Schizophrenia is a complicated disease fraught with obstacles to accurate diagnosis and effective treatment. Increasingly, we are recognizing the heterogeneity of this disorder based on differences in clinical presentation, response to treatment, long-term outcome, and biological markers.

A particularly vexing dimensional problem in schizophrenia is persistent negative (or deficit) symptoms such as asociality, blunted affect, avolition, alogia, and anhedonia. Dr. Rado (see page 265) notes that these issues are common in the disorder; adversely affect or worsen other problems, such as cognition and mood; markedly impair social, recreational, and work activities; and are much less responsive to antipsychotics than positive symptoms.

He then summarizes the existing treatment approaches, noting there is not yet a specific FDA-approved therapy for these symptoms. Medication approaches with preliminary positive outcomes include armodafinil and mirtazapine, chosen in part because of their unique mechanisms of action. In addition, neuromodulatory approaches that offer some signals for efficacy include electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS).

Twenty-five years ago, Dr. Weiden and colleagues addressed the issue of antipsychotic compliance in Psychiatric Annals, and it remains as relevant today. Thus, no matter how brilliant one’s diagnostic skills, now matter how cutting-edge the treatment approach, they are only academic exercises if patients do not adequately adhere. This issue is a major source of failed therapeutic trials in all of medicine. Add to this the inherent cognitive and psychotic symptoms associated with schizophrenia, and this problem is greatly magnified.

In this issue, Dr. Weiden and colleagues revisit the issue of nonadherence from two perspectives: the use of long-acting injectable (LAI) antipsychotics (see page 271); and the need to include a specific adherence assessment in the medication management visit of patients with schizophrenia (see page 279).

In the first article, the authors cogently describe two major sources of nonadherence: intentional and nonintentional. They underscore the different value of a LAI approach to address each of these situations. In the first scenario, while a LAI may not prevent a patient from stopping his or her medication, it does serve as an unequivocal and early alarm of nonadherence, allowing the treatment team to consider appropriate interventions and possibly avoid a recurrence of symptoms or relapse.

In the second scenario, a LAI approach may compensate for a patient’s inability to adequately adhere to an oral regimen. In this situation, nonadherence is not because of an unwillingness to take medication, but because of an inability caused by circumstances related to the illness itself and inadequate support systems to compensate for these barriers. In both contexts, the authors underscore the critical need for a delivery system that can effectively incorporate and support a LAI medication strategy.

In the second article, Dr. Weiden shares with the readers the importance of assessing for adherence and several practical “dos and don’ts” that may improve the interview process while also enhancing (rather than diminishing) the therapeutic alliance. In addition to reviewing common mistakes clinicians make, he reviews several recommendations on how to conduct a brief interview that increase the chance of accurately assessing adherence; and, as importantly, the opportunity to develop a more open, constructive
and successful relationship with one’s patient and family.

Lastly, as these controversial issues play out in everyday practice, the American Psychiatric Association (APA) is in the process of revising the criteria for schizophrenia and related psychotic conditions in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

In this context, Drs. Bruijnzel and Tandon (see page 289) provide a detailed and enlightening glimpse into the deliberation of the APA’s workgroup on schizophrenia, as well as into the evolving concept of this disorder over the last century and a half. Notable and unresolved issues are the validity and reliability of the existing subtypes of schizophrenia and schizoaffective disorder. In addition, one proposal involves a greater emphasis on the psychopathological dimensions (nine are currently being field tested) that characterize schizophrenia. Here, the focus is on how they affect the illness course, treatment response, and overall prognosis.

There is also a greater focus on how these symptom dimensions may vary in prominence and severity across patients, as well as within a given patient, at different stages of the illness. Ultimately, the recognition and measurement of these dimensions may greatly enhance our therapeutic management of these patients.

Another major proposed change is to add the category Attenuated Psychosis Syndrome. The hope is that this will help clinicians identify psychosis earlier in its evolution, more readily monitor its progression, and intervene sooner when appropriate.

REFERENCE


about the guest editor

Dr. Janicak is a Professor of Psychiatry at Rush University in Chicago, IL; Medical Director of the Rush Psychiatric Clinical Research Center; and Distinguished Life Fellow in the American Psychiatric Association. He completed his medical training and psychiatric residency at Loyola University of Chicago in 1976. In 1978, he became a research psychiatrist at the Illinois State Psychiatric Institute. He was the Medical Director of the Psychiatric Clinical Research Center and the Associate Program Director for the NIH General Clinical Research Center at the University of Illinois Medical Center from 1994-2004.

Dr. Janicak’s primary research interests are the assessment and treatment of mood and psychotic disorders. He has conducted several relevant clinical trials, including repetitive transcranial magnetic stimulation for major depression. He has been an NIMH grant awardee as both a principal and co-investigator. He has authored, co-authored, or edited over 500 publications in the psychiatric literature and is first author of Principles and Practice of Psychopharmacotherapy, now in its fifth edition.

Dr. Janicak is the editor of the Psychopharm Review (formerly the International Drug Therapy Newsletter); serves on the Editorial Boards of Current Psychiatry, Psychiatric Annals, and Essential Psychopharmacology. He has also been a reviewer for several journals, including: The American Journal of Psychiatry, Archives of General Psychiatry, Biological Psychiatry, Journal of the American Medical Association, Journal of ECT, Journal of Clinical Psychiatry, Journal of Clinical Psychopharmacology, Psychiatric Annals, Psychiatry Research, and Schizophrenia Research. Dr. Janicak has been listed in the Best Doctors of America since 1996 and Who’s Who in America since 2002. Dr. Janicak was named Psychiatrist of the Year by NAMI Illinois for 2003. In 2009, he received the John M. Davis Researcher of the Year Award from NAMI of Greater Chicago. He has participated as a principal lecturer in over 500 courses, seminars, symposia and related professional presentations.