Patients' perspectives. Subjective experiences and attitudes of patients with recent onset schizophrenia

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Chapter 2.2.

Early intervention, social functioning and psychotic relapse of patients with recent onset schizophrenic disorders

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Lieuwe de Haan, Don Linszen, Rob Gorsira
Summary

Objective: To find indications whether low-dose antipsychotic drugs and early intensive intervention would reduce psychotic relapses and improve social functioning.

Method: Social functioning and psychotic relapse were examined retrospectively in an early intervention programme in 133 young patients (mean age 20.3 years, SD 2.3) with recent-onset schizophrenia and related disorders. The programme included a combination of: (1) pharmacotherapy; (2) psychoeducation of patients and parents; (3) individualized disease, medication and stress management; (4) support in the finding of structural activities; (5) establishment of parent groups; and (6) provision of continuity of care for both patients and parents.

Results: After 1 year of outpatient treatment, 89 patients (67 %) who were inactive at admission had structured activities. Twenty-nine (21.8%) patients suffered from a psychotic relapse of which 13.5% were severe and 8.3 % mild. A severe relapse was, in most cases, followed by readmission. The length of time between the first contact with psychiatric services and admission to the treatment programme was associated with negative symptoms at the end of the treatment period.

Conclusion: Early psychosocial intervention combined with antipsychotic medication appears to improve social functioning and to reduce the relapse rate in recent-onset schizophrenia.
2.2.1. Introduction

Psychotic relapses are a major factor in determining the severity of schizophrenia and are associated with an increasing likelihood of further psychotic relapse, as well as an increase in negative symptoms (WHO, 1979) and risk of suicide (Drake et al., 1985). In addition, psychotic relapses have a negative impact on education, career and self-image (Greenfeld et al., 1989; Lally et al., 1989). As the severity of schizophrenia can increase in the first 5-10 years of the disorder (McGlashan 1988, Eaton et al., 1992), early intensive treatment programmes have been developed aimed at reducing the rate of relapse and improving social functioning (Lam, 1991). In a prospective study examining the effect of early treatment in 76 patients with recent-onset schizophrenic disorders (mean age at admission 20.3 years, SD. 2.3), psychotic relapse during the first year after admission was relatively low (16%; Linszen et al., 1996). Early treatment may therefore lead to a decrease in the incidence of psychotic relapse. Change in social functioning was not, however, evaluated in this study. Indeed, it is difficult to achieve both prevention of psychotic relapse and improvement of psychosocial adaptation. This has been shown in studies by Kane et al. (1983, 1985), in which treatment with high dose antipsychotic drugs resulted in fewer psychotic relapses, but also in poor social functioning. This study, therefore, in a comparable population and using the same treatment programme as in an earlier study by the same group (Linszen et al., 1996), investigated whether low-dose antipsychotic drugs and early intensive intervention would reduce psychotic relapses and improve social functioning.

2.2.2. Patients and Methods

A total of 133 young patients with schizophrenic disorders were treated at a specialised unit, in the Academic Medical Centre, Amsterdam, The Netherlands, in an early intensive treatment programme with a minimum of 12 months of outpatient care following admission. Patients were eligible for the treatment programme if they had an axis I schizophrenic disorder according to the criteria of the third revised Diagnostic and Statistical Manual of mental disorders (DSM-III-R; American Psychiatric Association, 1987). The diagnosis was made at a clinical consensus meeting (comprising three psychiatrists and two residents) and involved the use of all available information, including medical records, and interviews with patients and with parents.

Inclusion criteria were the need for continuous antipsychotic medication, and age between 15 and 26 years. Patients with primary alcohol dependence, drug dependence (other than cannabis) or brief drug-related psychosis were excluded.
Treatment
The primary aims of treatment were the prevention of relapse and improvement of quality of life. This was to be achieved by (1) decreasing psychotic symptoms using medication, stimulus reduction and careful confrontation with reality; (2) preventing relapse through the reduction of stress and early intervention in case of prodromal symptoms; (3) preventing suicide by careful confrontation with the illness, support during the process of mourning and actively discussing suicidal thoughts; (4) decreasing negative symptoms through mild stimulation, optimal medication and treatment of depression; (5) using the individual qualities of patients and the help of family and friends. The mean duration of the clinical and day-treatment phase was 3.6 months. Outpatient treatment lasted for 12 months. All patients received standard antipsychotic medication (haloperidol, or its equivalent, at a mean dose of 3.5 mg/day SD = 1.9).
During the inpatient phase, the family was contacted as soon as possible after admission. Psychoeducation of the family according to the method developed and described by Anderson et al. (1986) was started (Linszen et al. 1996). During the outpatient phase, patients were seen weekly during the first 6 weeks, fortnightly for the following 3 months, and then at monthly intervals. Patients could be seen more frequently if necessary. Patients were intensively coached in finding structural daily activities. Choices were made on the basis of patient’s behaviour in the ward and during therapeutic sessions, and in accordance with patient’s own wishes and ability. Modest target activities were deliberately chosen in order to maximise the success rate. This part of the treatment program involved frequent contact with parents, teachers and other care-givers.

Measurements
The following information was retrieved from the medical records at the time of admission: (1) DSM-III-R diagnosis; (2) structural activities; (3) first contact with psychiatric services (4) time of admission. Careful clinical records (including prodromal symptoms, relapse and social functioning) up to follow-up 1 year after admission to the unit were available for all patients. These records were used to assess (1) the number of mild psychotic relapses, defined as a recurrence or exacerbation of psychotic symptoms requiring an increase in medication, without a significant decline in social functioning and remission within 1 week; (2) the number of severe psychotic relapse, defined as a recurrence or exacerbation of psychotic symptoms requiring an increase in medication, with a significant decline in social functioning or a duration of more than 1 week, or both; (3) readmission; and (4) social functioning. An independent researcher reviewed the charts and a random sample of 36 patients was studied by another researcher. There was disagreement about the severity of the relapse in only one patient (overall kappa coefficient = 0.89), but the records of all patients with a relapse were re-examined by both
workers to reach consensus about the categories of relapse severity. From 88 consecutively admitted patients (a subpopulation of the 133 patients) the severity of negative symptoms at the end of the treatment programme was rated on a three-point scale (none, mild, severe).

2.2.3. Results

The length of time between the first contact with psychiatric services and time of admission to our hospital, was 18 months (mean, SD = 14). Before admission to our hospital, patients were admitted once (mean) to another psychiatric hospital. The study population consisted of 101 men and 32 women and their mean age at admission in our hospital was 20.3 years (SD = 2.3 years).

The diagnoses according to DSM-III-R criteria are shown in table 1.

<table>
<thead>
<tr>
<th>Table 1. Patient characteristics</th>
</tr>
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<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Diagnosis according to DSM-III-R criteria</td>
</tr>
<tr>
<td>Schizophrenic disorder</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
</tr>
<tr>
<td>Schizophreniform disorder</td>
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<tr>
<td>Bipolar disorder, manic (discongruent psychotic)</td>
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<tr>
<td>Psychotic disorder (unspecified)</td>
</tr>
</tbody>
</table>

Social functioning

For 29 of the 133 patients (22 %), there were no data describing their structural social activities after the 12-month period of outpatient care; these patients were rated as having no structural activities. Some patients were active in more than one category, for example in both study and hobby, but were rated only once for the activity done most intensively. Of the patients without any structural activities at admission, 89 (67 %) had structural activities after 12 months of outpatient treatment: 13% (re)started a hobby, 27% started volunteer work, 9% (re)started study and 18% had paid work (Table 2., page 73).
Table 2. Social functioning at admission and after 12 months out-patient care of 133 young patients with recent onset schizophrenia and related disorders

<table>
<thead>
<tr>
<th>Social functioning</th>
<th>n (%)</th>
<th>After 12 months of outpatient care</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>At admission</td>
<td></td>
</tr>
<tr>
<td>No structural activities</td>
<td>104 (78.2)</td>
<td>15 (11.3)</td>
</tr>
<tr>
<td>Hobby</td>
<td>4 (3.0)</td>
<td>13 (9.8)</td>
</tr>
<tr>
<td>Volunteer work</td>
<td>1 (0.8)</td>
<td>22 (16.5)</td>
</tr>
<tr>
<td>Study</td>
<td>19 (14.3)</td>
<td>33 (24.8)</td>
</tr>
<tr>
<td>Paid work</td>
<td>5 (3.8)</td>
<td>21 (15.8)</td>
</tr>
<tr>
<td>Missing data</td>
<td>0 (0.0)</td>
<td>29 (21.8)</td>
</tr>
</tbody>
</table>

Psychotic relapse
During the 12-month period of outpatient treatment, 11 (8.3%) patients had a mild relapse, 18 (13.5%) had a severe relapse and 16 (12%) were readmitted. The mean duration of readmission in patients suffering from a severe relapse was 62.5 days.

Effect of early intervention
The time interval between the patient’s first contact with psychiatric services and time of admission to our hospital correlated with severity of negative symptoms at the end of the treatment programme ($\chi^2 = 12.21; p < 0.01$).

2.2.4. Discussion

The main finding of this retrospective cohort study of young patients with recent-onset schizophrenic disorders was the major increase in structural activities during the treatment period (mean 15.6 months). This is important, because patients consider having meaningful activities as primary determinant of their quality of life (Mercier, 1994). The improvement in social functioning is probably related to the low relapse rate during the 12 months of outpatient care. In the present study, low dose pharmacotherapy resulted in relatively few psychotic relapses and was not associated with a worsening in social functioning. The relatively low proportion of patients experiencing relapses is in agreement with a previous prospective study in a comparable population (Linszen et al., 1996).

Patients were young when admitted to our hospital, and the time between the first contact with psychiatric services and time of admission to our hospital
was modest. In a subgroup of the studied population, early intervention was associated with fewer negative symptoms at the end of the outpatient phase. Early intervention therefore seems to be important in achieving a favourable outcome. The addition of psychosocial intervention may also be important to counteract demoralization and loss of social functioning, and provide support to young patients with recent-onset schizophrenic disorders.

A major limitation of the present study is the relative short 1-year timespan of treatment in a disease such as schizophrenia. Nevertheless, the decrease in psychotic relapse and readmission during the first year after the intensive treatment is significant, especially as most psychotic relapses and readmissions take place during the first year after admission (Eaton et al., 1992a, 1992b).

The retrospective design of the present study and the lack of controls permit only tentative conclusions. Improvement in social functioning and relatively few psychotic relapses could be caused by evaluating a selected patient population. However, the large number of patients with comorbidity (i.e. cannabis abuse in 37 out of 133 patients), the young age at onset of the disease (Johnstone et al., 1989) and the predominance of men (75%) does not support a positive outcome a priori. In addition, the 42 patients with a diagnosis other than schizophrenia did not improve the results: patients with a bipolar disorder had a relapse percentage of 33.3%, while the relapse rate in patients with a schizophreniform or schizoaffective disorder, or a psychotic disorder not otherwise specified did not differ from those with a schizophrenic disorder.

Our results are in agreement with those of other studies evaluating the combination of pharmacotherapy and psychosocial intervention (Goldstein et al., 1978; Leff et al., 1982; 1985; Falloon et al., 1982; 1985; Tarrier et al., 1988) and social skills training and family interventions (Hogarty et al., 1986; 1991). In addition to early timing of intervention, individually tailored intervention, continuity of care, cooperation with parents, and early intervention in case of prodromal symptoms of psychotic relapse contribute to relatively few psychotic relapses and to an improvement of social functioning. Parents also play an important role in the implementation and maintenance of the treatment.

Although the results after 1 year of treatment are promising, a prospective study with a longer duration is clearly needed. Furthermore, the results suggest that in studies on the duration of untreated psychosis, delay in starting intensive psychosocial intervention might be a critical factor which needs to be taken into account.
References


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