Supporting Treatments

By Jack M. Gorman, MD

There are several psychiatric and neurological illnesses for which medication is virtually always the first-line approach to therapeutics. For example, schizophrenia, bipolar disorder, epilepsy, and Parkinson's disease. Others, including depression, anorexia nervosa, panic disorder, and rehabilitation from stroke, can be treated with non-medication approaches as a first attempt at intervention. Once these approaches become rarefied in the clinician's mind, it can be difficult to consider alternative therapies.

The treatment of schizophrenia is a good example of a therapy with an abundance of positive efficacy data that still seems to need aggressive advertising to change clinical practice. Ever since the introduction of antipsychotics in the late 1950s, it has been an abiding principle that patients with schizophrenia are almost always to be treated with medication. Indeed, many studies have clearly documented that patients with schizophrenia who adhere to antipsychotic regimens have substantially less risk for relapse and repeat hospitalization than patients who refuse to continue their medication. There is no longer any question that antipsychotics work, despite their many adverse effects, and it is a rare schizophrenia patient who is better off without medication.

Still, as previously written in this column, the benefits of antipsychotics are limited. It is a rare patient with schizophrenia for whom medication is sufficient to permit a return to premorbid levels of occupational or social function. Yet how many clinicians recognize that psychosocial approaches to treatment can often accomplish just that? Take a patient suffering with positive symptoms of schizophrenia—a patient who is delusional and experiencing auditory hallucinations—and place that patient on an atypical antipsychotic. Within days or weeks it can be expected that most of the positive symptoms will be in remission. Then, offer that patient vocational training, family therapy, social skills training, or assertive community interventions—just a few of the evidence-based psychosocial treatments available—and the odds are good that the patient will be able to work, go to school, socialize, and live independently. This is not a promise that all patients will realize, of course. Schizophrenia varies enormously in response to therapy and severity. Yet one could fill volumes of journals with rigorously conducted clinical trials showing that psychosocial treatments for patients with schizophrenia who are also taking antipsychotic medication add incrementally to their success in life.

The frustration is that these psychosocial treatments are still poorly disseminated and often overlooked. Part of this comes from our current preoccupation with psychotropics. I believe it is now strangely the case that psychiatrists are behind other medical specialists in their openness to try non-medicinal approaches either before or in addition to medication. What internist would forget to tell a diabetic that a major part of treating her illness is restructuring her lifestyle around increased exercise and careful nutrition? Is there an orthopedic surgeon in the world who would operate on a patient with lower back pain before a bona fide attempt at physical therapy?

An even larger part of the problem, I believe, is the failure of healthcare systems to incorporate psychosocial approaches for the treatment of schizophrenia into their routine protocols. Many patients with schizophrenia receive their treatment via state-funded insurance programs. Only a few enlightened states have managed to incorporate medication and psychosocial approaches into a seamless system of care in which the most cutting-edge pharmacologic management and the best evidence-based psychosocial therapies are offered regularly to patients and their families. Cost is certainly a factor; healthcare payers persistently believe that a patient who can be managed with monthly, 15-minute medication visits to a psychiatrist at a state-operated clinic represents a savings in cost. Obviously, the savings in such a scenario are purely illusory if the result is a patient who can do little more than sit at home and watch television all day.

When I first formulated my interest in devoting an issue of *CNS Spectrums* to psychosocial treatments of schizophrenia, I asked Forrest P. Foster, MSW, to take the role of guest editor. Mr. Foster assembled a who's who of experts in the field to contribute, and the result, I believe, is an outstanding compendium that summarizes the work—and the hope—that psychosocial treatment represents for patients with schizophrenia. I am grateful to all of our guest editors and authors throughout 2004 for providing us with these cited insights. CNS

ERRATUM

In Remington G, Shammi C. (Vol 9, No 8: 579-586) reference 33 was incorrectly cited. The correct reference is Woods SW, Breier A, Zipursky RB, et al. Randomized trial of olanzapine vs placebo in the symptomatic acute treatment of patients meeting criteria for the schizophrenia prodrome. *Biol Psychiatry*. 2003;54:453-464. In Table 2 of the same article, reference 28 should have been cited as reference 33. We regret the errors.

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