



Life and treatment goals of individuals hospitalized for first-episode nonaffective psychosis

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ABSTRACT

First-episode psychosis typically emerges during late adolescence or young adulthood, interrupting achievement of crucial educational, occupational, and social milestones. Recovery-oriented approaches to treatment may be particularly applicable to this critical phase of the illness, but more research is needed on the life and treatment goals of individuals at this stage. Open-ended questions were used to elicit life and treatment goals from a sample of 100 people hospitalized for first-episode psychosis in an urban, public-sector setting in the southeastern United States. Employment, education, relationships, housing, health, and transportation were the most frequently stated life goals. When asked about treatment goals, participants' responses included wanting medication management, reducing troubling symptoms, a desire to simply be well, engaging in counseling, and attending to their physical health. In response to queries about specific services, most indicated a desire for both vocational and educational services, as well as assistance with symptoms and drug abuse. These findings are interpreted and discussed in light of emerging or recently advanced treatment paradigms—recovery and empowerment, shared decision-making, community and social reintegration, and phase-specific psychosocial treatment. Integration of these paradigms would likely promote recovery-oriented tailoring of early psychosocial interventions, such as supported employment and supported education, for first-episode psychosis.

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1. Introduction

Nonaffective psychotic disorders often emerge during late adolescence or early adulthood, a time in life when individuals normally achieve important educational, vocational, and relationship milestones. People with emerging schizophrenia spectrum disorders are often derailed at this stage, developing significant educational, occupational, and interpersonal deficits (Hafner et al., 1995). The early stages of psychosis are often considered to be a “critical period” (Birchwood, 1999), as long-term follow-up studies show that two-year outcomes strongly predict longer-term illness outcomes (Harrison et al., 2001). Evidence suggests that treatment is more effective when implemented earlier, though early intervention is a relatively new concept in the mental health field (Drake et al., 2000).

The early intervention paradigm involves timely, phase-specific initiation of both pharmacologic and evidence-based psychosocial treatments. Yet, these ideal approaches are often complicated by little availability of specialized services and problems with patients' insight and adherence. Impaired insight, which is not a willful denial but rather a part of the illness itself, commonly results in noncompliance with medications and psychosocial interventions (Lysaker and Bell, 1994; Burton, 2005; Tasang et al., 2009) and differences in treatment goals between patients and their providers only compound this situation (Chue, 2006; Diamond, 2006). To bridge this gap, the recovery model, a more personalized and patient-centered approach to caring for persons who have mental illnesses, has emerged (Jacobson and Greenley, 2001).

The traditional medical concept of “recovery” (i.e., a person is cured from or no longer contends with an illness), has been replaced by some within the medical field with a new conceptualization, which is believed to better account for the oftentimes persistent nature of serious mental illnesses. Within this framework, recovery is thought to be a process rather than an outcome, and is focused on the individual and his or her journey toward attainment of personal recovery and life goals, rather than just the absence of symptoms (Buckley et al., 2007).

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Fundamental elements of the recovery model include consumers assuming more responsibility in developing plans for achieving their goals, and working collaboratively with mental health providers and their support systems (Jacobson and Greenley, 2001).

To embrace the recovery model, clinicians, researchers, and program planners must understand consumers' own goals. At present, there is a paucity of research investigating what people with first-episode psychosis want from treatment. The objective of this investigation was to summarize the life and treatment goals of a sample of individuals hospitalized for treatment of first-episode nonaffective psychosis, along with their perception of how mental health professionals could assist them. Understanding their goals may reveal essential implications for recovery-oriented tailoring of early psychosocial interventions.

2. Methods

2.1. Setting and sample

Participants were recruited from the psychiatric units of a large, urban, university-affiliated, public-sector hospital ($n = 82$) and a suburban county psychiatric crisis center ($n = 18$), as part of a larger, ongoing study in the southeastern United States. These treatment centers predominantly serve urban African Americans. To be eligible, individuals must be hospitalized for a first episode of a nonaffective psychotic disorder and provide written informed consent. Those with known mental retardation, a Mini-Mental State Examination (Cockrell and Folstein, 1988) score of <23 , a significant medical condition compromising their ability to participate, prior antipsychotic treatment of >3 months duration, previous hospitalization for psychosis occurring >3 months prior to index hospitalization, or inability to provide informed consent were excluded.

2.2. Procedures

The procedures were approved by all relevant ethical review boards. The assessment typically took place after the initial stabilization of symptoms and treatment planning (hospital day mean and median of 5.1 and 5.0). The index hospitalization was the first professional help-seeking contact for 44 (44.0%) of participants. Of those who had had previous contacts, the mean and median number of previous healthcare contacts (typically an outpatient appointment with a psychiatrist or an emergency room visit) was 4.2 and 2.

A number of sociodemographic variables were assessed. Employment status was determined by asking if the participant had a job during the past month. Information about household income was obtained from the individual and, when available, family members. Presence of Axis IV psychosocial problems (including problems in the following areas: primary support, the social environment, education, occupation, finances, housing, access to health care, interactions with the legal system, and other areas) was determined after the full research assessment (typically lasting about 6–7 h, and including questions in these areas) was complete. Nonaffective psychotic and substance use disorder diagnoses were derived with the *Structured Clinical Interview for DSM-IV Axis I Disorders* (First et al., 1998).

For this report, qualitative descriptions of participants' life and treatment goals were gathered through a brief, structured interview that was developed based on existing literature on the recovery model. The interview included five open-ended questions pertaining to life and treatment goals, three of which are examined herein:

1. How could mental health professionals be helpful to you in the upcoming few years?
2. What are your top three goals for the upcoming few years?
3. What would your top three treatment goals be, working with mental health professionals?

Participants were given adequate time to generate as many responses as they would like. In addition, four closed-ended questions were used to assess participants' desire for certain services, including those related to "finding a job," "going back to school or getting more education," "staying off drugs," and "getting rid of symptoms." Questions were formatted as follows, *If services were available, would you like assistance from mental health professionals with [finding a job]?*

Participants' responses were written and entered into a dataset. Salient themes were elicited through an inductive approach, such that similar responses were grouped together and emergent categories were first observed, then refined (Pope et al., 2000). The development and finalization of themes within each category was conducted by two of the authors and then reviewed by another.

3. Results

The participants ($n = 100$) were, on average, 24.3 ± 5.1 years of age, with a mean educational attainment of 11.7 ± 2.9 years. As shown in Table 1, this sample is predominantly single, male, African

Table 1

Demographic and clinical characteristics of individuals with first-episode psychosis ($n = 100$).

Age at hospitalization, years	24.3 \pm 5.1
Gender, male	74 (74.0%)
Race, Black or African American	89 (89.0%)
Relationship status, never married	87 (87.0%)
Has children	36 (36.0%)
Years of education	11.7 \pm 2.9
Currently or very recently employed	33 (33.0%)
Income below the federal poverty line ($n = 79$)	29 (39.2%)
Number of Axis IV psychosocial problems	3.9 \pm 2.2
SCID psychotic disorder diagnosis	
Schizophrenia	56 (56.0%)
Psychotic disorder not otherwise specified	17 (17.0%)
Schizoaffective disorder	14 (14.0%)
Schizophreniform disorder	8 (8.0%)
Delusional disorder	3 (3.0%)
Brief psychotic disorder	2 (2.0%)
SCID alcohol use disorder ($n = 93$)	
No disorder	62 (66.7%)
Abuse	12 (12.9%)
Dependence	19 (20.4%)
SCID cannabis use disorder ($n = 92$)	
No disorder	37 (40.2%)
Abuse	14 (15.2%)
Dependence	41 (44.6%)

American, and unemployed. Other demographic characteristics, as well as SCID-derived diagnoses for psychotic, cannabis use, and alcohol use disorders are presented in Table 1.

When asked to list their top three *life goals* for the upcoming years, the top priorities, as shown in Table 2, included goals in the following domains: employment, education, relationships, housing, health, transportation, and others. On average, 2.8 ± 0.87 distinct life goals were elicited and only 3 individuals did not report any life goals for the next few years, while 85 reported 3 or more. Over half of participants reported wanting a job. Some had specific employment goals (e.g., establishing a barbershop) while others placed value on "finding a stable job." Education was a priority for more than a third, many of whom wanted to go to college or complete high school

Table 2

Life goals of individuals with first-episode psychosis for the upcoming years ($n = 100$).

Goal	Percentage of participants who spontaneously listed the goal	Important themes or representative quotes
Employment	53.0%	Finding a job. Owning a business. Practicing a trade.
Education	38.0%	Obtaining a high school degree. Going to or finishing college. Obtaining vocational training.
Relationships	35.0%	Focusing on family. Raising a child. Developing new relationships.
Housing	25.0%	Having one's own place to live.
Health	15.0%	"I want to get my life on track". "I want to have fun again". "I want to have my own car".
Transportation	15.0%	"I want to get my own record label".
Art and music	12.0%	Obtaining wealth.
Financial stability	11.0%	Money management.
Recovering from current mental illness	10.0%	"I want to appreciate what I've been through and realize that things will get better".
Spirituality	8.0%	Developing a relationship with God. Joining a church.
Other	8.0%	Un-replicated or vague responses.
Improving physical health or athleticism	5.0%	"I want to get my body the way I want it to be".

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