Schizophrenia and Psychosis

Diagnosis, Current Research Trends, and Model Treatment Approaches with Implications for Transitional Age Youth

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KEYWORDS

• Schizophrenia • Psychotic disorders • Therapeutics • Education • Adolescence

KEY POINTS

- Current best-practice models of schizophrenia treatment are multidisciplinary, recovery oriented, and include medications, with psychosocial interventions involving as many of the patient's supports as possible.
- Psychosocial interventions with families may be helpful to improve outcomes for youth at high risk for psychosis, but these interventions still require significant validation.
- There are imprecisions in the definitions of psychosis and first episode, especially in the ultrahigh-risk/clinical-high-risk literature.
- The emerging adult period is a critical stage in which the developmental trajectory can be significantly altered but can also be a time of higher treatment responsiveness toward stable remission.

INTRODUCTION

At first glance, a diagnosis of schizophrenia seems distinct, and the clinical signs have long been described by Kraepelin and Bleuler.[1] Frequently with onset coincident with the developmental age of emerging adulthood, particularly in young men, its annual incidence is up to 0.70/1000/y consistently worldwide.[2,3] There is a well-known bimodal peak of onset during ages 15 to 24 years, which is slightly

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weighted toward men, and weighted toward women at 55 to 64 years.[3,4] The disorder affects men and women, with a higher lifetime risk in men.[4]

Having genetic familial clustering, schizophrenia carries a standard mortality ratio of 2.6, usually from suicide or cardiovascular risk.[5] Although familial clustering is important (eg, 22q11.2 deletion), sporadic cases of schizophrenia occur more often, possibly due to associated decreased fertility and fecundity.[6,7] The reasons for this decrease are unclear, but clinicians should still discuss family planning, social, sexual and romantic relationships, particularly in the late adolescent and young adult population. Familial risks of schizophrenia are outlined in **Table 1**.[3,8,9]

The course of schizophrenia, from acute to stabilization and recovery phase, varies widely from total incapacity to remission.[10] Rapid initiation of antipsychotic pharmacologic treatment is indicated; when the first episode of schizophrenia is treated, it has a better prognosis and requires a lower antipsychotic dosage than a long duration of untreated psychosis (DUP).[10] The 5 years following the first episode, often called the critical period forecasting illness progression, usually includes relapse.[10,11] Beyond this initial critical period and through the following decade, schizophrenia tends to plateau and not devolve to a progressively deteriorating condition.[11] This is useful psychoeducation for young adult patients in order to instill hope, encourage compliance, and work toward recovery. Some favorable prognostic indicators of schizophrenia are listed in **Box 1**.[10]

Readers are invited to contemplate how the disorder and treatments described can affect traditional adolescent and young adult milestones: for example, self-reliance and affiliation with peers; sense of identity; empathy; affect regulation and impulse control; development of sexuality and intimate relationships; ethical and moral development; and negotiating familial relationships. Additional milestones include expanded capacity for abstract thought, creative pursuits, and academic and/or occupational productivity. The model program NAVIGATE described in this article addresses the treatment of schizophrenia that follows system-of-care values and principles and emphasizes individual placement and supported employment.[10,12] This publication has also produced a 2013 edition dedicated to psychosis in youth, referenced throughout this article.[13]

MAKING THE DIAGNOSIS: CURRENT CRITERIA

Schizophrenia

Using the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Revision, schizophrenia is identified by signs of disordered thinking manifest in disorganized

Table 1
Familial risks in schizophrenia

General Population Prevalence (12 mo)	1% (1 in 100)
Lifetime Development Risk (%)	0.7 (0.3–2)
Family History First-degree Relative (%)	9–18
Family History Second-degree Relative (%)	3–6
Family History Third-degree Relative (%)	2–3
Nontwin Sibling Risk (%)	8 (9–18)
Twin Risk: Monozygotic (%)	47–48 (41–65)
Twin Risk: Dizygotic (%)	12 (0–28)
Child with 1 Parent with Schizophrenia (%)	12–14 (2–35)
Child of 2 Parents with Schizophrenia (%)	40–46 (40–60)

Data from Refs.[3,9,10]