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Adolescent insanity revisited: Course and outcome in early-onset schizophrenia spectrum psychoses in an 8-year follow-up study

Barbara Remberk[a,*], Anna Katarzyna Bażyńska[a], Anna Krempa-Kowalewska[b], Filip Rybakowski[a,c]

[a]Department of Child and Adolescent Psychiatry, Institute of Psychiatry and Neurology, ul. Sobieskiego 9, 02-957 Warsaw, Poland
[b]GfK Polonia, ul. Ludna 2, 00-406 Warsaw, Poland
[c]University of Social Sciences and Humanities, ul. Kutrzeby 10, Poznan, Poland

Abstract

Objectives: Despite inclusion of adolescent insanity—a concept proposed by Thomas Clouston in late XIX century—into the broader nosological entity of dementia praecox, the uniqueness of early psychosis is still discussed. The aim of the current study is the assessment of course and outcome in the large sample of early-onset psychosis subjects.
Method: Of 299 patients hospitalized in the period 1998–2008 in an adolescent psychiatry ward with schizophrenia spectrum diagnosis 158 completed a follow-up interview. Data concerning current diagnosis, further admissions, current treatment status and occupational and relationship outcome were analyzed after a mean of 8 years of follow-up.
Results: Mean age at the index admission and the follow-up was 16.6 ± 1.2 and 24.5 ± 3.0 years respectively. After the subsequent discharge almost all subjects (97%) at least briefly continued psychiatric treatment and 75% of patients had been readmitted. Overall diagnostic stability was 42%. For schizophrenia spectrum disorders and schizophrenia diagnostic stability was 72% and 78%, respectively. At the follow-up assessment 119 (77.3%) of the traced subjects declared current psychiatric treatment and 110 (73.3%) were receiving pharmacotherapy. Almost half of the subjects (48%) were employed or studying and more than a third (35.8%) remained in a stable relationship. Different distributions of baseline diagnoses were observed in males and females, and the latter showed a better outcome.
Conclusion: Early-onset psychoses were characterized by limited diagnostic stability, a necessity for further treatment and hospitalizations and significant percentage of unfavorable functional outcomes. Baseline diagnosis of acute and transient psychotic disorders and female gender were associated with an overall better outcome.
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1. Introduction

Adolescent insanity is a diagnosis developed in 1873 by Thomas Clouston. The condition is characterized by a high heredity factor and could terminate in two differing ways: in about 30% of asylum patients Clouston [1] observed secondary dementia while in 50%–60% of subjects the outcome was recovery. Later Kraepelin's [2] definition of *dementia praecox* absorbed the concept of adolescent insanity. However in 1904, Clouston [3] argued that the term *dementia* should not be used for the potentially curable condition. The issue of nosology and outcome of adolescent-onset psychoses remains unsettled also in modern time [4].

Although the classification systems ICD [5] and DSM [6] cover the whole age spectrum, in the literature the subtype of early-onset psychoses (EOP) is defined. It is suggested that EOP (as psychoses starting before the age of 18) may be more diagnostically challenging than psychotic disorders with adult onset [7]. During 1–2 years of follow-up constancy of the diagnosis in EOP is about 50% [8,9]. Transient psychotic disorders show the lowest diagnostic stability with the most common diagnostic shifts to schizophrenia or to bipolar disorder [8,10,11]. On the contrary, once the diagnosis of schizophrenia below age 18 is made it is relatively stable, and is considered to have poorer prognosis and outcome, than its adult-onset

* Corresponding author. Tel.: +48 22 4582806; fax: +48 22 6421272.
E-mail addresses: bremberk@ipin.edu.pl (B. Remberk), abazynska@ipin.edu.pl (A.K. Bażyńska), anna.krempa-kowalewska@gfk.com (A. Krempa-Kowalewska), filrybak@yahoo.com (F. Rybakowski).

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counterpart [12]. In the schizophrenia subgroup, non-insidious onset [13,14] and paranoid subtype [14] were associated with better outcomes. A substantial minority of EOP subjects may exhibit a complete remission of psychotic symptoms, and remain asymptomatic at follow-up [13,15,16].

A review of studies analyzing long-term functional outcome in early-onset psychosis was performed by Clemmensen et al. [12]. The results varied considerably across studies with good outcome varying from 0% to 29% of patients and poor outcome from 24% to 79%. Factors associated with higher probability of poor outcome included pure early-onset schizophrenia (versus mixed psychoses) samples, longer duration of follow-up and male sex. Traditionally early-onset schizophrenia is considered a more severe form of the illness [17]. Indeed childhood-onset schizophrenia seems to have poor prognosis, however direct comparisons of childhood- and adult-onset schizophrenia are rare [18]. Data concerning adolescent-onset psychosis are also ambiguous: some studies confirm more severe course of adolescent-onset schizophrenia [18], others assessing the whole psychosis spectrum did not find differences in terms of medical and functional outcome [19,20]. Even more striking results were obtained by Amminger et al. [15]. In the specific setting of Early Psychosis Prevention and Intervention Centre a better outcome in the early-onset SSD than in the adult-onset SSD was observed.

In their follow-up study Valevski et al. [11] proposed an interesting construct of Transient Adolescent Psychosis (TAP). TAP seems to be a subtype of acute and transient psychotic disorders with no bizarre or negative symptoms and the content of symptoms focusing on problems associated with adolescent crisis. Although the diagnostic stability of TAP was low, this diagnosis was associated with a relatively benign course and outcome.

To summarize, follow-up studies on EOP display a varied outcomes possibly associated with limited diagnostic stability. The common limitations of previous studies on outcome in EOP were either a small sample size or moderately short period of follow-up.

1.1. Aim of the study

The aim of the current study is the assessment of course and ultimate outcome in the large sample of EOS subjects in the longer time frame.

2. Methods

The current study is a part of a larger follow-up of EOP project [21]. The study has been performed in accordance with the 1964 Declaration of Helsinki. The design of the study has been accepted by the Bioethics Committee (Institutional Review Board) of the Institute of Psychiatry and Neurology in Warsaw.

2.1. Participants

Two hundred ninety-nine patients had been hospitalized in the Department of Child and Adolescent Psychiatry, Institute of Psychiatry and Neurology, Warsaw, between June 1998 and June 2008 with the diagnosis of early-onset non-affective psychosis. All patients hospitalized in this period with a primary diagnosis within the schizophrenia spectrum were included in the study. Diagnoses comprised schizophrenia spectrum disorders (schizophrenia F20, schizotypal disorder F21, pervasive delusional disorder F22, acute and transient psychotic disorder F23, schizoaffective disorder F25, other psychotic disorder F28 and psychotic disorder not otherwise specified F29) made according to the diagnostic criteria specified in International Classification of Disease-10 [5]. Following previous studies of Valevski et al. [11] we used a broader definition of adolescence and included all patients hospitalized in Child and Adolescent Psychiatry Ward extending age range to 20.0.

Baseline psychiatric diagnosis was made in the few-steps procedure. Preliminary diagnosis was proposed by attending clinician after semi-structured psychiatric interview with a patient and his/her parents at the admission stage. The semi-structured interview was focused on the patient's history and clinical assessment and followed the practical guidelines of adolescent mental state examination. The preliminary diagnosis was established following the ICD-10 guidelines (ICD-10 diagnostic criteria, [5]). Final diagnosis was established after further observation of symptoms during admission and verification within a multidisciplinary treatment team including experienced senior psychiatrists. Baseline data were stored in the medical records from which they were obtained during the current study.

Mean age at the baseline hospitalization was 16.6 ± 1.2 years (range 14.0–20.0). Of the 299 subjects, 159 (53.1%) could be traced and interviewed at the follow-up. One of the subjects after the follow-up assessment withdrew her consent for participation in the study and so finally158 subjects (52.8%) were included.

2.2. Ratings

The following data were obtained from the medical records: age of the first admission in the Institute of Psychiatry and Neurology, baseline diagnosis, length of hospitalization and discharge in accordance to or against medical advice.

In the follow-up assessment the structured interview was used. Data obtained during the interview included: current ICD-10 diagnosis, current psychiatric treatment (yes/no), consecutive hospitalizations (yes/no, number), current pharmacotherapy (yes/no, what of medication), current marital status (married/single), being currently in any stable relationship (yes/no), current educational or occupational activity and receiving a disability pension associated with psychiatric handicap (yes/no). Data were coded as categorical variables (ICD-10 diagnosis, type of current activity),

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