Schizophrenia: Early Detection and Adherence Strategies

Schizophrenia is a progressive neurodevelopmental disorder, and the duration of untreated psychosis is associated with worsening outcomes. The prodrome of schizophrenia is the period of altered functioning or subtle symptoms that occur before the onset of frank psychosis [Yung AR et al. *Schizophrenia Bulletin* 1996]. This is a pivotal time from a diagnostic standpoint, as disease recognition during the prodromal phase may allow clinicians to proactively treat the illness and alter disease progression. Symptoms that fall within the schizophrenia prodrome include hearing voices or seeing visions, suspiciousness, a change in object perception, misinterpretation of events, odd or eccentric behavior, preoccupation with new or unusual beliefs, social withdrawal, loss of motivation, anxiety, changes in appetite, depressed mood, irritability, poor sleep, poor hygiene, deteriorating functioning at work or school, and poor concentration. Kristin Cadenhead, MD, University of California, San Diego, CA, discussed the psychosis prodrome as it applies to clinical practice.

The psychosis prodrome may be identified early using a variety of tools, such as Structured Interview for Prodromal Syndromes (SIPS), which provides a rating scale, based on the number of symptoms; Schizotypal Personality Disorder (SPD) scale; and Global Assessment of Functioning (GAF). Genetic risk (ie, family history of psychosis) and severity, duration, and frequency of symptoms may also assist clinicians in early detection.

According to the North American Prodrome Longitudinal Study (NAPLS), the risk of conversion from prodromal syndromes to psychosis was 35% higher among those who had a family history of psychosis plus deterioration in functioning, suspiciousness/paranoia, unusual thought content, decline in social functioning, or a history of substance abuse. The conversion risk increased to 80% when three of these factors were combined [Cannon TD et al. *Arch Gen Psychiatry* 2008]. While risk factors, such as those in NAPLS, and vulnerability markers, such as body dysmorphia, olfactory measures, neurocognitive deficits, informational processing, and neuroimaging, may provide valuable information regarding psychosis prediction and conversion moving forward, further studies are needed to establish predictive protocols and guide the treatment of high-risk patients.

Poor adherence to antipsychotic medication is another barrier to better outcomes that clinicians encounter every day in the treatment of schizophrenia. In fact, nonadherence is common with approximately 75% of patients, with schizophrenia becoming nonadherent within 2 years of hospital discharge, and is a major factor in explaining the high rates of relapse that are seen in this disorder [Weiden PJ et al. *Psychiatry* 1995; Morken G et al. *BMC Psychiatry* 2008]. Peter J. Weiden, MD, University of Illinois Medical Center, Chicago, IL, discussed various therapeutic approaches that are intended to foster adherence.

Establishing a strong therapeutic alliance between patient and clinician is imperative. While this is the ultimate goal, there are barriers that may impede such an alliance. Communication difficulties, negative symptoms, rejection of the diagnosis due to associated stigmas, and previous negative experiences with other mental health clinicians may cause barriers from the patient's standpoint. Additionally, clinicians may inadvertently create barriers by underestimating the importance of the relationship, conveying a sense of hopelessness, a lack of interest in life goals, or overemphasizing medication with less focus on other treatment-influencing factors. A major challenge is to sort these reasons out in a way that allows for clinical intervention. One approach, suggested by Dr. Weiden, is to differentiate patient adherence challenges according to two broad categories: those who "can not" take medication regularly because of symptomatic or environmental barriers, and those who "will not" take medication due to an intentional decision to stop medication. The first step in this "sorting" process is to obtain accurate information about the patient's recent adherence as well as their attitudes toward medication. Patient reluctance to fully disclose their rationale for lack of adherence may make this process more difficult [Weiden P. *J Clin Psychiatry* 2007].

Dr. Weiden suggests that nonadherence interviews should be approached tactfully and that efforts should be made to "normalize nonadherence" in order to avoid perpetuating the cycle of nonadherence. In other words, the assessment should not reinforce deception, and clinicians should try to avoid intervening too early. When faced with a case of nonadherence, clinicians should try to continue to foster the alliance and focus on "harm reduction," such as encouraging taper methods of medication discontinuation rather than abrupt cessation, reviewing early warning signs with family, and discussing the next therapeutic step with the patient.

There are also various pharmacological strategies that may aid in medication adherence. Several advances have been made in the area of long-acting injectable atypical antipsychotic agents over the past decade. These

injectable medications may help with adherence, as they are more easily monitored with regard to dosage and adherence status. Additionally, medications can be taken consistently without the need for the patient to remember to take their daily pill. However, these strategies are not without challenges, because they present administrative and logistical issues that pertain to the injections. There are also limited choices with regard to current injectable antipsychotics, and clinicians and patients may have concerns about injectable psychotics, based on professional philosophies or perceived stigmas [Velligan DI, Weiden PJ, Sajatovic M, et al. *J Clin Psychiatry* 2009].

Psychosocial interventions also play a role in medication adherence. Cognitive behavior therapy (CBT), which focuses on symptoms rather than acceptance of diagnosis, may create a collaborative therapeutic environment and circumvent medication rejection that is based on unwillingness to accept a diagnostic label of schizophrenia [Rathod S et al. *Schizophr Res* 2005; Turkington D et al. *Am J Psychiatry* 2006]. When it comes to side effects and adherence, Dr. Weiden emphasized that it is more important to focus on the degree to which the side effect is distressing to the patient and others in his or her network than its actual medical severity. Additionally, family involvement in patient care may be a valuable resource when trying to achieve adherence.

Ultimately, medication adherence relies on matching individual patient factors with the treatment intervention. Using assessment tools and interview strategies, the clinician may be able to format a treatment plan based on potential adherence barriers in order to optimize adherence. The treatment of schizophrenia can be challenging, as it involves many factors and symptom manifestation may change over time. Early detection may help with the management of psychosis and minimize the worst aspects of illness progression. A clear understanding of adherence barriers and individual treatment goals are also vital components of psychosis treatment. The clinician is left with the responsibility of evaluating these factors and guiding treatment accordingly.

New Research: Study Shows Benefits in Flexible, Comprehensive Eating Disorder Treatment

Patients with eating disorders who underwent an integrated yet individualized treatment protocol significantly improved not only in the eating disorder illness (Figure 1), but across a range of areas, including decreases in depression and anxiety, according to research presented at the American Psychiatric Association's Annual Meeting in New Orleans.

Figure 1. Struggling with an Eating Disorder.

The study was conducted in a large integrated private group practice that addressed eating disorders and comorbid conditions simultaneously, using both verbal and non-verbal treatments such as art therapy in both outpatient and residential settings. A multidisciplinary team provided patients with integrated individual and group therapy, psychoeducuation, nutritional counseling, and medication.

The study integrated comprehensive initial and outcome assessments of eating disorder symptoms, anxiety and depression, life functioning, and eating behavior into private practice. The study participants showed significant improvement in eating disorder scales, significant decrease in anxiety and depression scores, and improvement in overall- and within-family-functioning. Dramatic improvements with the flexible treatment model were statistically and clinically significant across a range of psychosocial areas, the researchers concluded.

Researchers also identified variables that predict dropout risk, including the long duration of the eating disorder