# Unique Needs Early-Stage Versus Chronic-Stage Psychotic Disorders

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# Psychotic disorders emerge during adolescence and young adulthood

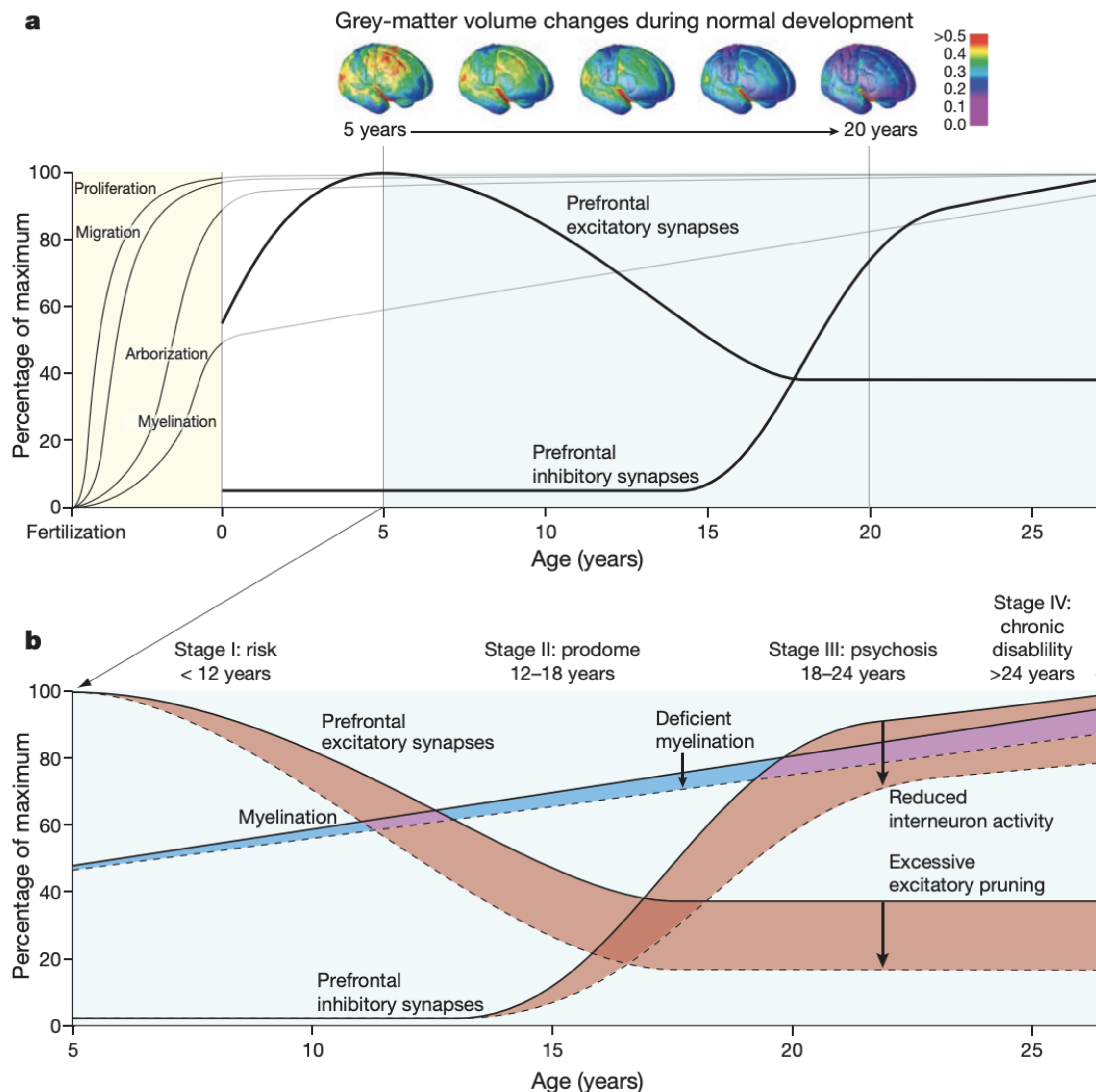
- Coincides with active developmental processes
  - Brain maturation
  - Psychological development
  - Social development
- Parents/caregivers have pivotal roles
- The illness hasn’t fully declared itself: Diagnostic challenges
- Responsive to pharmacological treatment
  - Psychotic symptoms often remit, response rates are high
  - Little toleration for side effects, (especially “zombie”)
  - Remission doesn’t equate to being “cured”
- Trajectory of illness may be altered
  - Beliefs about illness and treatment are malleable
  - Reduce negative social and psychological consequences of repeated relapses
  - Re-establish psychosocial developmental opportunities
  - Alter pathological processes
  - Impact long-term health outcomes

# Developmental Processes

# Normal Brain Development: Refinement of connectivity

Brain maturation between ages ~15–25:

- Refinement of fronto-striatal and fronto-limbic circuits
    - Maturation (synaptic pruning) of prefrontal cortical and association corticies
    - Myelination of long-range connections
- Brain maturation results in cognitive maturation of executive function, emotion regulation, and social cognition
- These changes are experience-dependent




Gotay et al. 2004 PNAS 101:8174-8179; Giedd JN et al., *Nat Neurosci*, 1999; Lebel C & Beaulieu C, *J Neurosci*, 2011; Blakemore SJ, *J R Soc Med*, 2012

Inself, Nature, 2010

# Normal psychosocial development

Adolescence and emerging adulthood involve a normative shift in **social reference points**

- Shifts from: parents/family members → peers, teachers, mentors, employers, romantic partners
- Parental role shifts towards consultants

Psychosis emerging during adolescence or young adulthood interrupts:

- Identity formation
- Autonomy development
- Educational and vocational skill acquisition
- Social and emotional maturation
- Executive function development

# Challenges: Disruption of Normative Developmental Trajectory

- **Typical young adult development**
  - Parents shifting from **authority figures → consultants**
  - The young adult gaining:
    - Autonomy
    - Financial and practical independence
    - Psychological separation
  - The relationship becomes more **reciprocal and less supervisory**
- **Impact of chronic severe illness**
  - This trajectory is **interrupted or reversed**
  - Parents are often pulled back into roles involving:
    - Monitoring
    - Decision support or control
    - Practical caregiving
    - Crisis management
- **Result:** A mismatch between *developmental expectations* and *illness-driven needs*.
  - Role confusion
    - How much autonomy is safe?
    - When is support over-control

# Development Derailment: Clinical Relevance to FEP Treatment

- **Treatment Goals:** Aim to restore developmental momentum and protect education, work, and social roles
- **Medication Strategies are Developmentally Calibrated:**
  - Lower doses may be effective
  - Sensitivity to side effects, cognitive dulling, sedation, and metabolic burden risk *worsening* developmental arrest
- **Psychosocial Interventions Are Core Treatments**
  - Supported education and employment & peer support provide developmental opportunities
  - Family & individual therapy:
    - initially stabilizes the developmental environment
    - with recovery supports autonomy, enhances self-identity
- **Engagement Requires a Future-Oriented Frame**
  - Emphasize goals ("getting back on track") rather than illness identity
  - Avoid premature labeling that threatens identity formation
  - Build alliance around developmentally meaningful outcomes
- **Early Gains Compound Over Time**
  - Small improvements in school, work, or relationships → lifelong impact
  - Mitigates the functional losses that later define chronic schizophrenia

Blakemore SJ. *J R Soc Med*, 2012

# Family involvement

# Families are Involved in Recovery from FEP

- 75-85% of persons live with family at entry to care
- Families are the primary housing and support system for persons recovering from FEP
- Parents are active regulators of the patient's environment, stress exposure, sleep, routines, and treatment adherence
- Families often provide resources needed for treatment engagement
  - Logistics: e.g., Transportation to clinic, obtaining medication refills
  - Cover health care costs (co-pays, deductibles, etc.)

# Importance of Involving Parents in Treatment of FEP

Involving parents improves clinical outcomes and reduces relapse risk

- Onset of psychosis for one family member is a crisis to the family system
  - Family members are often confused about why their loved one is behaving so differently
  - Psychoeducation can improve understanding of how the illness influences behavior, **reduces risk of dangerous behaviors**
  - Reducing the family-system stress level and **elevated express emotion reduces risk of relapse and rehospitalization**
- Parents influence the patient's attitudes and beliefs about the illness and the role of treatment in the illness
- Parents benefit from help identifying and addressing aspects of the home environment (e.g., sleep routines, daily structure, substance use, etc.) that may be influencing symptoms

# The illness hasn’t fully declared itself:
Diagnostic challenges

# Henry

- Henry is an 18 year-old male living with his parents and younger sister
- High-school senior
  - average student in middle school, decline in grades in high-school
  - over past year school attendance is poor & he has withdrawn from friends and outside activities
- History of ADD treated with Ritalin and ODD
- Over past year has been using cannabis-products daily
- Hospitalized for auditory hallucinations, belief that his food is being poisoned, depressed & anxious mood, disrupted sleep, weight loss, suicidal thoughts, aggression towards mother (pushed her)

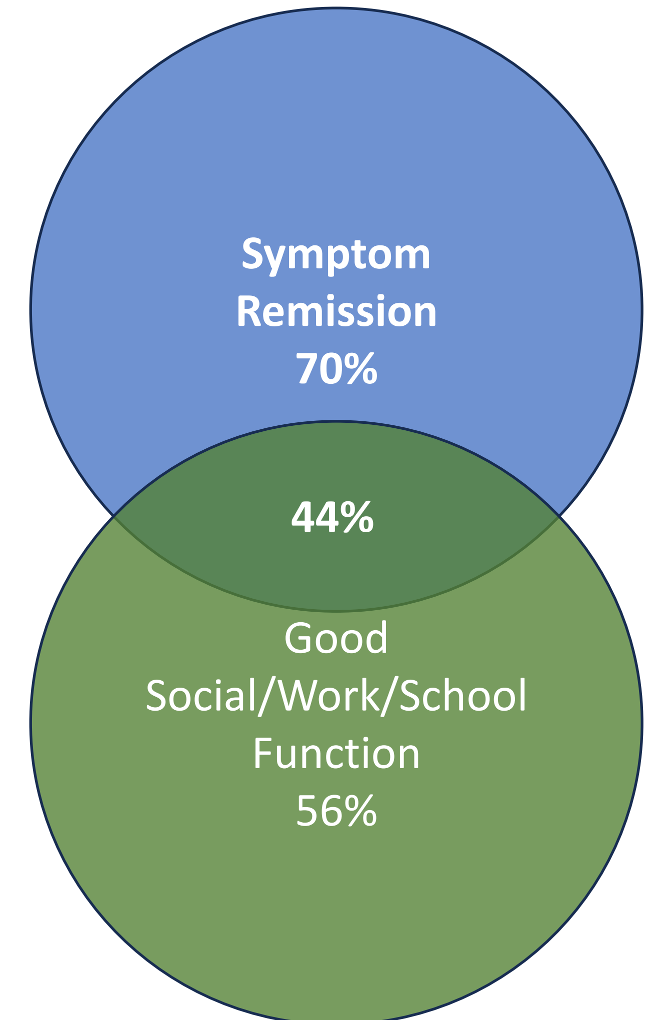
# Diagnostic Challenges

- Is this a drug-induced psychosis (Ritalin abuse or Cannabis)?
- Does the patient have Depression?  Schizophrenia?
- Are there psychosocial stressors that are contributing to symptoms?

Highly responsive to pharmacological treatment

# Recovery in Persons with First-Episode Psychosis Treated with Long-Acting Injectable Antipsychotics

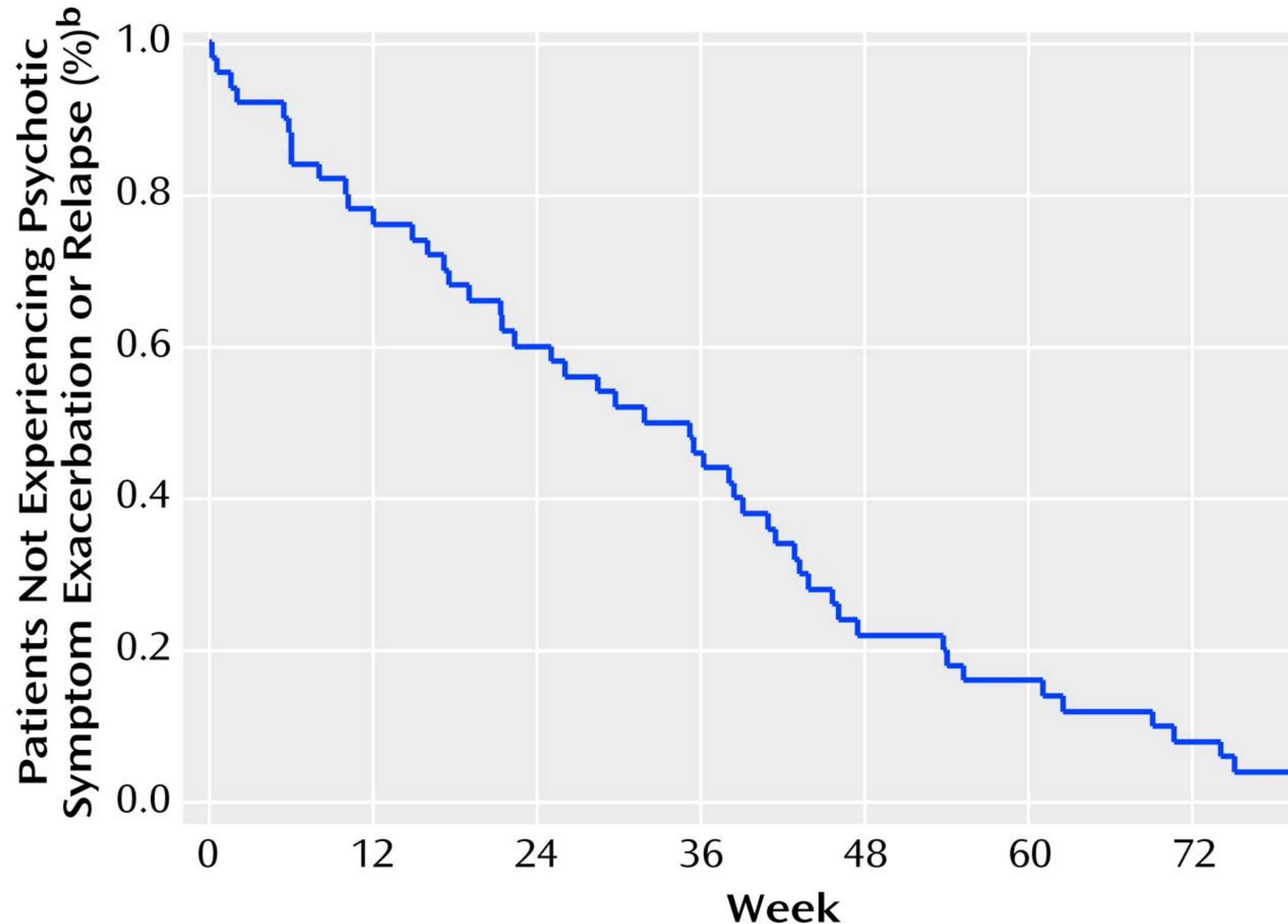
- Psychosis symptoms remit in most persons with FEP
- Residual negative symptoms (apathy, low motivation) are most often secondary to:
  - **dopamine-blocking effects of antipsychotics**
  - Depression/discouragement
- Functional improvements highly dependent on support from families and psychotherapy




*npj Schizophrenia* (2020)6:2 ; https://doi.org/10.1038/s41537-019-0091-y

# Relapse Risk is High

Time to relapse in 50 Stable Patients With Recent-Onset Schizophrenia Who Voluntarily Entered an Antipsychotic Withdrawal Protocol

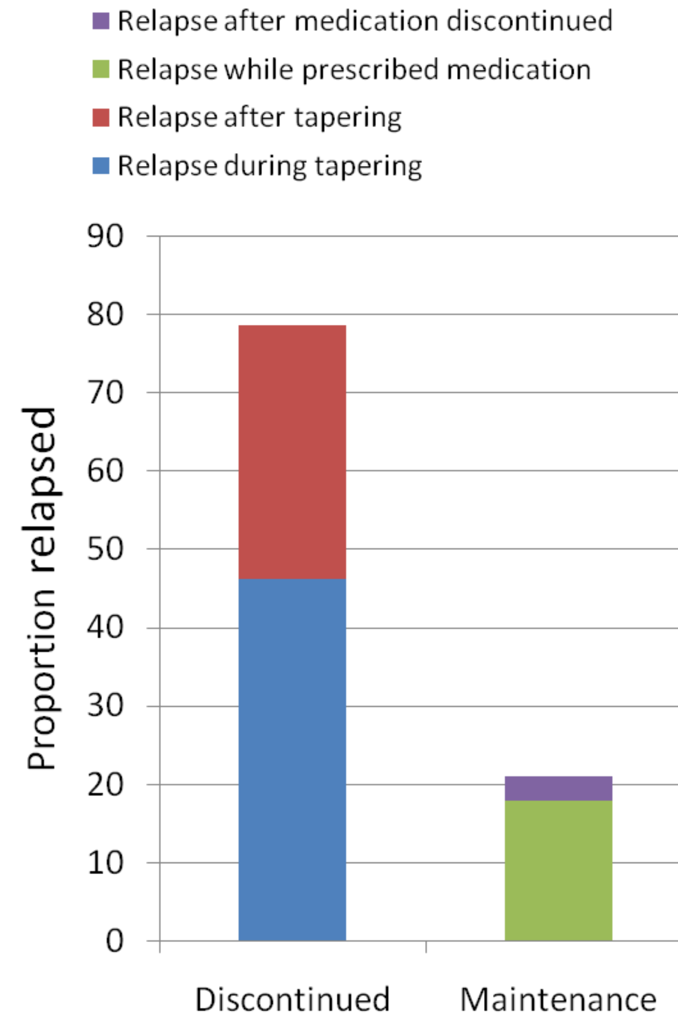



Gitlin et al., Clinical outcome following neuroleptic discontinuation in patients with remitted recent-onset schizophrenia. Am J Psychiatry 2001 158:1835-42.

# Maintenance Antipsychotic Treatment Greatly Reduces Relapse Risk

**Guided Discontinuation versus Maintenance Treatment in Remitted First-Episode Psychosis: Relapse Rates and Functional Outcome**

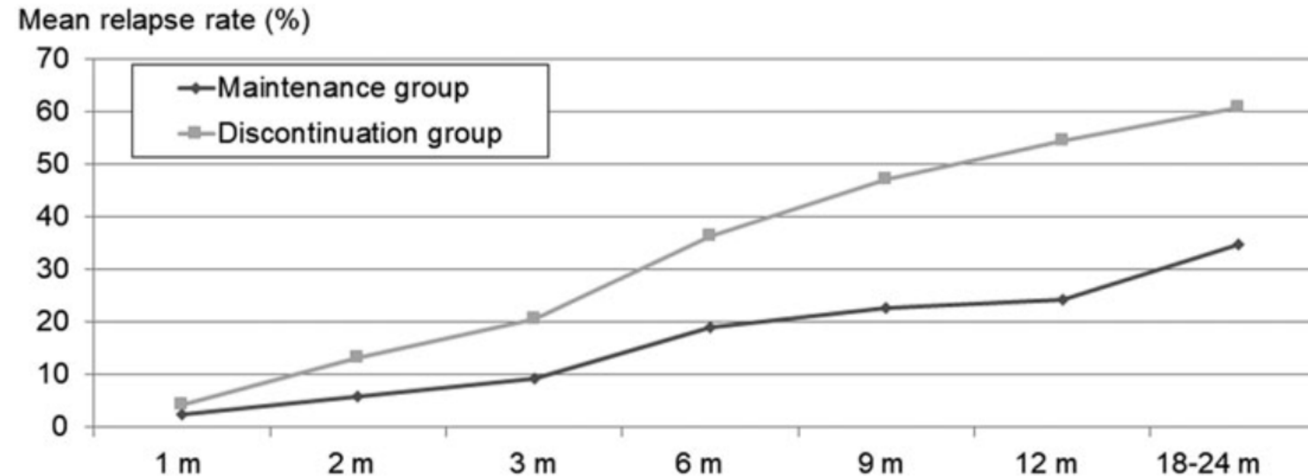
- DESIGN
  - 131 remitted first episode patients age 18-45 with < 3 months of antipsychotic (schizophrenia or related psychotic disorders)
  - Randomized to maintenance treatment (n=63) or guided discontinuation (n=68)
  - Followed for 18 months
- PRIMARY OBJECTIVES
  - Relapse: Clinical deterioration for at least one week having consequences (med change, admission, more frequent visits) and PANSS positive item $\geq$ 5




*Wundering J Clin Psychiatry (2007) 68:654-661*

# Maintenance Antipsychotic Treatment Greatly Reduces Relapse Risk

Meta-analysis: Continued maintenance versus
discontinuation of antipsychotics in FEP

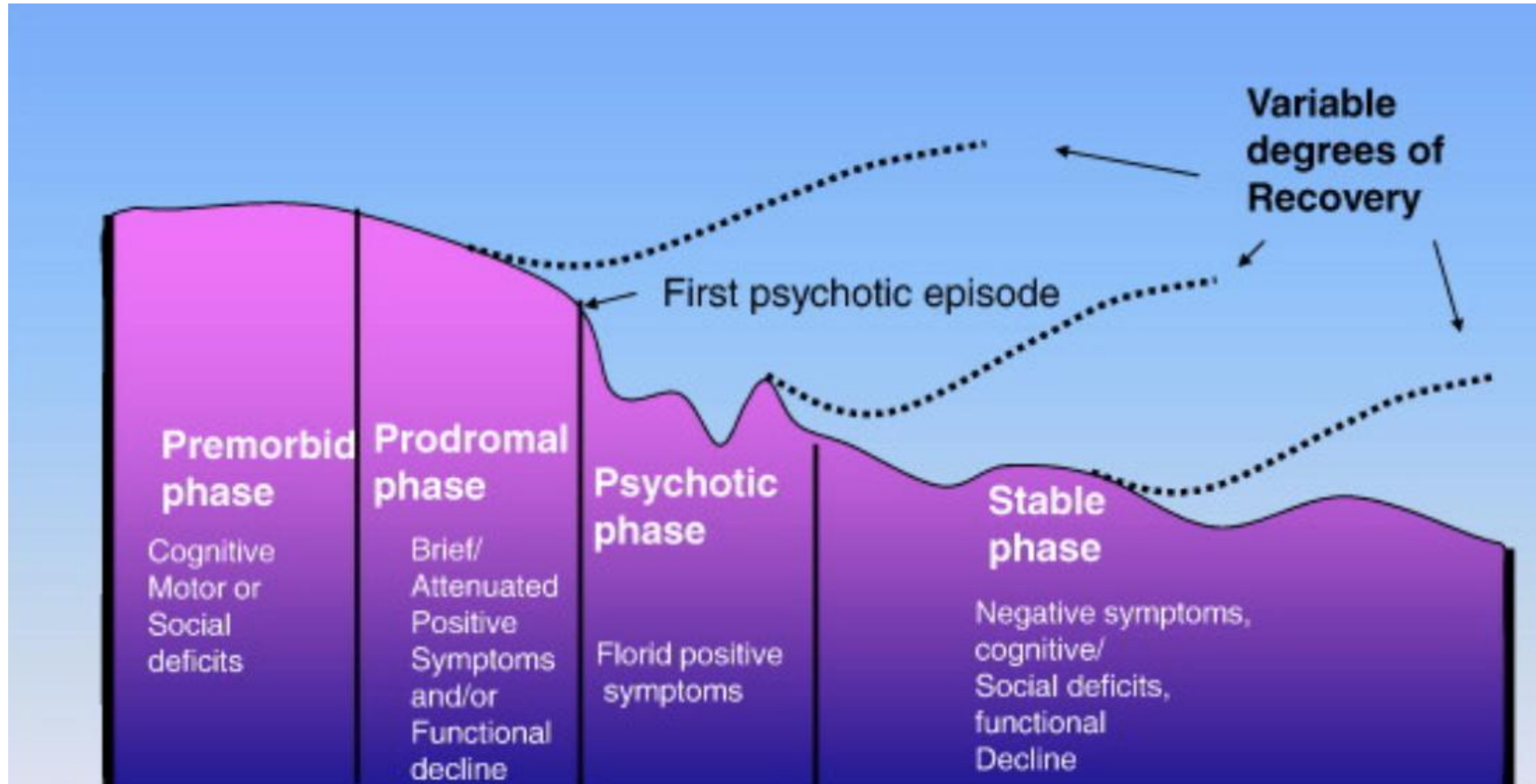



| | 1 m | 2 m | 3 m | 6 m | 9 m | 12 m | 18-24 m |
|---|---|---|---|---|---|---|---|
| *N* (*n*) | 6 (605) | 6 (605) | 6 (605) | 6 (605) | 6 (605) | 10 (739) | 4 (383) |
| RR | 0.55 | 0.49 | 0.46 | 0.55 | 0.48 | 0.47 | 0.57 |
| 95% CI | 0.21−1.41 | 0.29–0.85 | 0.30–0.70 | 0.42–0.72 | 0.32–0.70 | 0.35–0.62 | 0.41–0.80 |
| p | 0.21 | 0.01 | 0.0002 | <0.00001 | 0.0002 | <0.00001 | 0.001 |
| $I^2$ | 0% | 0% | 0% | 0% | 44% | 31% | 43% |
| NNT | na | 13 | 9 | 6 | 3 | 3 | 4 |

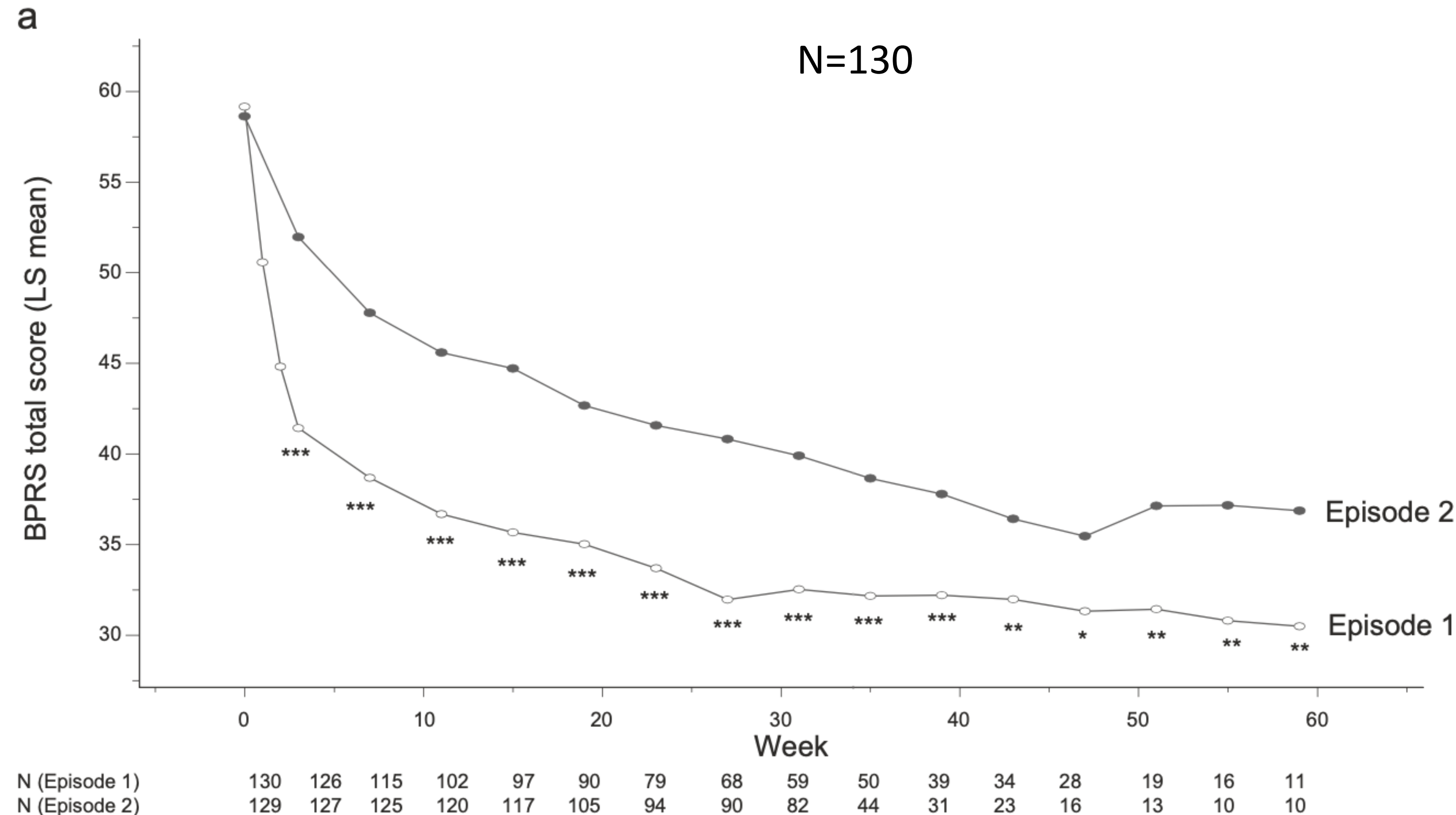
Kishi T, Ikuta T, Matsui Y, Inada K, Matsuda Y, Mishima K, Iwata N (2019). Effect of discontinuation v. maintenance of antipsychotic medication on relapse rates in patients with remitted/stable first-episode psychosis: a meta-analysis. Psychological Medicine 49, 772–779. https://doi.org/10.1017/ S0033291718001393

# Trajectory of illness may be altered

# Stages of Psychotic Disorders



# Does relapse contribute to treatment resistance? Antipsychotic response in first- vs. second-episode schizophrenia




*Neuropsychopharmacology* (2019) 44:1036–1042; https://doi.org/10.1038/s41386-018-0278-3

# CSC Treatments Aims to Alter the Illness Trajectory: Reduce Relapse Risk & Support Functional Recovery

- Individual and Family Psychotherapy
  - Address consequences of psychosis to self-identity, stigma, self-concept
  - Improve emotional regulation and reduce stress sensitivity
  - Trauma and crisis processing
- Supported Employment & Peer Support
  - Functional Recovery: Re-establish psychosocial developmental opportunities
  - Help client implement strategies to manage symptoms
  - Wellness planning
- Medical Management
  - Reduce negative consequences of repeated relapses
  - Potential to impact long-term health outcomes (e.g., weight gain)

# Henry’s First Outpatient Visit

- Henry discharged from hospital on 4 mg of risperidone
  - Psychosis symptoms are minimal
- Parents:
  - Monitor medication adherence
  - Worried about his future
  - Concerned that he is ”lazy”
- Henry doesn’t like risperidone
  - Not sure risperidone is “doing anything” except making him feel “tired” and “unmotivated”
  - Sleeps 14 hours a day
  - Has gained 10 pounds

# Henry at Six Month Follow-Up

- Dose of risperidone initially reduced to 2 mg, then switched to aripiprazole due to side effects of secondary negative symptoms
- Psychosis in remission
- Motivation and energy level “back to normal”
- Returned to school, passing his classes
- Socializes with a few close friends
- Wants to know ”when can I stop taking this medication”

# Empowerment Model

- Goal: increase patient’s capacity to understand and manage their own health
- Decisions made *with* person, not *for* them
- Medication refusal or ambivalence is information, not bad behavior

| **Paternalistic** | **Empowerment** |
| --- | --- |
| “You need to take this medication.” | “Here are the options—what matters most to you right now?” |
| “Nonadherent patient.” | “Something about this plan isn’t working for you—let’s understand why.” |
| Focus on compliance | Focus on role treatments play in person achieving their goals |

# How Do Early Psychosis Coordinated Specialty Care Services Address Unique Needs?

- Treatments considers psychosocial development, emotional and cognitive maturation
- Multiple interventions address high risk  of relapse & dangerous behaviors
- Family therapy key component
- Treatment team routinely explores patient and family beliefs about illness and treatment (e.g., motivational interviewing)
- Strive for good outcomes, utilize clozapine for partial responders and routinely offer LAIs
- Peer Support and Supported Education and Employment specialist work in the community to increase psychosocial developmental opportunities and support functional recovery