Take Home Lessons on Schizophrenia

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If the models in this discussion are disseminated and used, costs will drop and patients will enjoy an improved quality of life.

“Those who do not learn history are doomed to repeat it.”
—George Santayana

There are many variations of this famous quote. One other is: “Those who fail to learn from the mistakes of their predecessors are destined to repeat them.” This may be the take-home point of the APA 2015 meeting regarding schizophrenia.

What I found out affirmed and extended what Dr Thomas Insel conveyed in his Director’s Blog: Best of 2014.

The Bigger Question Is Not the Medication
I attended the Workshop, “Rethinking the Long-Term Use of Antipsychotics in Schizophrenia: For Everyone, No One, or Some?” chaired by the well-known community psychiatrists, Sandra Steingard and Carl Cohen that included panelists from Great Britain. What makes Workshops so potentially valuable is the opportunity for live interaction and discussion. This topic was obviously of interest, as it drew an overflow crowd.

However (and I can only speak for myself here), the “rethinking” seemed to end up as being close to a reaffirmation of what was previously known, or should have been known, for at least 25 years. Of course, such reaffirmation is of value in itself.

We know that, in general, the dosage of antipsychotics matters. Whether through absorption, metabolic, or receptor variations, there are small subgroups of patients who require high dosages for help. The challenge is to have enough time with patients to discuss and process the role of medication among other aspects of treatment that can potentially help.

In Dr Steingard’s admirable self-study of her own attempt to reduce medication slowly and carefully (should patients so desire), the outcomes in those who reduced medication and those who did not seem to me to be very strikingly different after a few years. Those patients who did the worse by far seemed to be those who suddenly discontinued their medication on their own.

A Genetic Imbalance
I also attended a presentation by the well-known researcher, Daniel Weinberger, MD, “On The Simple Truth About the Genetic Complexity of Schizophrenia.” He maintained that we are entering a historical opportunity to understand the molecular mechanisms leading to vulnerability to what we now call schizophrenia. The problem may relate to an accumulation of many common genetic variations—small variations that, together, can lead to major challenges later in life.

This thesis led me to wonder if it is now time to stop explaining schizophrenia and other disorders as “chemical imbalances.” More correct, and perhaps even less stigmatizing, may be to tell patients that they have a “genetic imbalance,” or, better yet, a “genetic variation.” This is not to ignore the importance of the environment on this condition, including epigenetics, where life stress can alter genes and genetic expression, including what is passed on to offspring.

A Case For Clozapine
I also attended the Case Conference “Treatment-Refractory Schizophrenia: A Clinical Conundrum That is Still Not Going Away.”

Here we learn again that abrupt discontinuation of medication, in this case clozapine, generally leads to the worse outcomes—even when the same medication at the same dosage is re-started. Yet again, we heard that clozapine is the most effective anti-psychotic, but that it also tends to cause the most side effects. Perhaps this conundrum explains why some state Medicaid programs do not support the initiation of clozapine, and that it is being prescribed less often.

However, the main take home point to me was that we have to reconsider or relearn from the past. In this case, the last typical antipsychotic to become available was loxapine. Although it seemed to me to be effective and gentle in its side effect profile, it was not used much after the atypical anti-psychotics came out and the manufacturer turned its focus to ob/gyn medications. Yet
researchers suggest that its chemical structure resembles that of clozapine. Several in the audience vouched for its usefulness, and a new formulation is coming out.

**Lessons learned and key take-home points:**

- We need to find ways for those who develop psychosis for the first time to be assessed earlier.
- When treatment is needed for first-episode psychosis, the earlier the better.
- Our usual interventions generally fall far short of what can help the most.
- The choice of medication and the dosage both matter. Low dose risperidone is a reasonable first choice.
- Comprehensive psychosocial treatments are of tremendous value if they are available.

The session also raised this question: given that a third of the time the antipsychotic fails in a first episode psychosis, should clozapine be used earlier than usual as the second line choice? This question led to my last educational session.

**Raise a Toast to RAISE**

Here, I return to the topic of Dr Insel’s top story of 2014. This was a symposium led by John Kane, MD: “Two-Year Results of a Comprehensive Care Model in First Episode Schizophrenia: The Recovery After an Initial Schizophrenia Episode Early Treatment Program (RAISE ETP).”

The model and the results that are emerging are striking and promising. This is from an NIMH study that compares many community mental healthcare clinics across the states (those that initiated the model treatments for a first psychotic episode suggestive of the Schizophrenia Spectrum), with treatment as usual in the other clinics.

The goal was recovery and the desired outcome was improved quality of life. The model required reasonable adherence to 4 treatment domains: evidence-based psychopharmacology; family treatment; individual resilience training; and supportive employment and educational per the patient’s desire.

Diagnosis was by careful SCID criteria. Included were those who met these criteria and who were taking an antipsychotic medication less than six months. It was discovered, however, that psychotic symptoms had been present, on average, for over 70 weeks before any treatment was started. It is distressing, but perhaps not surprising, that 40% of those receiving were getting suboptimal psychopharmacology. On top of that, about a third were on some form of olanzapine, a drug viewed as not indicated for a first psychotic break due to its side effect potential. Moreover, all recommendations were for low dosage, but on average the dosage was high. Perhaps of even greater concern was the impression that the recommended psychosocial interventions were generally of very limited availability in the treatment as usual clinics.

Those staff trained in the study were generally able to become adherent to the models. Some unexpected findings are emerging. One was that acute psychosis in itself could prove traumatic, and treatment geared to post-traumatic growth was indicated. Overall results to date indicate a significant improvement in all measures.

The promise is that if these models are disseminated and used, the costs will not increase, except for training. Just think if managed care companies adapt these models. . . costs that are contained coupled with improved quality of life!

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