Peter Weiden, MD, is Professor of Psychiatry at the SUNY Downstate Medical Center in Brooklyn, New York. A senior clinical editor for Advanced Studies in Medicine (ASiM) interviewed Dr Weiden regarding the differences between a maintenance approach and a recovery approach in psychiatric care and the advantages and disadvantages of each for the practicing clinician.

ASiM: You have written about how the underlying treatment philosophy is a major factor in influencing medication decisions. Please explain.

Dr Weiden: First, let’s narrow our focus to patients that have already achieved a reasonable level of clinical stability, but at the same time are likely to remain symptomatic or impaired to a greater or lesser extent. I think there are 2 kinds of underlying treatment philosophies that clinicians use when working with this type of patient. One is a “maintenance” philosophy and the other is a “recovery” philosophy. A maintenance approach is focused on preventing relapse or other kinds of disasters, such as suicide. The underlying assumption of the maintenance philosophy is “schizophrenia is a devastating illness and achieving stability is a major achievement.” However, once stable, it becomes difficult if not impossible to achieve further gains in functioning. Therefore, patients should not be “pushed” to go beyond their capacity, and families should be advised to limit their expectations and not expect too much in the way of further improvement. Our main goal is to maintain the gains that have gone into achieving stability.

In contrast to the maintenance philosophy there is what is called a recovery philosophy. Although both philosophies share the belief that stability is a cornerstone of treatment, a recovery philosophy assumes that stability is a beginning not an end. Once stability is achieved, there should be continued effort on the part of the doctor, the patient, and the family to keep working at moving away from symptoms, limitations, and disabilities, and moving toward health and their life goals. One way to communicate this philosophy to patients is to say that “our goal is to get you a real life.” However, clinicians need to keep in mind that the recovery approach does not imply a cure, but a continued movement toward recovery.

ASiM: How can you tell if the clinician is using a recovery or a maintenance approach?

Dr Weiden: One method is by understanding the frame of reference to which the doctor calibrates the patient’s progress. In general, someone using the maintenance approach will compare his or her patient to other symptomatic schizophrenia patients. For example, when the doctor says that patient is doing well despite the patient exhibiting obvious negative symptoms, that doctor is calibrating his or her patient to the universe of patients with schizophrenia. Whereas, probably the doctor using a recovery approach will calibrate to normal, with normal being defined as what that person would be or would be doing without schizophrenia. The same patient—stable but with prominent or persistent negative symptoms—would not be seen as “doing well” by a recovery-oriented clinician.
ASiM: What are the advantages and disadvantages of each approach and the implications for the practicing clinician?

Dr Weiden: Depending on the patient, both approaches can be useful. They each have advantages and disadvantages. Let’s start with the advantages of a maintenance approach. It is true that if you keep pushing patients toward recovery, you will sometimes push the patient too hard and there will be setbacks. Thus, there are times when a maintenance approach would avoid a symptom exacerbation or relapse that would otherwise occur when using a recovery approach. Another advantage of a maintenance model is that it is less stressful for the patient, and is less time-consuming for the clinician than a recovery approach. For example, if you have a patient who is stable yet has persistent negative or cognitive symptoms, it is a lot more work to switch the patient’s medicine to something else in the hopes of offering more symptom relief than just keeping the status quo. Another advantage of the maintenance model is that it is less likely to disappoint patients and families in terms of overpromising. If I set the goal as “getting your life back,” it will be disappointing when this is not achieved. It helps the patient and family accept limitations related to the illness.

The disadvantages of a maintenance approach are almost the mirror image of its advantages. For example, lowering expectations can lead to a kind of self-fulfilling prophecy—if you expect nothing of someone then nothing will happen. Even when it may be “realistic,” a maintenance philosophy can be very demoralizing for many patients. Patients will not accept the idea that they will never get better beyond a certain point. From the patient’s perspective, he or she is left with a no-win dilemma. The patient has rejected treatment completely or accepts a treatment that is experienced to be depressing or stigmatizing. There is a cost in terms of the therapeutic alliance for some patients who reject this model and want more from their lives.

Finally, I think that the maintenance philosophy is quite unhealthy for clinicians working with severely ill patients. It tends to breed our own sense of hopelessness and cynicism and can make it harder for us to experience our patients as individuals who can do better in their lives. Ultimately, this loss of enthusiasm for our work and empathy is bad for us because it leads to devaluing our own sense of purpose and joy in what we do every day.

From my point of view, a recovery model is to be preferred whenever possible. In my opinion, there are many patients that are languishing in a maintenance model approach who would thrive in a recovery model. Today, the availability of the newer antipsychotic medications makes recovery much more attainable in clinical practice. The newer medicines offer much more in terms of treating symptoms, managing side effects, and providing an opportunity for recovery. The prognosis for schizophrenia is better than we ever thought.

ASiM: What is the best way to evaluate the effectiveness of a particular antipsychotic medication for this patient population?

Dr Weiden: A useful way of evaluating the efficacy of an antipsychotic medication is to divide the symptoms into several different domains: psychotic symptoms, negative symptoms, cognitive symptoms, and affective/depressive symptoms. Realizing that it is unlikely that you are going to get full remission, especially with cognitive and negative symptoms, you need to ask, what is the relative degree of wellness that I can get with this medication? How close to recovery can I get with this medicine? You also need to address safety side effects, including extrapyramidal symptoms (EPS), weight gain, metabolic issues, sedation, and anticholinergic effects. When making the decision as to which medication to use or when to switch medications, it is helpful to consider the relative degrees of wellness and then fitting the medication in a way that best meets the needs of the patient.

ASiM: How often should clinicians do a “treatment review” to evaluate the success of their current regimen?

Dr Weiden: That’s a very good question. The first step is to remind yourself to do a treatment review in the first place. It is quite easy to have one session just sort of meld into the next. It is so easy to forget to ask yourself, “where are we now; where are we going?” This is really important because the movement of symptom change or progress is measured in months, if not years. I recommend reassessing where we are and where we are going approximately every 3 to 6 months. Obviously, reassessment is more frequent for patients who aren’t doing well, who are suicidal, or who are relapsing.

ASiM: In your experience, do you find that many patients with chronic psychiatric illness, such as schizophrenia, experience persistent ongoing symptoms?
**Dr Weiden:** The answer is that most patients do have ongoing symptoms, and then the question becomes, what are we going to do about it? How do we evaluate whether we should address these persistent ongoing symptoms or just accept them for the moment? This is where I think a recovery approach can be very helpful. Let me give you a simple example. Suppose I see a patient with a delusion that there is someone behind the mirror who is recording all of his thoughts. He says to me, “That’s okay; it really doesn’t bother me.” In contrast, another patient has the same exact delusion, but he is tortured by it. I would be more likely to intervene for the second patient. Therefore, it is very important to evaluate what the symptom is doing to this patient in terms of his/her distress and limitations.

With positive symptoms, it is usually a bit easier to find a connection between the presence of the symptom and the distress that it causes. You ask the patient, “Does it bother you? Is it interfering with your concentration; your relationships?” It gets much harder to do this kind of assessment with symptoms that, by their very nature, are not likely to be noticed by or be reported bothersome or distressing to the patient. These are often the negative or cognitive symptoms that often cause a great deal of problems, but they run silent and aren’t necessarily evident in the evaluation. As such, clinicians have to try extra hard in the evaluation to kind of “dig them out.” For example, if you ask a patient with negative symptoms, “Do you want to change your medicine? Do you need help because you are not doing anything?” The patient is likely to say, “No, it doesn’t bother me doc.” Whereas if you ask the patient what he/she wants to accomplish in his/her life and the patient replies, “Well, I would like to be married or I would like to be able to work or enjoy my friends,” then you can work backwards and say, “Well, maybe we have some problems here, with your illness making it harder for you to achieve these accomplishments.”

Cognitive symptoms are more difficult to assess in an office or outpatient setting, thus it is a good idea sometimes to ask patients how their concentration is doing and link that to their life goals. Is it harder for them to enjoy activities, such as movies or reading? Is it harder for them to study or to find their way around town? Ask these types of questions and then evaluate these problems in that context.

**AS/M:** Therefore, it would also be important to differentiate the stable but symptomatic patients from patients who are experiencing acute exacerbations of breakthrough symptoms.

**Dr Weiden:** Correct. Breakthrough symptoms are symptoms that may occur under stress or under other specific circumstances. The evaluation needs to assess the precipitant of what is happening, and unless that precipitant keeps happening, it usually doesn’t mean that you would automatically have to change medicine or take an aggressive approach with medication. However, if the persistent symptoms or side effects don’t go away and are a burden to the patient and present an obstacle to any kind of recovery, that needs to be assessed and dealt with in collaboration with the patient. How do you do that when there are more than 1 of these symptoms going on at a time or more than 1 side effect that needs to be managed? You choose your battles. You work with the patient in terms of setting up a priority of goals and working toward each of these goals one at a time.

**AS/M:** Why is it that many patients don’t tell their clinicians that they have persistent symptoms or may be experiencing psychotic symptoms?

**Dr Weiden:** In my practice, I go out of my way to unearth persistent positive symptoms precisely because many patients are not forthcoming about these symptoms. Only after active and focused interviews will we learn that they are still hearing voices, seeing things, or having delusions, but they have learned not to say anything because they are stable and not getting into trouble. Another reason that patients won’t volunteer these symptoms is that they feel stigmatized or embarrassed. Patients may also worry that the clinician will put them into the hospital or give them more medicine than they are willing to take. Therefore, they are frightened to tell the truth, and other patients don’t say what is going on because no one asks them in the right way, in a way that is consistent with hearing about their own interpretation. If we as clinicians would put aside for a moment our biases that “voices” or other psychotic symptoms are biologically based, would not quash patients with lectures about how it is their brain chemicals, and try to attune ourselves to the fact that the symptoms may have particular meaning to the patient, it may be easier for the patient to admit to these symptoms.

It can be very frustrating when patients don’t admit to persistent positive symptoms because it often leads...
to incorrect treatment decisions. When we find that there are other positive symptoms “lurking under the hood” that we missed, it represents a lost opportunity because the truth is that it is easier to treat persistent positive symptoms. The newer antipsychotic medications can be completely effective for many patients with positive symptoms, even though for some patients it takes time and luck to find the right medication. Therefore, if you are lucky enough to find the right medication for any given patient, you can completely eradicate positive symptoms. I think we can do a better job being proactive in assessing them. It can be very helpful in terms of adjusting medicines, switching medicines, or addressing those problems.

**AS/M: What are the clinical approaches that you would take in your practice when assessing negative symptoms?**

**Dr Weiden:** The way I like to assess negative symptoms is make sure that these are not readily explained by anything else that resembles negative symptoms. For example, I have had several cases of people with negative symptoms of poor hygiene—they didn't bathe. On interview, one woman thought that the shower would give off poison gas as in Auschwitz; another woman thought that she would be raped in the shower. In both cases, it was positive symptoms underlying the negative symptoms. In these cases, the obvious approach is to address the persistent positive symptoms. Once the positive symptoms are better, the apparent “negative” symptoms will get better. Likewise, look for depression and EPS side effects of antipsychotics. I think that the way to regard negative symptoms and their assessment is to keep in mind that negative symptoms are like psychic anesthesia—the patients, by definition, do not feel emotions, thus they cannot register the distress or the psychological pain. Therefore, clinicians have to go around it in terms of what are the consequences of negative symptoms in this person's life and would they be interested in an alternate way of living that will help them achieve their goals.

**AS/M: Would the same elements apply in terms of cognitive symptoms? How would you assess for the cognitive symptoms or a decline in cognitive capabilities?**

**Dr Weiden:** It is very difficult to assess for cognitive symptoms in a routine follow-up visit because we don't have neuropsychiatric testing in our offices. However, there are ways to get around this problem. I like to educate patients that they may have cognitive symptoms and that this does not mean mental retardation or dementia. I use more of a learning disability model or learning problem, explaining that it may be hard for them under certain circumstances to retain information. I usually try to bring up the question with the patient: Is it the illness or is it the medication? Sometimes that can be hard to tease out. Although we don't want to blame the medicine, it may be partly medication at times. Also, try to find things that the patient likes to do or wants to do and then see if the cognitive problems limit or interfere with those activities. For example, if the patient likes to go to the movies, but has trouble following the movies, or if the patient wants to go to school, but can't concentrate, it is often a less stigmatizing problem for the patient to say that he/she has trouble concentrating or has trouble with attention than saying, “I hear voices.” Therefore, I may do an interview related to what are they doing and are they having problems doing what they want to do? Can they organize the housework? What about traveling? These can then be used as a yardstick for me to do a rough clinical assessment of cognitive functioning. A final word about cognitive symptoms is that it can sometimes be helpful to guide patients into understanding that some of their positive symptoms may really stem from a cognitive problem. For example, many patients get ideas of reference when they watch TV—someone in the TV station is talking to them. Well, if you think about it, a TV is a very small area where there is a lot of intense light and sound bombarding the senses all at one time. Patients with schizophrenia can get overwhelmed with all this sensory stimuli and when that breaks down and they are not thinking right, their conclusion is that something from the TV is doing this to my brain. There you have an idea of reference, thus tracing back the cognitive problem as a sort of root cause can be a relief for patients who are stigmatized by their positive symptoms.

**AS/M: In evaluating a patient with persistent symptoms, when would you decide to switch from one antipsychotic medication to another?**

**Dr Weiden:** The first thing that I would do is to make sure that I have given the previous treatment a reasonable amount of time to work, thus the patient is about where I think he/she is going to be. If the patient has had a previous switch or a relapse and has
responded to the current medicine, I would wait at least 6 months before assessing the level of response to the current medicine. Additionally, I would make sure that the dose and treatment plan were optimized on the current medicine. There is more to deal with when switching medications compared with just raising the dose of the medicine. I would also want to make sure that the goals are realistic. If the person is smoking pot every day and has problems with negative symptoms, changing medicine is not going to help that person’s negative symptoms.

Having said that, for an elective switch I would first wait for the current trial to run its course over 6 months to 1 year. There may be gradual improvements that are not seen before that time, thus switching may be unnecessary. If symptoms are still not adequately controlled, I would switch again after approximately a 1-year trial, assuming adequate pharmacologic conditions have been met. If the patient is nervous about switching in 1 year, I may wait 2 years. However, if after 2 years the patient is still having significant life problems and limitations on current medicine or significant side effects, such as weight gain or EPS, I would switch the patient between 1 year at minimum and 2 years at maximum, provided I have a cooperative patient who is willing to try a switch and can report to me what is going on.

Another important aspect to elective switching is doing your best to ensure that the timing is right when initiating a switch. With the recovery model, where you are trying to help someone deal with a persistent symptom—the person is not relapsing, not suicidal, and not in an emergency situation—time is your friend. You can choose a time to begin the switch that is reasonably stress-free for the patient and for you, and you have an opportunity to educate the family. For example, if I am planning on switching a student because of persistent cognitive problems that hurt academic performance, and that student is doing poorly in school because of concentration problems, an ideal time for the switch would be the summer break.

In summary, try to do the switch within 1 or 2 years for those patients embarking on a recovery model when they still have symptoms, educate the patient and family on the switching process, and pick a time for starting the switch that you feel will most likely succeed.

AS/iM: When switching medications, what if a patient is experiencing side effects, such as weight gain or other metabolic issues, in addition to the breakthrough symptoms?

Dr Weiden: Let’s assume that we are talking about switching between first-line atypical antipsychotics, and leave clozapine out of this discussion for now because the issues are not the same. It may be helpful to divide your elective switches into 2 types. The first is someone who is on an antipsychotic and is being switched because of suboptimal efficacy, as his or her symptoms are not being adequately controlled on the current antipsychotic. This is an efficacy switch. If you assume that the antipsychotics have equal efficacy on average, but that for individual patients one medicine may work a whole lot better than another, then it is wonderful news for the patient who is embarking on an efficacy-related switch because if they don’t do well on one antipsychotic, they still have a chance to do well on another. What I say to my patient is “the fact that these medicines work differently in each patient is good news and will work to our advantage.”

The second type of switch is a person who has positively responded to an antipsychotic but has serious side effects or is distressed from the side effects of the antipsychotic, such as weight gain or EPS. The good news for this patient is that there are really terrific choices these days in terms of different side-effect profiles, and patients don’t have to stay on medicines that cause EPS, weight gain, or sedation. There are several differences in side-effect profiles among the atypicals, and we can leverage that to find an antipsychotic that will help alleviate their most problematic or distressing side effects. However, the bad news is that the same differential efficacy that was helpful for an efficacy switch is now a major problem for this side-effect switch because there is no assurance that the next medicine will be as effective for the patient’s symptoms. Again, this has to do with the fact that these medicines aren’t the same in individuals. It doesn’t mean that one medicine is better than the other; it just means that there is differential efficacy for individual patients. Granted, this is an oversimplification. In practice, we are usually switching for multiple reasons, partly efficacy and partly side effects. There is no question that if I am switching for efficacy reasons, I am going to also pick a drug that has the best side-effect profile for that particular patient.

AS/iM: What is the best approach to changing medications for the patient?

Dr Weiden: There are 3 keys to successful switching: educate the patient and family before switching to
manage their expectations; stay with therapeutic doses at all times, and that applies to the old medicine or the new medicine to which you are switching (if your switching technique doesn’t incorporate this principle, you will get into trouble); and be available for hand holding, TLC, and to answer questions. These steps really help support the patient and family through the switching process.

**ASiM:** Are there specific strategies that the clinician should look at or consider when switching? Is there a single approach or are there multiple approaches?

**Dr Weiden:** There are multiple approaches, especially with how long you do the cross-taper. Leaving aside clozapine, you can do the switch relatively quickly within 1 week or even a few days, or you can extend it out over a few months. Your time frame will depend on the patient’s preference, your preference, your clinical setting, and other factors. Let me give you a couple examples of when you may switch quickly or slowly, depending on nonpharmacologic factors. Let’s say you switch a patient from a high-weight gain medicine, such as olanzapine, to a low-weight gain medicine, such as ziprasidone or aripiprazole, and you have cautioned the patient about the differential efficacy involved in switching from one medicine to another. For weight gain, unless there is acute diabetes or some urgent medical problem, you probably would want to do a slow switch because you would want the person to get used to the new medicine. However, what I have found many times in my practice is that sometimes patients are so eager to lose weight that once they start [ziprasidone] they want to be off olanzapine “yesterday” and will abruptly stop their olanzapine and be left on subtherapeutic ziprasidone. This is not a good idea. Therefore, I have learned that if the patient is going to refuse to do a slow cross-taper, I will have to do a faster cross-taper because if the patient stops the previous medicine and is on subtherapeutic doses of the new medicine, there will be problems. You have to be alive to the clinical realities in adapting your switching plan.

Another example is when you have a patient or a family member who is extremely nervous about switching antipsychotics. Perhaps, the last time the patient switched was years ago and the patient relapsed, thus everyone is very nervous about giving up the old medicine. With that kind of patient you may want to switch over 3 months and start by adding very small amounts of the new medicine onto the old regimen without touching the dose of the current antipsychotic and not do anything else for 1 month. As you can see, many psychosocial factors need to be taken into account, in addition to the pharmacokinetics and the pharmacology of the medicines.

**ASiM:** Therefore, it underscores knowing the overall situation and having a working therapeutic relationship.

**Dr Weiden:** Absolutely. Although a careful switching plan does take time and effort, a successful switch can help someone’s life forever, and we have the gratification of knowing that we have made a difference.