Understanding and Navigating the Complexities of Treatment in First Episode Psychosis

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Disclosures

The speaker has no commercial interests to disclose
Objectives

At the end of this presentation learners will

1. Understand the trajectory of symptoms prior to a “first-episode” presentation to mental health treatment services

2. Understand needs of first-episode patients and families and the clinical modifications of regular care that should be considered during an acute psychotic episode

3. Understand challenges of long-term treatment, especially adherence issues, for patients who have responded to initial treatment and are beginning long-term treatment for relapse prevention and recovery-oriented care

Questions about “first episode” psychosis

- What does it mean when you learn psychotic symptoms are there and this was not known beforehand?
- What does it mean if the person has major problems, seems odd, needs help, but does not report psychotic symptoms?
- What is “first-episode” psychosis? Is it the same as “first-episode” schizophrenia?
Begin with going backwards in time. Let’s start with someone with recently diagnosed schizophrenia and press the “rewind” button.

Kathryn is a 19-year-old college student originally from Eastern Europe living with her mother.

She was admitted to the inpatient unit after begging her mother to “Kill me please. I cannot take it anymore…everyone is reading my mind and knows I am a lesbian”. She is paranoid and admits also to auditory hallucinations.

No prior history of psychiatric treatment prior to a few months ago. Her mother took her to a PCP who diagnosed depression and prescribed an SSRI for anxiety which made her fears worse. Mother then took her to a psychiatrist after she stopped going to classes.
Physical examination and lab testing was WNL. The differential diagnosis included brief psychosis, schizophreniform disorder, major depression with psychotic features, bipolar disorder with mixed features and possibly PTSD.

She was discharged on 4mg of oral risperidone and her paranoid delusions seemed better.

The patient and mother are referred for continued outpatient treatment.

Clinical Characteristics of First Episode Psychosis

- By definition, the person has prominent psychotic symptoms
- No prior treatment history for a psychotic disorder*
- May have had treatment for other nonpsychotic disorders
- Usually psychotic symptoms have been there for some time
  - Psychosis is a LATE sign
  - Psychosis present for months if not years
  - Other non-psychotic symptoms predate conversion to psychosis, and often include social withdrawal, depression, and failure to keep up with developmental expectations
- Families are often actively involved but frightened and overwhelmed

* Does not include prior treatment exposure for depression, ADHD, etc
The family moved to the Chicago from Europe when Kathryn was 13 years old. The family lived in a middle-class suburb, and she did well in her high school studies. Although she had a good command of English, she did not socialize extensively after she was teased and ostracized by her Midwestern-born classmates for “looking different” and having a British accent. Her mother reported that she was social isolated and very anxious in new situations. She graduated high school and started a local college.
“First-Episode” Psychosis Conceptual Journey

Kathryn shows symptoms of social isolation, social anxiety, social withdrawal

- Initial problems and symptoms are common and often include social isolation, withdrawal, anxiety
- Most adolescents and young adults will NOT convert to psychosis or schizophrenia
- Not specific but indicates need for help
- Called “prodrome” only AFTER conversion

<table>
<thead>
<tr>
<th>Childhood</th>
<th>Puberty</th>
<th>Young Adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Normal”</td>
<td>Any symptom</td>
<td></td>
</tr>
</tbody>
</table>

After her first semester, she started to withdraw from her family and spent hours in her room on the internet. She began to neglect her studies and refused to respond to expressions of concern from her family. Soon she began to stay home during her class days and lock herself into her room. She started to refuse to leave the house, saying that her neighbors “accused her of being a lesbian”. Her family brought her to a counselor for psychotherapy for sexual identity problems, and her pediatrician started an SSRI for depression.
A Word about Attenuated Risk Syndrome (ARS) and DSM5

- Specialty research programs have identified and characterized young people deemed to be at higher risk for eventually converting to a diagnosis of schizophrenia.
- These high risk individuals are sometimes called “ARMS” (at risk mental states”) or “UHR” (ultra high risk).
- About 80% of the highest risk patients DO NOT convert to schizophrenia.
- These individuals need help but NOT antipsychotics.
- Studies of ARMS/UHR have been done to see if antipsychotics can delay or prevent conversion. **ANTIPSYCHOTICS DO NOT PREVENT CONVERSION!!!**
- DSM5 considered adding Attenuated Risk Syndrome (ARS) but this was rejected and probably was a very bad idea.

<table>
<thead>
<tr>
<th>“normal”</th>
<th>any symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>childhood</td>
<td>puberty</td>
</tr>
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</table>

Understanding Antecedents to “First-Episode” Psychosis

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precursor Signs and Symptoms</td>
<td>Signs and symptoms from a diagnostic cluster but are not specific nor do they predict future diagnosis with certainty</td>
<td>Many of these signs are overlap with other disorders, such as Depression, Alcohol or drug use, OCD</td>
</tr>
<tr>
<td>“Prodromal” Period</td>
<td>Period prior to meeting the full-blown criteria of disorder (schizophrenia), but some signs and symptoms have begun</td>
<td>Can only be defined retrospectively, after the diagnosis is confirmed. Prodrome “ends” when psychotic symptoms begin</td>
</tr>
<tr>
<td>Attenuated Psychosis Syndrome (“At Risk” or “Ultra High Risk”)</td>
<td>Individuals who have signs and symptoms falling short of overt psychosis who are at high risk of “converting”</td>
<td>Earlier studies showed ~ 30% conversion but later studies much lower conversion (~10%). Proposed for DSM-5. VERY CONTROVERSIAL</td>
</tr>
</tbody>
</table>
“First-Episode” Psychosis Conceptual Journey

- At some point, psychotic symptoms start
- This is always serious but the person often resists help
- Period of crisis and uncertainty for family

The psychiatrist told mother that Kathryn had paranoid symptoms and recommended an antipsychotic, which Kathryn refused. The psychiatrist recommended hospitalization but mother was ambivalent, but the situation worsened and mother brought Kathryn to ER for admission after Kathryn asked to be killed.
“First-Episode” Psychosis Conceptual Journey

- Sentinel events forces treatment intervention
- Often a period of chaos and crisis
- Often treatment is unwanted by individual

Asks mother to kill her

“normal” | any symptom
---|---
childhood | puberty | young adulthood

After “Conversion” to Psychosis

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of Untreated Psychosis (DUP)</td>
<td>Time from first discernable psychotic symptom until initial presentation</td>
<td>✓ History often unreliable &lt;br&gt; ✓ Shorter DUPs associated with a more favorable outcome</td>
</tr>
<tr>
<td>“First-episode” psychosis</td>
<td>Psychotic symptoms established but diagnosis is not clear</td>
<td>✓ diagnostic uncertainty is rule, not exception &lt;br&gt; ✓ Most common diagnostic dilemmas are substance-induced psychosis and bipolar disorder &lt;br&gt; ✓ Catchall “psychosis NOS” diagnosis</td>
</tr>
<tr>
<td>“First-episode” schizophrenia</td>
<td>After a diagnosis is reached with reasonable confidence. No consensus definition but most studies anchor the definition to initial treatment exposure</td>
<td>✓ Usually patient has been symptomatic for &gt; 1 year &lt;br&gt; ✓ Perhaps more accurate to name this “first-presentation” schizophrenia</td>
</tr>
</tbody>
</table>
Reported Mean Duration of Untreated Psychosis

Time to Remission by Prior Duration of Psychosis

Lieberman JA et al. Neuropsychopharmacology. 1996;14:13S-21S.
Summary of Before the Initial Presentation

- Do not prescribe antipsychotics UNLESS psychotic symptoms are established already; antipsychotic do NOT prevent “conversion”
- Psychotic symptoms are often a LATE sign, especially for patients who will be diagnosed with schizophrenia
- Presence of psychotic symptoms narrows the differential diagnosis, but expect diagnostic uncertainty
  - Presence of drugs, alcohol or affective symptoms does NOT rule out schizophrenia
  - Presence of bizarre delusions or hallucinations does automatically mean a diagnosis of schizophrenia
- “first-episode” schizophrenia really means “first presentation” because problems have been there for quite awhile

How do we manage the initial psychotic episode once the person comes to our attention?
Special Needs of “First-Episode” Patients and their Families

- First encounters with mental health clinicians occur during crisis when person and family most vulnerable
- Little in the way of past experience with mental health services
- Payment and insurance problems usually more challenging than a comparable catastrophic medical event
- Shame and stigma
- Many of the side effects of medication are distressing and visible to others
- Difficulty attributing improvement with medication
- Uncertainty of diagnosis and prognosis

Square Peg into a Round Hole: Systems problems with treating first-episode patients and families

Most treatment services are calibrated for more persistently ill patients and have trouble adapting for first episode patients and families
- Families more demanding, need more time and TLC
- Psychoeducation may be oriented to more chronic patients
- Medication choices and dosages (including PRNs) are set for patients who have been ill for years
- Mental health clinicians may not have specific training on adapting treatments to these circumstances
First Encounters of the Treatment Kind: Patient Perspectives

At the time of initial presentation, the person
• May have been ill for quite some time
• Is angry and fearful
• Is overwhelmed and traumatized
• May not acknowledge any problem
• May be unable to recognize medication benefits even if a problem is acknowledged

First Encounters of the Treatment Kind: Clinician Perspectives

At the time of initial presentation, the clinical team
• Has to deal with an immediate crisis
• May have a treatment routine based on chronic patients
• May not be flexible for needs of first-episode patients
• May have to contend with an overwhelmed family
• May have to contend with a family frustrated or angry at mental health system
• Has to consider long-term recommendations despite diagnostic uncertainty
Psychosocial Treatment Needs of First Episode Patients

- Psychoeducation focused on understanding the experiences as an illness
- Provision of a model for understanding causes
  - stress-diathesis is useful
- Support in avoiding rapid return to pre-illness stressful activities
- Family psychoeducation
- Development of coping strategies to deal with stress and symptoms
- Support of continued need for medication

During First-episode presentation

- “First – episode” refers to clinical vantagepoint; most first-episode patients are already persistently ill
- Time of crisis and stress for patients and families
- Uncertainty is an important factor
- Clinician sensitivity to time of crisis is important
- Aim for excellent acute response, do not accept partial response without aggressive treatment plan
- Consider sensitivity to dose and adverse effects as part of the treatment plan
**Clinical Outcomes for Antipsychotic Therapy in First-Episode Period**

- Good to excellent response to antipsychotic medications
- Antipsychotic doses often lower than for more persistently ill patients
- Much greater vulnerability to adverse effects of antipsychotic medication

**Roadmap Survey Results**

**Treatment of “First-Episode” Schizophrenia**

- Recommendations for patients in the early phases of their recognized illness
  - At initial treatment of acute psychotic episode
    - Medication choice, target dose, titration
  - “First-episode” patients without adequate response
  - When complicated by persistent noncompliance or substance abuse
Initial dose and titration schedule for a 1st-episode patient with no complicating conditions affecting dosing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Usual starting dose (mg/day)</th>
<th>Interval between dose increases</th>
<th>Usual dose increment</th>
<th>Usual initial target dose range (mg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Avg (range)</td>
<td></td>
<td>Avg</td>
<td>Low (range)</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>10 5–15</td>
<td>1 week</td>
<td>5 (or 10 mg)</td>
<td>10 5–15</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>10 5–15</td>
<td>1 week</td>
<td>5 mg</td>
<td>10 7.5–12.5</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>150 50–250</td>
<td>3 days</td>
<td>150 mg</td>
<td>300 wide range</td>
</tr>
<tr>
<td>(but wide range)</td>
<td></td>
<td>(but wide range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>1.5 1–2</td>
<td>1 week</td>
<td>1.5 mg</td>
<td>2 1–3</td>
</tr>
<tr>
<td>(but wide range)</td>
<td></td>
<td>(but wide range)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>60 40–100</td>
<td>4 days</td>
<td>40 or 60 mg</td>
<td>100 60–140</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>3 1–4</td>
<td>1 week</td>
<td>2–4 mg</td>
<td>5 2–8</td>
</tr>
</tbody>
</table>

*Results converted to “real world doses”


Cumulative Recovery Rates in First Episode Schizophrenia

Robinson et al AmJPsychiatry 2004
**Remission Rate**

- **Definition of remission:** response for 4 consecutive weeks
- **Definition of response:** no ratings >3 (mild) on PANSS items P1, P2, P3, P5, and P6; and CGI severity ≤4

<table>
<thead>
<tr>
<th>Weeks on treatment</th>
<th>HAL*</th>
<th>OLZ*</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>60%</td>
<td>65%</td>
</tr>
<tr>
<td>104</td>
<td>80%</td>
<td>85%</td>
</tr>
</tbody>
</table>

- \( p = .11 \)
- \( p = .08 \)

*HAL: haloperidol*
**OLZ: olanzapine**


How do we manage the person once a diagnosis of schizophrenia has been established (or is likely)
The patient and mother are referred for continued outpatient treatment.

She is referred to a day program but refuses after the first day, saying the others are “really sick people” and “I’m not one of them”.

She and her mother show up for the first follow-up appointment with you.

Kathryn says she is taking her medication but asks you when she can get off the medication.

Now what?

**Evidence Treatment Outcomes from Multi-element Programs**

- **OPUS trial (2005) from the Netherlands**
  - 2 years of integrated treatment vs TAU
  - Improved adherence, reduced symptoms
  - Improved outcome, reduced suicide

- **LEO trial (2004) from the United Kingdom**
  - Results at 18 months
  - Reduced relapse
  - Improved adherence, QOL, user satisfaction, social relationships

- The United States does not fund specialty first-episode programs so this is not available for Kathryn
After Schizophrenia is Diagnosed
The implication of a formal diagnosis of schizophrenia is:
1. Maintenance medication needed for relapse prevention
2. Recovery is likely to be slower
3. Prognosis is going to be unpredictable
4. Patient and family need to prepare for “long haul”

What do patients want?

- When can I stop my medication?
- When do I stop seeing you?
- Will I be normal?
- When do I get my life back?
What do families ask?

- What is wrong?
- Will it get better?
- Is it my fault?
- Can my child go back to...school, work, have a job, get married, have kids...
- What does this diagnosis mean?
- How long are medications needed?

“Natural History” of Schizophrenia is Debated

- Premorbid
- Prodromal
- Onset/ Deterioration
- Chronic/Residual

Gestation/Birth 10 20 30 40 50
Puberty
Years
What is Clinical Trajectory Mean?  
Debate is over 100 years old

Progressive Degenerative Disease

Neurodevelopmental Disorder

Emil Kraepelin

Eugen Bleuler


Disease Models and Treatment Planning
CVA vs Alzheimer’s Disease

<table>
<thead>
<tr>
<th></th>
<th>CVA (stroke)</th>
<th>Alzheimer’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNS Reversible?</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>CNS Progression?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Progression of clinical symptoms?</td>
<td>Expected</td>
<td>Good outcome</td>
</tr>
<tr>
<td>Long-term symptom improvement?</td>
<td>Good outcome</td>
<td>Not expected</td>
</tr>
<tr>
<td>Full recovery to premorbid level?</td>
<td>Uncommon but possible</td>
<td>Never</td>
</tr>
</tbody>
</table>

What about ongoing antipsychotic medication for the long-term treatment after the initial psychotic episode gets better?

After Initial Response: The Road to Recovery

After treatment of acute psychotic episode and initial diagnosis

- Attribution of response
- High rates of side effects, including behavioral toxicities
- High rates of post-psychotic depression and high suicide risk
- Patterns of “revolving door” begin
- Patterns of persistent negative symptoms begin
**Risk of Relapse Following Recovery in First-Episode Patients**

Relapse risk is 5 times higher after a first-episode patient stops antipsychotic medication.

Relapse risk is highest in the first year after recovery from the first episode.

**Stopping Medication Is the Most Powerful Predictor of First-Episode Relapse**

What can improve adherence or lower relapse risk?
Are the newer medications helpful?
What about long-acting antipsychotics?

**Oral Risperidone More Effective Than Oral Haloperidol for Relapse Prevention After the First Acute Episode**

Days from response to relapse

% Remaining stable since initial episode

Oral risperidone

Oral haloperidol


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**European First-Episode Schizophrenia Trial (EUFEST)**

- Randomised, 1-year, pragmatic trial
  - Haloperidol, amisulpride, olanzapine, quetiapine, ziprasidone

- 498 patients with:
  - Schizophrenia (53%)
  - Schizheniform disorder (40%)
  - Schizoaffective disorder (7%)

- Primary outcome measure: all-cause treatment discontinuation

- Secondary outcome measures: PANSS, CGI, GAF, CDSS, MANSA, adherence

Pharmacologic Approaches to Improve Adherence in First-Episode Schizophrenia

- Antipsychotic class
  - Conventional antipsychotic
  - First-line atypical antipsychotic
  - Clozapine
- Route of medication delivery
  - Long-acting depot conventional antipsychotic
  - Long-acting depot atypical antipsychotic
Time Until Medication Discontinuation
Olanzapine vs Haloperidol After First-Episode

Strata: Therapy=HAL
      Therapy=OLZ
HAL median time to dropout=118 days
OLZ median time to dropout=229 days, p=.004


Possible Advantages of Initiating Long-Acting Antipsychotics for First-episode Patients
Starting Maintenance Treatment

- Directly improving adherence when
  - Nonadherence is caused by disorganization or cognitive symptoms
  - When motivation for adherence is based on relationship with family or clinician
  - Bypassing intermittent medication gaps due to substance or alcohol misuse, prescriptions running out, etc
- More effective tracking of adherence status
  - Eliminates guessing about compliance status
  - “Alarm clock” – alerts clinician when nonadherence starts
  - Helps disentangle reasons for poor response
PREvent First Episode Relapse study (PREFER)

- Randomized clinical trial
- After first-episode patients were stabilized, patients randomized to recommendation of:
  - Long-acting injection with risperidone microspheres (RLAI)
  - Continue with oral atypical antipsychotic regimen (ORAL)
- Single treatment site (Kings County Hospital Center in Brooklyn, New York)
- Enrollment between 2004-2007; follow-up through 2008


Key Aspects of PREFER Design (I)

- Both clinician and patient are randomized
- Recommendation delivered by clinician to patient and family over 2 sessions
- Randomization assignment continued throughout follow-up, so randomization continued for patients restarting antipsychotic medication after a medication gap
- Patients assigned to ORAL would continue with oral antipsychotic but could change medications as per patient and clinician judgment
Time until Initial Onset of Nonadherence

**Whole cohort 104 weeks**

<table>
<thead>
<tr>
<th>Weeks after treatment onset</th>
<th>Estimated</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>0.0</td>
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</tbody>
</table>

Ci, confidence interval


Oral vs. RLAI Time until Initial Nonadherence: Actual Treatment

Fifteen of 19 subjects (79%) reached a gap event in the RLAI group, compared with 15 of 18 (83%) in the ORAL group (Fisher exact test \( p = 1.000 \)).

Median time to gap event was 42 weeks (95% CI [10, 56]) in the RLAI group, 12 weeks (95% CI [2.0, 45]) in the ORAL group (log-rank test chi-square=1.73, \( df=1, p=0.188 \)).
What else can we do to improve the likelihood of a recovery-oriented trajectory?

Basic life management
- No cannabis or other drugs
- Keep attending school and work
- Connect with others
- Share thoughts and beliefs with others when safe and get feedback
- Avoid physical and sexual abuse
- Deal adequately with emotional stress
Importance of the Therapeutic Relationship

Doctor-patient relationship most salient reason for adherence in first-episode not multi-episode patients

Use a Developmental Model and Expect Nonadherence
Rather than “Stop” it, go “harm reduction”
Nonadherence as a Method of Control and Communication


Risk Factor Domains for Nonadherence Aka “The Laundry List”

Categorize Nonadherence Risk Factors in a Clinically Useful Way

- Can not adhere
- System not adhering
- Will not adhere

How Does Adherence Influence Outcome? (1)

Direct effects
- Greatly increases odds of relapse
  - 11% per month vs. 3% month
- Associated with increased symptoms
- Increased risk of suicidal or threatening behaviors

How Does Adherence Influence Outcome? (2)

Indirect effects can damaging

- May result in wrong medication, inadvertent overmedication, or too many medications prescribed
- Tension between clinician and patient over “obedience” can hurt the therapeutic relationship


Problems with Current Approaches to Adherence Interventions

- “overselling” of medication benefits
- Minimizing risks of medication
- Use of fear tactics “every relapse leads to brain damage”
- Reliance on “education” without sufficient understanding of individual’s perspectives
- Trying to “stop” or “prevent” nonadherence
- Linking medication adherence to a diagnostic model of illness
**Strengths of a CBT Platform to Address Medication Adherence for Patients who Do Not Agree with Diagnosis**

CBT focuses on personal goals and distressing symptoms rather than insisting on acceptance of a diagnostic label.

A CBT approach may, therefore help the person patient accept and continue medication without forcing him/her to stop medication and to reject the diagnostic label.


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**Integrating Medication Adherence in Dialogue**

- Medications are going to be recommended
- The person needs to decide what to make of these recommendations
- Often the person’s feelings and opinions about medication are ignored or misunderstood
- Difficult for patient to find a safe place to discuss his or her beliefs and perspectives
Approach to Adherence (1)

- Emphasize HEALTH over ILLNESS
- Emphasize ALLIANCE and ENGAGEMENT over COMPLIANCE
- Emphasize role of medication (and adherence) in achieving (or interfering with) goals

Approach to Adherence (2)

- Do not focus exclusively on “better” adherence as an outcome
  - Delay not prevent nonadherence
  - “harm reduction” with medication discontinuation
  - Prevent “hardening” of attitudes against medication
When the Person Discloses Current or Intended Nonadherence

Areas to cover

- Encourage “harm reduction” approach
- Support the positive and healthy reasons for decision
- Discuss what to tell treatment team and family
  - Honesty or concealment
- Suggest behavioral experiment with slow dose reduction
- Review alternatives if problems happen during discontinuation
Preliminary Results
HDI N=16

• Reasons for Adherence
  ▪ Symptom reduction 78%
  ▪ Help achieve goals 64%
  ▪ Relapse prevention 57%
  ▪ Doctor and/or family want me to 21%

• Reasons for Nonadherence
  ▪ Side effects - physical 64%
  ▪ Stigma 57%
  ▪ Side effects - emotional 50%
  ▪ Prevents achieving goals 36%
  ▪ I don’t need meds 21%

HDI Case Example

<table>
<thead>
<tr>
<th>Pros – Influences for Medication Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life goals – Pt believes that medications can help him achieve his goals of living independently, having steady employment, and finding a girlfriend.</td>
</tr>
<tr>
<td>Current illness belief status – Pt acknowledges that he has psychiatric problems.</td>
</tr>
<tr>
<td>Self-image – Pt views taking medications as consistent with him having a psychiatric illness.</td>
</tr>
<tr>
<td>Social network/Community – Pt’s mother actively supports him taking medications and will coerce him if he does not, e.g., not give him money for gas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cons – Influences for Medication Nonadherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention – Pt does not fear relapse.</td>
</tr>
<tr>
<td>Side effects – Pt is unhappy with current medications due to significantly distressing side effects, which he experiences as greater compared to previously taken meds. He describes the following: &quot;I can’t think. It’s like I have a blanket over my head, my brain.&quot; “It makes me stand still. It keeps me from moving towards goals.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conflicted statements – Influences for both, Medication Adherence and Nonadherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom relief – Pt believes that he still has some relief from symptoms due to taking antipsychotic meds, but he also thinks that the effects of the medication may have worn off.</td>
</tr>
<tr>
<td>Current illness belief status – Pt is not sure whether or not antipsychotic medications are still required as part of his treatment.</td>
</tr>
<tr>
<td>Stigma – Pt does not feel stigmatized by his friends for taking meds. &quot;All my friends are junkies, so they just look at the meds as another drug.&quot; However, pt does feel that his parents look at him differently for taking medications. Specifically, he believes that &quot;They think they can take their problems out on me because I have meds to help me deal with it.”</td>
</tr>
</tbody>
</table>
Conclusion

• Medication adherence is an important mediator of long-term outcome, especially relapse prevention
• Most direct adherence interventions are not effective and probably trigger nonadherence in some individuals
• Revisiting this issue may be an opportunity to improve the overall effectiveness of CBTp
• We think it is possible to integrate adherence without compromising core CBT values