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Letter to the Editor

Could CBT sustain long-term remission without antipsychotic medication in schizophrenia?

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Dear editor

Based on a comprehensive literature review, Zipursky et al. address the challenge of advising patients with sustained remission from a first episode of psychosis over risks and benefits of medication discontinuation (Zipursky et al., 2020). A strong statement is made on the need to continue antipsychotic medication in the long term for those with a confirmed diagnosis of schizophrenia or schizoaffective disorder. For the many individuals who choose to interrupt medication, gradual suspension is recommended, with ongoing psychiatric follow-up for at least three years. However, whether follow-up should be limited to observational visits or enriched with psychosocial interventions, some of which are known to reduce medication use in schizophrenia (Cooper et al., 2019), is not specified.

We report the case of a patient diagnosed with Schizophrenia who has been successfully followed up within our Department for 7 years after onset and 4 years after suspending medication (Fig. 1).

K is a caucasian male admitted to our inpatient unit for a First Episode Psychosis (FEP) when he was 23 years–old. Immediately prior to onset, he experienced a severe and protracted jet-lag during a holiday break from University with friends in Seoul. Here, he progressively developed sensory distortions, simple auditory hallucinations and complex, polymorphic delusions including persecutory, reference and control themes in the context of a Reality Show–like atmosphere (D'Agostino et al., 2014). During a 3–month hospitalization upon return to his home country, self–disturbances and passivity phenomena (he experienced an involuntary movement of eyelids ascribed to invisible chains operated by an unknown force) were also observed. Prior history was negative until age 20, when he had begun to privately see a therapist for intermittent hypochondriac symptoms and a sleep disturbance characterized by sleep-wake inversion and partial social withdrawal. He had used Zolpidem 10 mg on a couple of occasions but rapidly discontinued it after developing pseudo-hallucinations. Other subthreshold phenomena that had occurred in the previous years included sound/light hypersensitivity and a tendency to misattribute salience to irrelevant environmental stimuli.

The patient's mood remained stable and affectivity was slightly restricted. Neurological and physical examinations were unremarkable as were routine laboratory blood tests. Urine toxicology screen for major substances of abuse was negative; high–density EEG during wakefulness and sleep and MRI scans did not reveal signs of other known brain disorders. The treating physicians (A.D'A. – A.C.) formulated a diagnosis of Schizophreniform Disorder and made three unfruitful pharmacological attempts with atypical antipsychotics (Olanzapine up to 20 mg/day, Aripiprazole up to 20 mg/day and Paliperidone up to 6 mg/day), all discontinued due to insufficient response and/or hypersensitivity to side effects (hypotension, excessive daytime sedation, akathisia and dystonia). However, a fast and optimal response – without disturbing side effects – was obtained when Clozapine was slowly titrated up to 200 mg. Upon discharge, the patient was randomized to an ongoing trial that has been detailed elsewhere (Lasalvia et al., 2017) in which he was assigned to a psychosocial intervention including cognitive-behavioral therapy (CBT) with an expert in FEP youth (D.A.). K recognized the benefit of the therapy, remained compliant and did not relapse in the 3 subsequent years, during which he was kept at a low maintenance dose of Clozapine 75 mg/day by the treating physician of the outpatient unit (A.P.).

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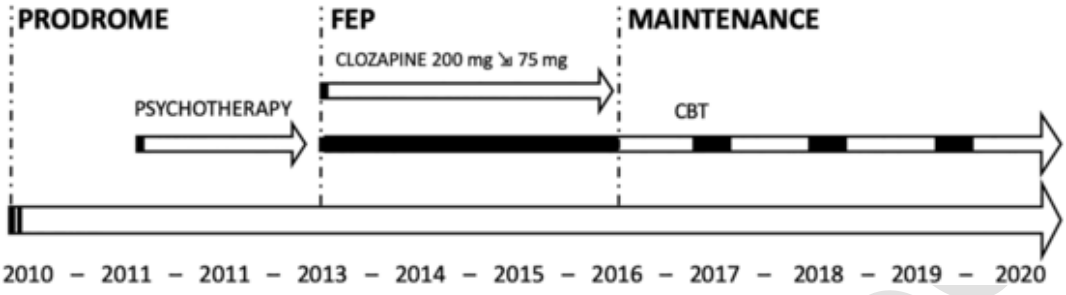
Fig. 1



The patient's psychosocial functioning remained suboptimal for his age and intelligence but he was able to keep temporary part-time jobs. A diagnosis of Schizophrenia was confirmed due to the persistence of mild negative symptoms and a slightly eccentric, aloof attitude. Despite a substantial lack of side effects, the patient asked to interrupt his medication after three years of treatment. Clozapine was discontinued very slowly, over a period of several months, 25 mg at a time. At the same time, the weekly CBT sessions he had asked to continue after the trial, became monthly or bi–monthly follow–up visits that are still ongoing. Occasionally, the patient presented disturbed sleep for which he was successfully prescribed Clotiapine 10–30 mg (3–9 drops) for a few weeks. Although classified as antipsychotic, this drug was always prescribed at a sub–therapeutic dose (Mazhari et al., 2017), and was never required over the past 2 years. When ideas of reference and persecutory thoughts re–emerged, the clinical team intensified medical visits and CBT sessions, returning to once–weekly sessions on 3 occasions. Each time, overt psychotic episodes were controlled without hospitalization or re–introduction of Clozapine. Although ambivalent on having a mental disorder, the patient has maintained surprising insight over his previous psychotic symptoms. Over the past three years, K attended a one-year paid civil service in a Social Resource Center, he resumed university and graduated.

Cognitive therapy has been shown to reduce symptoms and to be a safe alternative for patients who refuse long–term antipsychotic drugs (Morrison et al., 2014). Most available studies of psychosocial interventions in patients with minimal or no treatment report favorable outcomes, although higher–quality studies are needed (Cooper et al., 2019). Our case appears to confirm that some people can successfully discontinue antipsychotic medication (Hui et al., 2020). However, we do acknowledge that cost–effectiveness of this type of continuous CBT follow–up remains to be demonstrated.

Zipursky et al. (2020) recognize that a minority of patients diagnosed with a first episode of schizophrenia will be able to sustain remission without antipsychotic medication. However, they fail to identify supportive psychosocial interventions that we consider fundamental to this aim, especially in first-episode psychosis. Ongoing research should also aim to identify schizophrenia subtypes associated with functional outcomes (Chand et al., 2020) and validated biomarkers will then hopefully inform tailored intervention strategies in individual patients (Dazzan et al. 2014). Until then, given the lack of consistent predictors, offering this approach to all those patients who wish to discontinue treatment should be considered a sufficiently evidence–based practice.

Contributions

AC and ADA drafted the manuscript and ADA prepared the figure. DA and AP reviewed case notes and provided details on follow–up. All authors critically reviewed the manuscript.

Declaration of competing interest

The authors have no conflict of interest to declare.

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