Pearls

Peter J. Weiden, MD, on

Promoting compliance in schizophrenia—one month at a time

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Schizophrenia is a lifelong disorder, but new-onset patients often do not see it that way. Many patients responding to an acute episode believe they need only a few days of medication—or none at all. Unfortunately, research has repeatedly shown that maintenance antipsychotics are needed to prevent or delay recurrence.

How do you get patients to accept long-term treatment? How do you prepare them for a lifetime of antipsychotic therapy, with its stigma, hassle, and side effects?

Basically, you don't. Just as a reader will not commit to a 3-year magazine subscription without first receiving a couple of free issues, a therapeutic alliance with the newly diagnosed schizophrenia patient must be built over time. Honesty is paramount, but if you insist on the need for long-term antipsychotic medication right after an initial hospitalization, chances are you'll turn the patient off to any treatment.

Breaking treatment down into shorter periods

I first ask the patient how long he or she plans to take the medication. If the answer is in days (or hours), I'll try to convince the patient to agree to 1 month of antipsychotic therapy. I say, "I know you don't think you need this medication. But you should know that based on experience with similar patients, I think this medication will help you stay out of the hospital. Just take it until your next appointment, then we'll see what happens." I have not mentioned long-term medication, but I haven't lied either.

Simply telling the patient, "Not taking this medication could lead to a relapse," will not work. The patient invariably will respond, "I'm the exception. Relapses happen to other patients, not me."

Often patients realize by the next visit that the medication is helping them function better and continue taking it. Conversely, if the patient is adamant about stopping the regimen, we agree to disagree. I'll say, "I still think you need this medication, but I'm not the one who's taking it." I do, however, urge the patient to taper over the next month to lessen the severity of a prospective psychotic episode.

Discussing life goals can convince some patients that adherence to an antipsychotic prescription is in their best interests. Let's say that a young woman who has just suffered her first psychotic episode tells me she hopes to return to school, advance her career, or find a husband. I respond, "Your recent hospitalization was devastating, wasn't it? The way I see it, another hospitalization would delay your reaching these goals or even jeopardize them, is that correct?"

I then explain, "Taking the medications, as unpleasant as they can be, will decrease your chances of another hospitalization and allow you to live your life." I'm not changing the patient's fundamental attitude toward psychiatric treatment, but I am extending care for a month or two. In the bargain, I'm strengthening our therapeutic alliance with the hope that the patient will call me if he or she decides to resume treatment later on.

Discussing a clozapine trial

This approach also is helpful when prescribing clozapine. For patients who have not responded to other antipsychotics, a clozapine regimen can be a particularly hard sell. The agent is effective, but the patient often is discouraged after learning of the need for weekly blood draws to check for agranulocytosis. It is frightening to commit to lifelong blood draws before you know if the medication will be helpful.

Rather than ask for a lifelong commitment to blood draws, I try to persuade the patient that a therapeutic trial of clozapine is worth the trouble. I say, "Just put up with 12 blood draws in the next 3 months. After that, you can stop the medication if you'd like." When taking this tack, I've found that roughly one out of three patients who might otherwise have refused clozapine stay with the medication beyond the first 3 months.