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Community-oriented family-based intervention superior to standard treatment in improving depression, hopelessness and functioning among adolescents with any psychosis-risk symptoms

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ABSTRACT

The aim of the present study was to compare change in functioning, affective symptoms and level of psychosis-risk symptoms in symptomatic adolescents who were treated either in an early intervention programme based on a need-adapted Family- and Community-orientated integrative Treatment Model (FCTM) or in standard adolescent psychiatric treatment (Treatment As Usual, TAU). 28 pairs were matched by length of follow-up, gender, age, and baseline functioning. At one year after the start of treatment, the matched groups were compared on change in functioning (GAF-M), five psychosis-risk dimensions of the Structured Interview for Psychosis-Risk Syndromes (SIPS), and self-reported anxiety, depression, and hopelessness symptoms (BAI, BDI-II, BHS). FCTM was more effective in improving functioning (20% vs. 6% improvement on GAF-M), as well as self-reported depression (53% vs. 14% improvement on BDI-II) and hopelessness (41% vs. 3% improvement on BHS). However, for psychosis-risk symptoms and anxiety symptoms, effectiveness differences between treatment models did not reach statistical significance. To conclude, in the present study, we found greater improvement in functioning and self-reported depression and hopelessness among adolescents who received a need-adapted Family- and Community-orientated integrative Treatment than among those who were treated in standard adolescent psychiatry.

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1. Introduction

Early detection and intervention have been shown to be beneficial to young people in the at-risk state for psychosis, and during the last decade many early intervention services have been implemented around the world (McGorry et al., 2002; Marshall and Rathbone, 2011; Bechdolf et al., 2012; Morrison et al., 2012; Stafford et al., 2013). These early intervention services are intended for young people who are seeking help for their first psychosis episode or for psychosis-risk symptoms. Young people seem to benefit from early intervention in the sense of psychosis symptom reduction, even though currently it is not clear if special treatment models can lead to lower conversion rates from the at-risk state to psychosis (Bechdolf et al., 2012; Morrison et al., 2012;

Stafford et al., 2013). Psychosis-risk symptoms are more prevalent in the general population of young people than in the part of the population which develops psychosis (Kaymaz et al., 2012), and a valid distinction between young people who are at risk and those who are not is difficult to make (Schimmelmann and Schulze-Lutter, 2012). Nevertheless, given that many adolescents seeking help with or without at-risk symptoms are in need of care, Schimmelmann and Schulze-Lutter (2012) have suggested that treatment is justified independent of conversion risk to psychosis as at-risk adolescents and their caregivers experience distress and impairment. At the moment, there is insufficient evidence to delineate appropriate strategies for early intervention (Schimmelmann and Schulze-Lutter, 2012). However, specific psychological treatment methods, such as cognitive behavioural therapy, seem to have a stronger effect on symptom reduction than standard treatment or supportive counselling (Stafford et al., 2013).

Psychological stress has been shown to have an impact on developing psychotic disorder according to the vulnerability-stress model of psychosis, which postulates that psychosis results

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from the combined effects of stress and trait-like vulnerability to psychosis (Zubin and Spring, 1977; Phillips et al., 2007). It has also been found that stress may generate other psychiatric symptoms, for example, depressive and anxiety disorders (Uliaszek et al., 2012). Loch et al. (2011) suggest that depression is present on a continuum of psychotic experiences; in their study, depression was present in a group of treatment-seeking subjects who had clinically relevant hallucinations and delusions, as well as in subjects who had no clinically relevant psychotic experiences.

Indeed, there is empirical evidence to suggest that emotional symptoms such as depression and anxiety may be intrinsic to the development of psychosis or may arise as a psychological reaction to psychotic symptoms (Nordström et al., 1995; Birchwood, 2003; Miller et al., 2003; Svirskis et al., 2005; Yung et al., 2008; Rietdijk et al., 2011; Marshall and Rathbone, 2011; Addington et al., 2011; Klonsky et al., 2012; Fusar-Poli et al., 2014). Perhaps even more clinically relevant is that an at-risk state is associated with a compromised level of functioning, as reflected by global assessment, and lowered general levels of functioning have been associated with increased risk for conversion to psychosis (Fusar-Poli et al., 2015).

Previous evidence suggests change in functioning – which is as important as symptom levels – among adolescents who are seeking help for psychiatric symptoms and who are treated in an early intervention service. However, the evidence is inconsistent as regards benefits resulting either from specific psychosocial or pharmacological treatment relative to standard or needs-based care. A pioneering Australian study (McGorry et al., 2002) of an early intervention treatment for subjects at clinical risk for psychosis reported an improvement in functioning in both a special treatment group (risperidone + cognitive behavioural therapy) and in a specific treatment group. Furthermore, no differences in the functioning ability of at-risk subjects who had received either cognitive therapy or monitoring were found after treatment in the multicentre study by Morrison et al. (2012). However, there was greater improvement in psychotic symptoms in the special treatment group (Morrison et al., 2012). Further, in a meta-analysis (Stafford et al., 2013) in which all available intervention studies (including antipsychotic medication, cognitive behavioural therapy, and omega-3 fatty acid supplement treatments) for psychosis risk were included, evidence of moderate quality indicated that cognitive therapy reduces transition to psychosis in at-risk subjects compared to standard treatment, and low- to very low-quality evidence for both omega-3 fatty acids and integrated therapy (individual cognitive behavioural therapy, cognitive remediation, group skills training and family treatment) showed reduced transition to psychosis at 12 months.

Family plays an important role in supporting adolescents (McFarlane et al., 2010), and thus family members' support to those who are undergoing adolescent psychiatric care is important. Family members need to know how to help and how to react in challenging situations (Wilson et al., 2010), but they also need the opportunity to express their own concerns about the family or the adolescent.

The emotional atmosphere in the family environment, parental attitudes, behaviour, and coping strategies are associated with functional outcomes and symptom expression in at-risk adolescents (O'Brien et al., 2008). In addition, a positive family environment predicts improvement in symptoms and social functioning among adolescents at imminent risk for onset of psychosis (O'Brien et al., 2006). Therefore, the family environment should be a specific target of treatment for individuals at risk for psychosis (Schlosser et al., 2010). Finally, previous studies have reported that adolescents with heightened risk of psychosis who seek help show significant improvement in psychotic experiences, quality of life, depression, anxiety, and hopelessness in a Family- and Community-orientated, need-adapted integrative treatment model (Granö et al., 2009, 2013, 2014).

A substantial group of studies shows that psychiatric symptoms are present in a continuum of psychotic symptoms (van Os et al., 2009). Furthermore, subsyndromal psychotic and emotional symptoms may be responsive to psychiatric treatment that focuses on stress reduction (Phillips et al., 2007). Our hypothesis was that stress-reducing care carried out in co-operation with family members in the community (schools, home) and with multidisciplinary workers from the community may have a stronger positive effect on the level of psychiatric symptoms and effectively supports functioning in help-seeking adolescents.

The aim of the present study was to assess change in functioning, level of psychosis-risk symptoms, as well as symptoms of anxiety, depression, and hopelessness in adolescents who participated in an early intervention and detection programme based on a Family- and Community-orientated treatment model. The idea was to compare the adolescents' improvement with a group of adolescents who were matched in age, follow-up time, and functioning and who received standard treatment (e.g. counselling and medication) in a secondary-care adolescent outpatient unit.

2. Methods

2.1. Procedure, interventions, and participants

2.1.1. Procedure

The participants were selected from two separate studies that investigated two different treatment approaches carried out in Finland, by two separate research institutions: a Family- and Community-orientated, need-adapted integrative Treatment Model (FCTM) and Treatment As Usual (TAU). The FCTM studied early detection and intervention in adolescents who were treated at primary care. The TAU study followed adolescents in standard secondary care, to collect information about the development of psychiatric symptoms in adolescents.

The baseline assessment time point was at the beginning of treatment and the follow-up assessment was scheduled after one year from the beginning of the treatment. This study presents the comparison of the outcomes of matched adolescents (Appendix 1) in the FCTM programme and in standard secondary psychiatric services. For the purpose of the present comparison, the FCTM study was designed in co-operation with the TAU study to have similar measurements and follow-up times. More specifically, we report the treatment outcome with respect to level of symptoms of clients in the FCTM intervention and their matched pairs in TAU in the secondary psychiatric services for adolescent outpatients.

2.1.2. Interventions

2.1.2.1. FCTM. FCTM (1 April 2009 to 31 October 2011) was designed as an early detection and intervention team and as a research project for adolescents at risk of developing psychosis. FCTM was a treatment model that integrated elements of family therapy, need-adapted treatment for psychosis by Alanen et al. (1991), Open Dialogue (Seikkula and Olson, 2003), and elements from cognitive behavioural therapy (for example, normalizing and psycho-education). It was based on community outreach and co-working with families of adolescents and primary health-care workers in the community (Table 1.). The catchment area consisted of five towns with a total population of half a million inhabitants.

The detection and intervention model of the FCTM team was originally developed by researchers from Helsinki University Central Hospital between the years 2006 and 2008 (Granö et al., 2009). The FCTM team was a multidisciplinary group consisting of psychiatric nurses, occupational therapists, psychologists, and a supervising psychiatrist. The FCTM team members met help-seeking adolescents who were between the ages of 12 and 22 in

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