

Overlooked first-line treatments for schizophrenia

By Xavier Amador, PhD

Given the fact that approximately one-third of all persons with schizophrenia do not take their medicine within two years of starting it—or if they do, take only a small portion of it—we need to address this serious problem.

Poor adherence leads to relapse, years lost to psychosis, and other negative outcomes like criminalization of persons with mental illness. Compounding this tragedy is the fact that we have known for many years that long-acting treatments (LATs), such as long-acting injectable medications, are the treatment of choice for the majority of patients with the common problem of poor adherence to treatment. And yet LATs continue to be seriously underutilized.

My experience and the research have taught me an important lesson which influenced how I helped my

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brother and countless patients in my practice on the road to recovery. Simply put, LATs should be among the first-line treatments rather than a treatment of last resort, as they have been considered for far too long. They are offered only after

all other avenues have failed, but both the research and my experience tell me that the opposite should be true.

For patients like my late brother, who have long-standing problems with insight (50 percent of patients do not understand they have schizophrenia)—and for many others who have difficulty with partial adherence—LATs should be among the first-line treatments. In other words, they should be among the first medications offered to someone when first diagnosed with a psychotic disorder.

I have seen this strategy work time and again; it’s common sense when you think about it. Before my brother Henry agreed to the injections of prolixin, a long-acting first generation antipsychotic, he would typically promise that if he were released from the hospital he would continue to take his medicine. In fact, he did just what any of us would

have done if we believed we’d been “wrongfully” forced into a hospital (from my brother’s perspective, I was very much in the wrong for calling the crisis team) and treated for an illness we didn’t believe we had: We would tell the doctors and our worried family members what they wanted to hear—“I see now that I am sick and need to take the medicine.”

Nevertheless, having to be dishonest with loved ones who are pushing you to take medicine and allying themselves with the psychiatrists who are convinced you are “crazy” is a terrible and lonely predicament to be in.

Out of the Shadow

Before I learned how to listen to my brother, I was angry and felt betrayed whenever he reneged on his promise. But after learning what it was like for him to have to hide pills and lie, after hearing how humiliated and bad he felt about being dishonest, I wanted to find a way to avoid putting him in that predicament again.

A simple solution was to lay everything out on the table and not create a situation in which he would be tempted

to secretly stop taking the medicine. That is one of several reasons a LAT was so helpful to him. All he had to do was show up for an appointment every two weeks and meet with someone he liked. The brief prick of the needle twice a month was far less difficult for him than having to struggle three times a day with the conflict between loyalty to his family and his desire to stop taking the medicine. He wanted to please our mother and me because he knew how worried we were about him, but because his illness had convinced him nothing was wrong, he found himself caught between a rock and a hard place more than 90 times a month.

Now it was just twice a month, and we all knew whenever the conflict got the best of him and the “denial” won out.

Another similar case with which I am personally familiar involved Millie Smiley, who is the mother of Tina Koltuski and Susan Smiley, and the subject of Susan’s documentary film *Out of the Shadow* (OutoftheShadow.com). I was the consultant for the film and I am also a family friend.

Like my brother, Millie has a long history of schizophrenia and of hiding the fact that she is not taking her medicine. Once, while flying on an airplane

on her way to visit Susan, Millie went into the bathroom, poured out the contents of every one of her capsules of antipsychotic medication, then put the empty capsules back together and into the bottle. She did this because she knew her daughter would be checking to see if she was swallowing the pills. I can’t blame Millie for what she did; she didn’t think she was ill. I wouldn’t want to take medicine for an illness I didn’t believe I had either—would you?

As the film shows, Millie does wonderfully when she is taking her medication, but she relapses whenever she is able to avoid taking it. It was during her last relapse, when Susan and Tina were talking together with me about Millie’s treatment options, that I strongly encouraged them to get her on a LAT. In this instance, given her treatment history, I recommended risperidone. She had previously done well on the oral form of this drug and I felt that a long-acting injectable would give Millie the best chance of staying well and recovering more fully.

Susan and Tina were able to use their positive relationship with their mother to convince her to accept twice-monthly injections and, not surprisingly, since she has been on this form of medication, there has not been another relapse to my knowledge.

Among other positive benefits, Millie is no longer tempted to secretly stop taking her pills. Like my brother, Millie is now on a steady dose of medication and unable to act on her natural ambivalence without her doctor and family knowing about it. ★

Portions of this column will appear in the upcoming 10th anniversary edition of *I am Not Sick, I Don’t Need Help! How to help someone with mental illness accept treatment* (Vida Press, 2010).

Xavier Amador, PhD, (DrAmador.com) is an adjunct professor at Columbia University and the author of numerous scholarly and trade publications. Learn more about Dr. Amador’s LEAP approach at LEAPInstitute.org.



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