Schizophrenia in Adults At A Glance*

Because schizophrenia is a chronic illness that influences virtually all aspects of life of affected persons, treatment planning has three goals: 1) reduce or eliminate symptoms, 2) maximize quality of life and adaptive functioning, and 3) promote and maintain recovery from the debilitating effects of illness to the maximum extent possible. Accurate diagnosis has enormous implications for short- and long-term treatment planning, and it is essential to note that ***diagnosis is a process rather than a one-time event.*** As new information becomes available about the person served and his or her symptoms, the diagnosis should be reevaluated, and, if necessary, the treatment plan changed.

Every person served should have as thorough an initial evaluation as his or her clinical status allows, including complete psychiatric and general medical histories and physical and mental status examinations.

ACUTE TREATMENT

The goals of treatment during the acute phase of treatment, defined by an acute psychotic episode, are to prevent harm, control disturbed behavior, reduce the severity of psychosis and associated symptoms (e.g., agitation, aggression, negative symptoms, affective symptoms), determine and address the factors that led to the acute episode, effect a rapid return to the best level of functioning, develop an alliance with the person served and the family, formulate short- and long-term treatment plans, and connect the person served with appropriate aftercare in the community.

If the bipolar sub-type is suspected then adding in a mood stabilizer (and an antidepressant if depressed) is indicated. If the depressive subtype is suspected then adding an antidepressant along with the antipsychotic is indicated. In general, all antipsychotics (both typical and atypical) have shown some degree of efficacy with the exception of clozapine because of its potential to cause agranulocytosis. There is no evidence of superior efficacy of any one mood stabilizer, however there is some evidence supporting use of newer as opposed to older (tricyclic) antidepressants.

Medical conditions that may contribute to symptom exacerbation can be evaluated by medical history, physical and neurological examination, and appropriate laboratory, electrophysiological, and radiological assessments. Measurement of body weight and vital signs (heart rate, blood pressure, temperature) is also recommended. Other laboratory tests to be considered to evaluate health status include a CBC; measurements of blood electrolytes, glucose, cholesterol, and triglycerides; tests of liver, renal, and thyroid function; a syphilis test; and when indicated and permissible, determination of HIV status and a test for hepatitis C. Routine evaluation of substance use with a toxicology screen is also recommended as part of the medical evaluation. It is recommended that pharmacological treatment be initiated promptly.

Adjunctive medications are commonly prescribed for comorbid conditions in the acute phase. Benzodiazepines may be used to treat catatonia as well as to manage anxiety and agitation until the antipsychotic has had time to be therapeutically effective. Antidepressants can be considered for treating comorbid major depression or obsessive-compulsive disorder, although vigilance to protect against the risk of exacerbation of psychosis with some antidepressants is important. Mood stabilizers and beta-blockers may be considered for reducing the severity of recurrent hostility and aggression.

Psychosocial interventions in the acute phase aim at reducing overstimulating or stressful relationships, environments, or life events and at promoting relaxation or reduced arousal through simple, clear, coherent communications and expectations.

STABILIZATION

During the stabilization phase, the goals of treatment are to reduce stress and provide support to minimize the likelihood of relapse, enhance the person's adaptation to life in the community, facilitate continued reduction in symptoms and consolidation of remission, and promote the process of recovery. If the person served has improved with a particular medication regimen, continuation of that regimen and monitoring are recommended for at least 6 months. Psychosocial interventions remain supportive but may be less structured and directive than in the acute phase.

STABLE PHASE

The goals of treatment during this phase are to ensure that symptom remission or control is sustained, that the person served is maintaining or improving his or her level of functioning and quality of life, that increases in symptoms or relapses are effectively treated, and that monitoring for adverse treatment effects continues. During the stable phase of treatment it is important to routinely monitor all persons served treated with antipsychotics for extrapyramidal side effects and the development of tardive dyskinesia.

Antipsychotic medications substantially reduce the risk of relapse in the stable phase of illness and are strongly recommended.

A number of psychosocial treatments have demonstrated effectiveness during the stable phase. They include family intervention, supported employment, assertive community treatment, skills training, and cognitive behaviorally oriented psychotherapy. In the same way that psychopharmacological management must be individually tailored to the needs and preferences of the person served, so too should the selection of psychosocial treatments.

OTHER SPECIFIC TREATMENT ISSUES

1. First episode

It is important to treat schizophrenia in its initial episode as soon as possible. When a person served presents with a first-episode psychosis, close observation and documentation of the signs and symptoms over time are important because first episodes

of psychosis can be polymorphic and evolve into a variety of specific disorders (e.g., schizophreniform disorder, bipolar disorder, schizoaffective disorder). Further, in persons who meet the criteria for being prodromally symptomatic and at risk for psychosis in the near future, careful assessment and frequent monitoring are recommended until symptoms remit spontaneously, evolve into schizophrenia, or evolve into another diagnosable and treatable mental disorder.

2. Negative symptoms

Treatment of negative symptoms begins with assessing the person served for syndromes that can cause the appearance of secondary negative symptoms. Treatment of such secondary negative symptoms consists of treating their cause.

3. Substance use disorders

Nearly one-half of persons with schizophrenia have comorbid substance use disorders, excluding nicotine abuse/dependence, which itself exceeds 50% in prevalence in this group. The goals of treatment for persons with schizophrenia and a substance use disorder are the same as those for treatment of persons with schizophrenia without comorbidity but with the addition of the goals for the treatment of substance use disorders.

4. Depression

Depressive symptoms are common at all phases of schizophrenia. Thoughtful differential diagnosis considers the contributions of side effects of antipsychotic medications, demoralization, the negative symptoms of schizophrenia, and substance intoxication or withdrawal. Depressive symptoms that occur during the acute psychotic phase usually improve as persons served recover from the psychosis. There is evidence to suggest that depressive symptoms are reduced by antipsychotic treatment, and second generation antipsychotics may have greater efficacy for depressive symptoms than first-generation antipsychotics. Antidepressants may be added as an adjunct to antipsychotics when the depressive symptoms meet the syndromal criteria for major depressive disorder or are severe, causing significant distress or interfering with function.

5. Suicidal and aggressive behaviors

Suicide is the leading cause of premature death among persons with schizophrenia. Some risk factors for suicide among persons with schizophrenia are the same as those for the general population.

In general, persons should be cared for in the least restrictive setting that is likely to be safe and to allow for effective treatment. Indications for hospitalization usually include the risk that the person served poses a serious threat of harm to self or others or is unable to care for self and needing constant supervision or support. Other possible indications for hospitalization include general medical or psychiatric problems that make outpatient treatment unsafe or ineffective or new onset of psychosis.

6. Use of ECT and other somatic therapies in the acute phase

ECT in combination with antipsychotic medications may be considered for persons with schizophrenia or schizoaffective disorder with severe psychotic symptoms that have not responded to treatment with antipsychotic agents.

For most persons with schizophrenia in the stable phase, treatment programs that combine medications with a range of psychosocial services are associated with improved outcomes.

A major goal during the stable phase is to prevent relapse and reduce the severity of residual symptoms. Certain psychosocial interventions have demonstrated effectiveness; these include family education and support, assertive community treatment, and cognitive therapy.

Negative symptoms and cognitive impairments are more predictive of functional impairment. Because available medications have at best only modest effects on these illness dimensions, it is not surprising that there is scant evidence that medications improve functional status beyond that achieved through reduction of impairing positive symptoms. Consequently, certain psychosocial and rehabilitative interventions are essential to consider in the stable phase to enhance functional status.

Use of ECT in the stable phase

Clinical observations and a single randomized clinical trial suggest that maintenance ECT may be helpful for some persons who have responded to acute treatment with ECT but for whom pharmacological prophylaxis alone has been ineffective or cannot be tolerated.

*Adapted from Anthony F. Lehman et al. Practice Guideline for the Treatment of Patients With Schizophrenia Second Edition. American Psychiatric Association, 2004