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Personalizing Care Plans for Schizophrenia Patients: Key Factors to Consider

Ms. Baker:
Welcome to *NeuroFrontiers* on ReachMD. I'm psychiatric nurse practitioner Ashley Baker, and joining me today to share strategies for creating individualized treatment plans for patients with schizophrenia are Dr. Rakesh Jain and Ms. Desiree Matthews. Dr. Jain is a Clinical Professor in the Department of Psychiatry at Texas Tech University School of Medicine in Permian Basin, Texas. Dr. Jain, thanks for being here today.

Dr. Jain:
Oh, it's my pleasure, Ashley, and please call me Rakesh.

Ms. Baker:
And Desiree is a board-certified psychiatric nurse practitioner and the Clinical Director of Different MHP in Charlotte, North Carolina. Desiree, it's great to have you with us.

Ms. Matthews:
Thank you.

Ms. Baker:
To start us off, Desiree, can you tell us about the treatment options available for schizophrenia and why it's so important to tailor our approach to each patient?

Ms. Matthews:
Yeah, that's a great question, Ashley. I think we can all recognize that schizophrenia is a complex disorder with complex neurobiology. Schizophrenia is not just positive symptoms that we think of and garner so much of our attention, like hallucinations and delusions, but we also see oftentimes pervasive negative symptoms like anhedonia and cognitive dysfunction in many of our individuals living with schizophrenia, not to mention persistent mood symptoms like depression in about 1/3 of our individuals living with schizophrenia, even with stable schizophrenia, not to mention the cardiometabolic liabilities that these individuals live with. And oftentimes, it can be a result of our treatment that we're using.

We know that our current strategies for treating schizophrenia involve blocking D2, or dopamine, receptors postsynaptically. However, we know that the problem is actually presynaptically, in which we have too much dopamine release into the striatum, and this solution really has been the mainstay of our treatment, blocking D2 for over 70 years, and we know that not all individuals can either tolerate these medications because of the side effects and then some patients actually don't respond well or they have inadequate response to our current treatment. So this really leaves us with frustration, both on the patients and as well as on the clinicians. When we're really trying to incorporate strategies, we don't often have a lot to choose from. Certainly, we have our first-generation antipsychotics, and now we have second-generation antipsychotics that have some serotonin modulation, and we have partial agonism at the dopamine receptor. But all in all, blocking D2 postsynaptically has been the solution for a presynaptic excess dopamine release problem in these individuals.

Ms. Baker:
With that in mind, let's turn to you, Rakesh, and focus on how we can create individualized treatment plans. How do you assess and incorporate patient-specific factors such as symptom severity into your plan?

Dr. Jain:
Yeah, that's a great question, and perhaps we can take a step back and make sure we don't make the mistake of thinking that the treatment of schizophrenia is medications only. It's not. It's a much bigger plan, right? So just for a moment, think if schizophrenia were to arrive in your family, what would you want? Most likely what you'd be seeking is an understanding of the disease. So psychoeducation. Most likely you would need a safety plan. Most likely you would need social and vocational help, and that is as important as pharmacotherapy.

So your question about individualized plan is such a good one because if you met one person with schizophrenia, you have met just one type of schizophrenia; it looks very different in different people. Desiree's point was very exceptional, that the commonalities are positive symptoms, negative symptoms, and cognitive symptoms, at the very least, with sometimes even more difficulties.

And perhaps I might add this: you don't want to just think about the patient's brain; you want to think about the patient's body. They cannot be divorced. So when you create an individualized plan, you think about, what symptoms am I going after? What is the most effective treatment I have available? How do I combine it with nonpharmacological treatments? And how can I induce the very least damage in the body, such as metabolics or weight gain, or perhaps reducing the risk of movement difficulties or reducing the risk of target dyskinesia? So it's a pretty holistic plan. As a result, there isn't one correct treatment for all patients. It really is the best potential first-line treatment for the patient. And then, of course, you go step by step if that doesn't work, and you move the patient further up in the chain of treatment options.

Ms. Baker:
Rakesh, as a quick follow-up to that, how do comorbid conditions impact treatment planning in your approach?

Dr. Jain:
Enormously so. So comorbidities could be flavored in two-fashion. So one would be comorbidities of the psychiatric nature. So what if I have a patient who has the comorbidity of schizophrenia with a primary sleep difficulty, an anxiety disorder, or a depressive disorder? Depression absolutely can happen in someone with schizophrenia. But also the comorbidity of the body, what if the patient has diabetes and hypertension and obesity, what do you do then?

And how does it factor? Well, because we have so many different treatment options that have their own individualized profiles, you do your very best to obviously follow the rule of maximum benefit with least harm. Now as Desiree mentioned earlier, there might be ways to even think outside of dopamine D2 blockade. In time, that is expected to happen that radically improves the treatment options available, either as monotherapy or as combination therapy.

Ms. Baker:
And if we come back to you, Desiree, and look at one more factor, what strategies do you use to evaluate a therapy's side effect profile?

Ms. Matthews:
So when it comes to assessing the strategies for our treatment intervention and the potential for side effects, we have to kind of remember that our medications for schizophrenia at this point in time that block D2 postsynaptically, they can come with a common host of problems, like metabolic dysfunction. We can see problems with prolactin elevations. We can see movement disorders. So there's really a variety of ways for us to potentially assess for these side effects.

So I think first and foremost, clinically, getting a good baseline set of labs on our individuals to monitor for their CBC, glucose, lipid panels, and assessing for movement disorders. This is so very important, whether you're on maybe first-generation antipsychotics or second, to assess for movement disorders in these individuals. So tardive dyskinesia, for instance, we can use the AIM Scale to monitor and screen for this. We have drug-induced Parkinsonism, dystonia, and akathisia; all of these include both a clinical observation as well as really asking our patients about potential side effects. Now I love scales and screeners in my clinical practice, so you know there are a number in addition to the AIMS; there's also the Glasgow Antipsychotic Effect Scale that you can actually use as a patient-reported experience of side effects.

What's really important with side effects is that each individual may have a different threshold, right? Some people can gain a little bit of weight from medication, and they're okay with that. In other individuals, this is a dealbreaker, and they will stop treatment. So it's really important to understand and ask patients about their perception of the side effects, how distressing it is to them, and then we can go ahead and make changes based on their perceptions and how they feel about their medication. Messing with their cognition or their sexual functioning, many of these are dealbreakers for our patients, and it's important for us to recognize that these individuals will vote with their feet, so to speak, and stop treatment. So it's really important for us to check in with them often at every visit about potential side effects.

Ms. Baker:
Thank you. For those just joining us, this is *NeuroFrontiers* on ReachMD. I'm psychiatric nurse practitioner Ashley Baker, and I'm speaking with Dr. Rakesh Jain and psychiatric nurse practitioner Ms. Desiree Matthews about the factors they consider when creating individualized treatment plans for patients with schizophrenia.

Now, Desiree, it's clear from our discussion that there are a lot of factors to consider when developing a personalized treatment approach, but as we near the end of our program, I'm curious to know how you balance all that with the patient's priorities and goals.

Ms. Matthews:
Yes, Ashley, I would say this is walking a tight rope between both efficacy as well as the tolerability and the safety of treatment. When it comes to schizophrenia, as Rakesh mentioned, adherence can be a big concern, and it is for many of our patients. So relapse prevention, for me, is very key when I'm talking to my patients about their treatment of schizophrenia. And it's not just the patient; it's the family, it's the caregivers, it's the loved ones. How can we prevent a relapse of schizophrenia? And that's keeping them on treatment. And hopefully treatment that they agree with and they can tolerate.

And again, tolerability, for the most part, is really in the eye of the beholder: the person actually taking that treatment. Of course, we do put up safety guardrails, so if there is significant weight gain or we're seeing issues with glucose, lipids, and this is becoming kind of in, I would say, the yellow and red zone where this may become a problem, then certainly we may need to switch treatments. But ultimately, the patient is going to let me know whether they're tolerating the medication or not if we actually talk to them. So really touching base every single time and understanding that just because maybe an individual was doing well on medication you know 6 months ago, we could see development of side effects that may become untolerable.

Maybe they're trying to go back to school. Maybe they want to get back into the workplace. They feel slowed down from their medication. They're feeling sedated. They're feeling like a zombie. These are many symptoms that my patients, when they do want to reintegrate and start back recovering truly from their schizophrenia, that may become a problem. Or say they want to start dating or get married or have children, some of the medication side effects that weren't a problem before can become a problem.

So checking in with the individual and the family each and every time that we see them is really important to make sure that my priorities of relapse prevention are aligned with their own goals.

Ms. Baker:
Thanks, Desiree. And now I'll turn to you, Rakesh, for the final word. Any closing comments on how we can optimize our approach and create individualized treatment plans for our patients with schizophrenia?

Dr. Jain:
Sure, all I will do is I will underline all that Desiree just shared. That was a masterclass in how to acutely manage our patients, chronically manage our patients, to do it as a prescriber, but also do it as a human being whose heart literally bleeds for these poor patients. It's not very difficult when you keep in mind two things: the patient has a brain and a body. Don't forget either. This next thing to remember in treating schizophrenia is don't just focus on the positive symptoms being broad. And perhaps the third thing to remember is keep your mind very open. We've had this dopamine hypothesis at play for the last, what is it, 70-some years, but it's not the final word. So stay tuned. The developments in the world of schizophrenia are happening fast and furious, and I can't help but feel quite optimistic about the future of the treatment of patients who are afflicted with schizophrenia.

Ms. Baker:
That's a great way to round out our discussion on the subject. And I want to thank my guests, Dr. Rakesh Jain and Ms. Desiree Matthews, for joining me to discuss the importance of individualized treatment plans in schizophrenia. Rakesh, Desiree, it was great having you both on the program.

Dr. Jain:
And it was good to talk with both of you. Thank you.

Ms. Matthews:
Thank you.

Ms. Baker:
For ReachMD, I'm psychiatric nurse practitioner Ashley Baker. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.