disability.

So, I would like to talk to you today about what we must strive to accomplish in treating people with schizophrenia *after* the medications have been in place and done their job of decreasing the symptoms and stabilizing the illness. I believe that there still is a major role for the psychiatrist or other mental health professional in what is essentially a process of rehabilitation: a rehabilitation that will restore to people with schizophrenia some of what they have lost so that they can live their lives with dignity, fulfillment and

perhaps even satisfaction and happiness. And certainly, that they once again can feel that there is meaning to their lives.

By focusing today on the role of rehabilitation, by no means do I mean to convey to you that we have exhausted our attempts to find methods to prevent or to cure schizophrenia. The search for the underlying causes of the illness and the brain abnormalities that accompany them is stronger than ever. The development of even better medications is still a top priority. In that regard there has been a great deal of research devoted to finding new medications that target the serious cognitive impairments that we now know are such an important contributor to poor functioning. But for today, I will be stressing the need for rehabilitation “beyond medication” and the role of the treating person in fostering the highest level of functioning that is possible.

Before doing so, however, I must acknowledge that for too many patients with schizophrenia, we never even reach the “beyond medication” stage. That is because many patients, perhaps as many as 50%, refuse to take medication and continue to deny that they are sick. Even for those who are initially willing to take the new medications, there is a high discontinuation rate as shown by the CATIE study that I referred to. As I have mentioned many times at past conferences, “denial of illness” is often a neurological symptom of the illness itself and not merely stubbornness or a wish to deny a painful reality although those reasons may be present as well. But whatever its cause, many families have to endure years of serious illness in their loved ones without seeing the benefits of the medications that are available.

I am particularly conscious of this fact because, over the years, I have been consulted by many parents and siblings who have asked me quite desperately what can be

done in such situations. I am reminded of the parents who told me that their daughter was wandering around the country from city to city, refusing to get any help whatsoever. Another young man who had improved a great deal on medications always stopped taking them when he felt better, only to re-experience a worsening of his symptoms. I remember a father whose son had, for about 15 years, refused to see a psychiatrist and lived upstairs in the house never venturing out and not talking to anyone but his father. In that instance, the father came to me not only because he heard that new medications were available but in the hopes that I could do a psychiatric evaluation so that the son would be able to get disability insurance. Since the son refused to come to my office, I went to their house but neither the father nor I was able to persuade him to talk to me. Fortunately, I was able to put together enough information so that I could make a good case for the fact that the son was indeed disabled. Despite that successful intervention, the son, to the best of my knowledge, never did consent to taking medication.

In some situations like this, I discuss with the family whether there are any symptoms that their loved one complains of, for instance, poor sleep or inability to do a once loved hobby. Perhaps without confronting a patient with the statement that he is sick and needs help one can hold out the possibility that there is a medication that might relieve the specific symptom that is disturbing to the patient. For example, one young man loved to browse in bookstores but became very fearful of entering them. He was willing to take an anti-psychotic when told that it could relieve his anxiety and enable him to visit bookstores once more. Sometimes, one can use some leverage, such as providing some financial support in return for the patient acquiescing to see a

psychiatrist. There remains a painful reality, however, that sometimes nothing can be done to induce a person with this illness to take medication.

Although I will mainly be addressing the role of the psychiatrist in ensuring that our patients can once again lead productive and satisfying lives, I realize that, of course, other mental health professionals like psychologists, social workers and nurse practitioners can also play such a role. The requirement for them, just as it is for the psychiatrist, is a familiarity with the illness, the devastating symptoms that accompany it, the use of medications and an awareness of their side effects, and a willingness to include the family in the treatment process. Taking on this role also involves a commitment to be in charge, to assume responsibility for much of the professional care of the patient and to co-ordinate the various interventions that may involve the assistance of other people. For consumers in the public sector there often will be a team of people involved, each of whom has some expertise in a particular area of rehabilitation.

Above all, taking on this role of comprehensive treatment of a person with serious mental illness requires a commitment to remain involved over a long period of time plus the establishment of a long-term trusting relationship in which the patient feels he has an ally and a friend to whom he can always turn in times of need. I have spoken before about a man I have seen for about 18 years now. I started out seeing him twice a week after he was discharged from a hospital where he had been admitted following a suicide attempt. Although I was seeing him twice weekly he called me every day for reassurance about his symptoms. Over the years, he has done very well and we have gradually reduced the frequency of visits to three or four times a year. Yet he still calls me about twice weekly and sometimes more when things are not going so well for him. The phone

calls are the same as they were at the beginning when he used to call me every day. The messages go something like this: “Hey, it’s John. I’m not doing so well. I am worried that I am going to be fired from work. I’m at home. Give me a call.” I always call back within an hour or two. Almost as soon as I say “Hi, it’s Dr. Willick,” he says “These are some of my crazy thoughts, right?” I can hardly open my mouth to say “Yes,” when he says, “OK, Thanks a lot. Bye.” Of course, sometimes the call lasts a little longer, but the point is that it is primarily the contact he needs, contact with someone he knows he can trust and rely on, someone who has not let him down over the course of 18 years.

Therefore, the role of the psychiatrist in the process of rehabilitation has to take place in the context of the ongoing, long-term trusting relationship that must exist between the patient and the psychiatrist. It is why I object so much to the statement made by a psychiatrist to the father of a young man with schizophrenia to the effect that “psychotherapy is of no value in the treatment of that illness.” Such a statement stems from a misunderstanding of what psychotherapy for this group of patients really means. It no longer necessarily means an exploration of the psychological causes of the patient’s illness and symptoms, although talking about the issues that distress the patient is still important. A person with schizophrenia has conflicts like any other person and sorting these out can be very helpful. However there are, indeed, special issues that have to be addressed in psychotherapy, issues that are part of the illness itself. In order to help with the four areas of rehabilitation that I have mentioned, namely, housing, education, employment and social relationships, the psychiatrist has to shape the psychotherapy to deal with these issues.

There can be no rehabilitation without first achieving some semblance of stability of functioning. The term psychoeducation is often used to describe some aspects of the nature of the therapeutic contact between a therapist and a person suffering from schizophrenia. The psychiatrist must educate the patient as well as the family, when that is at all possible, about the importance of continuing to take medication in order to prevent relapse. Education includes making the patient aware of the side effects induced by these medications and teaching him how to distinguish these side effects from some of the symptoms of these disorders. The patient needs to learn what the particular stressors are for him or her, stressors that will be different for each individual and can exacerbate the symptoms and therefore impede further improvement. Both patient and therapist must be acutely aware that any new challenge or change can bring about a worsening of symptoms. In essence then, the patient has to gradually learn how to cope with symptoms that may persist.

If attempts at rehabilitation are to be successful a therapist must communicate to the patient a sense of hope about the future. I would add here that the same sense of hope should be conveyed to the family. I recently received a call from a mother who told me that both she and her daughter, diagnosed with schizo-affective disorder, were told that she had to live with her paranoid ideas because the medications she had taken had proven to be unsuccessful in alleviating those symptoms. Yet the truth is that there remained a number of appropriate medications that had not been tried. The staff was inadvertently imparting a sense of hopelessness that was unwarranted, especially for a young person. Although the late teen years and the twenties are often quite devastating, patients can

frequently improve as they age. Of course, it is also important not to give patients and their families a false sense of hope about expectations that may not be realized.

A person with severe and persistent mental illness cannot achieve stability while he or she is abusing street drugs or alcohol. It has been estimated that up to 50 % use substances that both interfere with the beneficial effects of medication and also impair their mental state. The psychiatrist must use all his or her powers of persuasion and build upon the positive nature of the relationship with the patient in order to make a convincing case that things will only get worse if the use of street drugs continues.

Anyone treating a person with schizophrenia has to also address the issue of the physical health of the patient. People with schizophrenia are at a higher risk for developing cardiovascular disease, diabetes, and cancer. They also smoke cigarettes much more than do those without the illness. To make matters worse, some of the new second generation anti-psychotics seem to cause a higher incidence of weight gain, hyperlipidemia, i.e., higher blood levels of cholesterol and triglycerides, and may also add to the risk of developing diabetes. Therefore we must try to help our patients deal with these increased risks by educating them about the benefits of good nutrition and exercise.

Patients often want to know what is the matter with them and how it came about. Psychiatrists should be willing to discuss the diagnosis and to tell the patient honestly what we currently understand about the causes of chronic mental illness. Constant work has to be done to help the patient to test reality, something that is easier said than done, especially when the patient's delusions are particularly intense.

I believe it is important for the psychiatrist to include the family in the treatment process. Most often the patient is living at home and even if he or she is not, there is still much reliance on parents and siblings for help. Psychiatrists should be aware that parents and siblings need guidance about how to deal with some of the patient's symptoms. At the same time, we have to learn to listen to the parents and their observations about their child's progress. Family members are often the first to notice changes in the patient and it can be very helpful for them to point these out to the treating mental health professional. As I will stress later, the family can also have an enormously positive role to play in the rehabilitative efforts.

Sometimes our insistence on the confidentiality of the treatment does not serve the patient or the family well. The new privacy regulations can make it even more difficult. Recently a mother, whose daughter refused to see or talk to her, called me in distress. Her daughter had been hospitalized in a nearby city for a medical illness. Despite the daughter's wishes, the doctors called the mother for information. The patient was subsequently transferred to a psychiatry unit where, ironically, the doctors refused to speak with the mother who wanted to give them the daughter's medication history. By doing so, the doctors were depriving themselves of needed information, much to the detriment of the patient.

The second most frequently asked question after "My son refuses to take medication, what can we do?" is this one: "My daughter's psychiatrist refuses to talk to us, what can we do?" One of the important tasks of the psychotherapist is to convince the patient that communications with their family will often be of help to both. Of course, sometimes it is not possible. The patient may insist that if the psychiatrist talks to the

parents he or she will break off the treatment. Sometimes in that situation a third party could be used who can talk to both the psychiatrist and the family, serving as both liaison and ombudsman.

Another important component that the psychiatrist may have to attend to is helping the patient apply for and receive Social Security Disability Benefits. This is often a formidable task because patients are often very reluctant to formally acknowledge their disability. Just as often, parents are also reluctant to do so. This is, of course, a painful step to take and requires considerable discussion with the patient and parents. However, the benefits, which include medicare or medicaid, often protect the finances of the family if lengthy or repeated hospitalizations are necessary.

Before I leave this discussion of these various aspects of psychotherapy, I would like to stress the importance of the psychiatrist's empathy and understanding of the patient's emotional experience. All of our patients want desperately to be understood and to get some help in sorting out in their mind what is happening to them. I have previously spoken at these meetings of a young man who came to me quite reluctantly after his parents had come for a consultation. He had been diagnosed as having schizophrenia and was living at home with little contact with anyone outside of his family. I was ten minutes into taking his history and asking him questions when he interrupted me and said, "This is not what I came for. I need help! I can't feel my face!"

I was able to find out the following: This feeling had come on quite suddenly three years before while he was driving his car and had persisted ever since. He did not remember if anything special or unusual had taken place around that time. He told me that he could feel his face when he touched it with his fingers and he recognized his face

when he looked in the mirror. Nevertheless, he continued to insist that, “I can’t feel my face.” After listening some more I spoke to him about the symptoms of schizophrenia. I said one of the most distressing symptoms that often occurs is a loss of the sense of oneself, that integrated feeling of who one is. Perhaps schizophrenia had robbed him of that very important feeling of selfhood and it was finding expression in feeling that he “can’t feel his face.”

He thought for a while and said maybe that was true. For the past three years he felt that he no longer knew who he was or what he had become. When he returned for another session he said he was feeling somewhat better. Then he said this, “I don’t know if your explanation is correct but you are the first person who actually tried to talk to me about it and try to explain it to me in some way that I could understand.” Indeed, I don’t know if my explanation was correct either, but I do know how important it was for him to feel that someone was listening to him in an empathic way and taking him seriously.

What I have been describing are some very important aspects of the psychiatrist’s role in maintaining stability and fostering improvement in the patient’s condition. Now I would like to turn to what I consider to be the most important message in my presentation today. *However important the medications are, and they are very important; however important it is for the patient to have an understanding and empathic therapist, and it is very important; both of these are not sufficient for fostering the growth and improvement that we are aiming for.* We want to restore, as much as is possible, those aspects of the patients’ lives that had been cruelly interrupted and interfered with. Therefore, the psychiatrist now has to pay attention to those vital aspects of the patient’s life so that the

process of rehabilitation can take place. And not only pay attention, but play an important role in ensuring that all the details fall into place.

We used to think of schizophrenia as a deteriorating condition. We now know that that is not true. Even patients who do not take medicine may do better after they reach midlife. Either the illness starts to abate or the person has been able to make certain adjustments to his disorder so that he can function better. The more we can help each individual take on those areas of functioning that he or she has left behind the more improvement there will be, even without changing or improving the medications. We used to tell patients and their families that they would have to lower their expectations of what could have been in the future. While it is true that a person with severe mental illness may never realize the potential that existed before the onset of the illness, many are now demonstrating that they can indeed lead much better lives than projected for them in the past. The more we can bring out their healthy ability to lead useful and productive lives, the less they will suffer from the symptoms of the disorder.

I know that I do not have to remind this audience of family members, consumers, and mental health professionals who treat people with serious mental illness of the devastating loss of self-esteem that accompanies these diseases. I was treating a young man who was getting very much better in his early thirties after years of illness. He said to me one day, "I feel like I have lost half of my life. My friends have finished college and are working. Some are married and having kids. I am living at home and doing some volunteer work. I feel terrible about myself." He was, in effect, mourning the loss of all those years when he was desperately ill. Nevertheless, his awareness of what had

happened to him went along with his improvement and enabled him to move forward and to pick up the pieces of what had been a shattered life.

Let me start with the task of helping the patient find appropriate, adequate and affordable living arrangements. Because of the devastation of the personality caused by the symptoms, people with schizophrenia often need to live at home with their parents and, in some cases, siblings, because they need the care and support the family can provide. They once more become very dependent on their family, although some of these patients had previously demonstrated that they could live independently, while others never had the chance to try. Although being at home with a loving family can be part of a healing process, after a time we must try to help a patient move on to the next step by seeing if there are possibilities other than remaining dependent and living at home. I remember a young man who, after two hospitalizations, was able to get a full time job and expressed the wish to live on his own. His parents, however, were unable to conceive of his moving out of their house. After much discussion with the patient, I had a meeting with the three of them together to see what they would all feel if they were able to find a small apartment nearby for him. His parents were worried because he still had many of the same symptoms he had had for years although they were disturbing him less. I said that just as he had been able to work with the same symptoms, he might be able to live alone with those symptoms. Indeed, he did find an apartment and paid for it with his salary plus some help from his parents. This move made an enormous difference in the way he felt about himself. But note that, very often, for them to live independently, people suffering from schizophrenia need ongoing support similar to what was being provided when they were living with their parents. An approach called supported housing

has been developed to meet this need. In those instances where parents cannot afford to help or the patient cannot pay for an apartment, the psychiatrist may have to elicit the help of others to find out what kind of subsidized housing is available in the community.

I want to tell you about what happened in New Jersey when, finally, the state government got something right. About a dozen years ago the state was determined to once more decrease the state hospital population, but this time, in contrast to the de-institutionalization programs of the past, money was earmarked for this purpose and preceded the patients into the community. A number of agencies around the state were funded to help people move from state hospitals into group homes or apartments that were to be either rented or purchased by the agency. In my county of Bergen alone, almost 100 former state hospital patients are living in one, two or three bedroom apartments. Most of the patients have a case manager supervising them, sometimes bringing them their medications, sometimes taking them for activities. But all of the former patients are living in their communities free to come and go as they please without the constraints of a hospital setting.

Perhaps the most remarkable thing of all is that many of the patients have the same symptoms or degree of impairment that sent them to the state hospital. And although I don't know all of the individual details, it does not take much to realize how much better these people feel about themselves now that they are living independently in apartments and not in a state hospital! I also believe that living in such supportive housing will, in and of itself, in contrast to hospitalization, lead to improved functioning.

Now let us turn to the topic of education. The education of many of our patients with schizophrenia has been interrupted. You know the toll that these illnesses take on

cognitive capacity and the ability to concentrate. Therefore many people just cannot continue with their education and have to drop out of school. Here again, the psychiatrist should take the lead in discussing with the patient the possibility of returning to school even when struggling with the symptoms of the disorder. There are many possibilities. One can start out by auditing a course, or perhaps taking just one course. Curricula should be chosen on the basis of what is of interest to the person, or what subjects have proved to be interesting or enjoyable in the past.

Some of the patients who are able to start or return to college may also need our help after enrollment. Most colleges now have Offices of Disability that are staffed by mental health professionals knowledgeable about mental disorders. Here, the psychiatrist can play a critical role in helping the patient get through the difficulties of returning to or starting college. For example, one of my patients, after a brief hospitalization in high-school, was accepted at a good private college in his state. He started out by taking two courses, then three the next semester, and since then has taken a full course load. As soon as he started I advised him to go to the disability office and explain to them that he would need extra help. I was in contact with his counselor, a clinical psychologist, from the first week, explaining to her his history and condition as well as the medications he was taking. Of course, this communication was with his and his parent's permission.

His disability counselor was able to effect a number of successful interventions. On two occasions he had to drop courses, but each time he avoided a failing grade because the counselor was able to explain the situation to his teachers. On a few occasions when medication changes led to side effects that interfered with concentration or led to excessive drowsiness, I have let the disability counselor know immediately or

have even written directly to professors. Sometimes psychiatrists also have to play an active role in asking for a medical leave for the patient when course work proves to be too much. Often the parents themselves can help their loved one reach the decision to take a leave or to discontinue. Such was the case with a young man I recently saw who started college after two years of deteriorating function in high-school. He came to see me at the end of the first week at school when he had been able to attend only a few classes. His parents had already realized that it would not be wise for him to continue. Because it was so early in the semester, I did not have to request a medical leave. He has responded very well to medication and has returned to school for the spring semester.

In some instances, it might be helpful for the mental health professional in charge of the treatment to have some contact with guidance counselors at the school. Some of these counselors are in the position of talking to and advising students not only about their choice of a major but also about choices of courses that would prepare them for a career. Once again this should only be done at the request of and permission from the patient who might welcome further input from the psychiatrist who might also be participating in such decisions.

I am sure you realize how much it means to a young person with serious and persistent mental illness who may have given up all hopes of advance education, much less earning a college degree, to take that walk during graduation ceremonies. And I am sure you can imagine what it means to the family as well. Even if the return to school does not lead to a degree, the ability to take some courses, as well as the experience of being with other students on campus can mean a lot to someone struggling with the symptoms of chronic mental illness.

Now let's turn to the rehabilitative value of work. There has been recognition on the part of everyone in the mental health field that the accomplishment of finding and keeping a job can be of enormous benefit to our patients, often resulting in a diminution of symptoms. For many years, work rehabilitation efforts which took place in mental health centers focused on patients doing some piece work like stuffing envelopes or putting together various kinds of packaging in sheltered workshops. It has been shown that these kinds of activities do not develop the ability to get and hold a job. Many clinics now have vocational rehabilitation counselors who help patients find and keep a job. Often patients are still symptomatic yet are able to perform work at various levels of difficulty. Similar to the situation with regard to housing, the term supported employment has been introduced to describe the support needed to allow many adults with severe mental illness to work productively. Sometimes supported employment counselors or job coaches accompany the patient to the job site and continue to provide ongoing support off site as well.

Psychiatrists must encourage their patients to think about finding employment even though they are coping with disturbing symptoms. It has been found that perhaps the single most important group of symptoms that impede getting and keeping a job is the level of cognitive impairment rather than the presence of delusions and/or hallucinations. However, even with such impairments many of our patients can work at some jobs effectively. Although they are not easy to find, there are firms willing to hire people with various kinds of disabilities. If the psychiatrist does not have sufficient information about the existing market for jobs he or she can get in touch with vocational rehabilitation counselors or DVR agencies that might provide assistance. Of course, a minority of

patients are able to work full time. However, even getting started at 10 hours a week can be beneficial. Work for pay turns out to be better than volunteer work in terms of the self-esteem that it provides. Patients desperately want to function like people without mental illness. The ability to work provides that feeling for many of our patients.

A question that is frequently raised by patients and family members is whether the person applying for a job should disclose the presence of a mental illness. This is not an easy question to answer but it is certainly one that has to be discussed. In three cases I am familiar with, the patients did not reveal that they had a mental illness and it has worked out well. Of course, many patients now get jobs with the help of vocational rehabilitation counselors, some of whom have been working with companies that have already committed themselves to hire people with mental illness. In that situation, there is no need to conceal the fact of the disability.

It would certainly not be outside of the psychiatrist's role to discuss with the patient actual want ads in the paper or through the internet in order to guide him or her to the kinds of jobs that might be suitable. If the mental health professional does not feel suited to that role, then he or she should elicit the help of a vocational rehabilitation counselor. Often family members can be very helpful in the process of finding a job. Setting up a family discussion so that the patient, the parents, and the psychiatrist are in some agreement about the suitability of certain jobs could be very useful.

Once the job is obtained, the patient needs help in keeping the job secure. Here the kind of help is the same that is being provided all along---that is, trying to keep the symptoms at their lowest possible level. One person's job was always in jeopardy because of recurrent paranoid feelings toward his co-workers and boss. Constant attention

to these symptoms was necessary. It was important to help him to see how he interpreted certain harmless statements by his co-workers and boss as attempts to ridicule and belittle him. Another patient would get extremely tired and sleepy at work whenever the stress was intense. Taking short breaks helped, but it was not until I added Ritalin, a psychostimulant, to his medication regimen that this symptom markedly diminished.

To foster the process of rehabilitation there are two general principles that we should keep in mind. One is that an individual with a serious and persistent mental illness should be encouraged to undertake only one major change at a time. If she is starting to take two courses in college, she should not think of moving from her home. If he has just taken a 10 hour a week job, he should not think about starting to audit a course. Every change, even those for the better, has the potential to exacerbate some symptoms because of the stress that is induced. Patients have to be taught to be prepared for some worsening of symptoms when changes are made, an increase in symptoms that does not necessarily require an increase in medication. Rather, the psychotherapy should include the reassurance that symptoms will gradually recede as the person adjusts to the additional stress.

The second general principle goes something like this: In between not stressing the patient at all and pushing him too much, some balance must be found that is unique for each individual. We do not want a patient with chronic mental illness to feel that she cannot once more engage in activities that she enjoyed before she became ill. On the other hand, we do not want to encourage patients to take on more than they can handle. These are never easy decisions, and sometimes we do not know exactly where that balance should settle until the person actually tries to take on the particular endeavor.

What we have observed, however, is that many patients are capable of improving their lives even when the medications have not brought about an end to their symptoms.

I would now like to turn to what may be the most difficult task in the rehabilitative process: helping patients once more develop some close interpersonal relationships that will be meaningful to them. You all know that the negative symptoms of schizophrenia markedly interfere with a person's ability to relate to others. Withdrawal into oneself is very common. It is extremely difficult for the person with schizophrenia to make new friends and to sustain relationships.

All too often their old friends abandon them and do not stay in touch. Former friends have moved on in life, graduating from college, choosing careers and starting families. In addition to the negative symptoms themselves, the person with schizophrenia often feels that he or she no longer fits in with former friends whose lives are so much different from theirs. The loss of self esteem and shame that the patient experiences makes it even more difficult to contact old friends.

So both the psychiatrist and the family are faced with a daunting prospect. How can we encourage and foster the re-establishment of meaningful personal relationships? Often the patient is living at home cut off from peers, or living in an apartment quite isolated and alone. The motivation to make new friends is frequently lacking. Unlike the three other dimensions of rehabilitation, i.e., housing, education and work, it is very difficult to come up with concrete suggestions to improve involvement with others. Social skills training for persons with schizophrenia has been shown to be helpful in improving their capacity to relate but it still may be difficult to arrange enjoyable interactions with others.

A few years ago I got together with a number of other parents to see if we could create a social gathering for our children who suffered from serious mental illness. We could not get it off the ground because there were too many logistical problems. It proved difficult to pick an agreed upon location and time, not to mention the fact that many of the young people refused to consider it. But there are things that can be done. In northern New Jersey, for example, we have two drop-in centers, free standing facilities where people with chronic illness can gather to talk and interact on an entirely voluntary basis. They are run by consumers, themselves, who are paid by state funding for the hours they work as facilitators in the center. Individuals feel free to come and go without pressure from any mental health professionals. In addition they have proved to be very good places to socialize with people eating together in the kitchens that are available. Computers are provided and their use often fosters interaction among the members who might then go on to discuss their plans for recreation, employment, and education.

For those who are consumers in the public mental health system, clubhouses, day centers and other programs in local clinics offer patients an opportunity to meet others who are like them. Sometimes friendships are forged through these contacts. Many families now attend NAMI or other self-help meetings and meet other parents who have struggled with similar kinds of problems. Sometimes the parents can foster the development of relationships between their children.

I will tell you a success story in this regard. A number of years ago I met a family who was relocating to this area from another city. They had a son with chronic mental illness who would be coming with them, losing even the few friends he had been able to maintain. My wife and I decided to host a backyard barbecue with this family and others.

I had found out that the young man had an interest in music and tennis, interests which my son shared. I asked my son if he would be willing to call and personally invite this young man to enjoy the barbecue and to play tennis with him. He said yes and it turned out very well. These two young men are now good friends and spend a great deal of time together. Of course, it is not always possible to arrange such a companionable get together.

Although I have been stressing the role of the psychiatrist or mental health professional in fostering these various aspects of rehabilitation, this example shows us that the role of the family can be not only just as important, but sometimes even more important in fostering active and fulfilling lives for their children. Parents are usually with their ill child, if not 24/7 then a great deal of time. They are in a position to advise, support and encourage efforts to return to school, seek a job or find suitable housing for independent living.

One day, when I was almost finished with writing this presentation, I was describing to my wife that I was trying to emphasize the importance of helping patients to be able to live independently, resume and perhaps complete their education, obtain and hold a job and to develop meaningful relationships with others. She turned to me and said, "Oh, you mean just like normal people!" And yes, I realized, that is the point! These things I have described are what all of us strive for in ourselves and what all of us want for our children whether they have mental illness or not.

Having a severe and persistent mental illness is a shattering experience both for patients having such an illness and for the family that cares for their loved ones. Even when the rehabilitative I have been describing are successful, our patients might still have

to struggle with painful symptoms of their illness. However, like other disabilities that people have to endure, there is much that can be done so that their lives can be lived with dignity and meaning.