

Evidenced-Based Practice in Schizophrenia

This NAMI seminar was held September 20, 2007, at the Ceder Lane Methodist Church by Dr. Anthony F. Lehman, M.D. M.S.P.H. Dr Lehman is a faculty member in the Department of Psychiatry at the University of Maryland.

Evidenced-based practice is a methodology that incorporates new scientific knowledge into medicine. “It is the combination of science with clinical experience and the values of the patient.”

Dr. Lehman contrasted the differences between efficacy and effectiveness in the treatment for schizophrenia. Efficacy is “a pure view of treatment,” that is, how well the treatment works in a tightly controlled treatment trial. Effectiveness is how well the treatment works in the real world.

Dr. Lehman thought there is too much emphasis on randomized trials in research on schizophrenia. It would be better to do research with typical groups of consumers: Example: treatment limited to consumers who use alcohol.

The relationship between the psychiatrist and consumer should be more collaborative. A clinician should not say “If you don’t take your medicine, you can’t come anymore for treatment.” Rather, the psychiatrist should point out the difference between taking medicine and the relapse rate of untreated patients.

Question: what happens if patients take medications intermittently instead of continuously, as many do. Dr. Lehman: an intermittent medicine schedule doesn’t work well. A clinician can identify early warning signs that the patient is decompensating, but the consumer might not have enough insight to recognize these signs, Better to take medicines continually, rather than intermittently.

Question: Should a consumer could take alcohol while on treatment? Dr. Lehman said that it’s OK if the family and consumer have an occasional drink together, but heavy drinking will cause problems. The threshold for having a problem with drinking is lower for someone with a mental illness.

Regarding nicotine on medicines: nicotine lowers the blood level of anti-psychotics. If a patient smokes, the dosage of the medicines may have to be adjusted. More consumers with schizophrenia smoke cigarettes than the general population because nicotine receptors have a therapeutic effect. Smoking is calming and improves the ability to concentrate in people with schizophrenia. There are different methods for stopping to smoke cigarettes: (1) stop cold turkey; (2) nicotine replacement treatment, like Zyban to reduce craving, dermal patches, or nicotine-containing gum; (3) joining a smoking cessation group. It is often more successful if one or more of these methods are used.

On Clozapine: Clozapine is an anti-psychotic drug has been shown to be the most successful of all the other drugs in treatment of schizophrenia, but there are so many side effects to Clozapine that other drugs should be tried first; Clozapine should be used only if the other drugs don't work. Nevertheless, Clozapine is often under-utilized because the medical side effects are more conspicuous to clinicians than the overall benefits to the consumer.

Anti psychotic drugs treat the positive symptoms of schizophrenia, like hallucinations and delusions, but they don't do as much for negative symptoms, collectively labeled "cognition." Everyone hopes for drugs that better treat cognitive impairment.

Regarding changing medications: Dr. Lehman said that in order to avoid side effects in the withdrawal of medication, it is often best to phase out the older medication over several months.

Beyond medication, it is usually beneficial for consumers to undergo cognitive behavioral therapy. Cognitive behavioral therapy is most effective for reducing delusions and relieving the distress associated with them.

Example of cognitive behavioral therapy: a consumer with paranoid thoughts on a bus thinks someone next to them is reading his mind. Later, the therapist asks the consumer if there might be other explanations for what happens when they get on the bus. The therapist gave him a card saying "I am not the center of the universe." Whenever the patient had paranoid thoughts he would read the card.

Dr Lehman speculated that it may be possible to change structural brain

function by therapy. Such changes go on in brain cells all the time. He calls such possible changes “cognitive remediation.”

Question: what about consumers who are ill and not in treatment. Dr. Lehman said that clinicians don't do a very good job identifying folks at risk for schizophrenia. For example, an adolescent might have a vague feeling that things aren't going well. He needs a way to seek help from someone who has something to offer. Even going to a clinic one needs an “intake.” That means sitting down to be interviewed and concentrating on his problems. Coercion may be a problem. If a consumer doesn't like his/her therapist, it might have a negative effect on seeking further treatment.

Dr. Lehman gave two suggestions for evidenced-based treatment for families. (1) psycho education: using professionals to run groups. Educators provide information on how to solve problems at home or handle crises. (2) the “Family to Family” program. This model lets peers run the education group. Both techniques get away from blaming families of consumers with schizophrenia.

Supportive Employment: This method is the “place and train model,” helping the consumer get an acceptable job. A job coach helps the consumer keep that job. The key to supportive employment is getting a competitive work force job with at least a minimum wage. It is up to the consumer to determine whether the job coach actively interacts with the employer. To have a job coach, one must be in the supportive employment program. In Montgomery County, that is the DORS (Department of Rehabilitation) program.

Notes by Rochelle Banta September 21, 2007