



Comparing illness presentation, treatment and functioning between patients with adolescent- and adult-onset psychosis



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ABSTRACT

Studies have shown that early- and adult-onset schizophrenia patients differ in pre-morbid traits, illness presentation, psychopathology, and prognosis. We aimed to compare adult-onset patients (age range 26–55 years) with an adolescent-onset cohort (15–25 years) in demographics, illness presentation and functioning at baseline. Participants were from two territory-wide early intervention services for adolescent-onset ($n=671$) and adult-onset psychosis patients ($n=360$) in Hong Kong. The adolescent-onset cohort had their initial psychotic episode from 2001–2003; retrospective data collection was done through systematic case note review. The adult-onset cohort was recruited for a larger interventional study from 2009–2011; information was collected via face-to-face interviews. Adult-onset psychosis was significantly associated with more females, fewer smokers, more non-local birth, more full-time employment, better functioning, poorer medication adherence, more psychiatric hospitalization and fewer with schizophrenia than adolescent-onset psychosis (mean age: 20.4). The effect sizes were small, except for medication adherence where a robust effect was found. No group difference in DUP was found. The finding that adult-onset patients had better functioning challenges the view that adolescent- and adult-onset psychoses share a similar prognostic trajectory. Implications for adapting intervention processes for adolescent- and adult-onset psychosis are discussed.

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1. Introduction

Psychotic disorders including schizophrenia are characterized by disturbances in one's perceptual, cognitive and motivational processes. While onset commonly occurs in early adulthood, it was found that over 50% of psychotic disorders start after this period (Penrose, 1991). Kraepelin observed that the onset of 'dementia praecox' was not only restricted to those in their youth and early adulthood but also occurs in late adulthood (Kraepelin, 1919). Literatures dating back to the 1980s suggest that patients with different ages of onset differ in pre-morbid traits, illness expression, psychopathology and treatment response (Harris and Jeste, 1988; Pearlson et al., 1989). Therefore, a need for specific management and treatment approaches including dosing, switching and side effect monitoring in early- and adult-onset psychosis has recently been proposed (Schimmelmann et al., 2013).

Presently, early intervention programs mainly focus on younger patients with onset in late adolescence and early adulthood (McGorry et al., 1996; Birchwood et al., 1998; Chen, 2004). Neglect of adult-onset patients in the arena of psychosis research and intervention may be related to the fact that no consensus has been made regarding the cutoff age and symptomatology of late-onset schizophrenia; thus the terminology is defined differently across studies (Harris and Jeste, 1988). In Hong Kong, when the Early Intervention Service for Young People with Psychosis (EASY) was established in 2001, service was only delivered to first-episode patients aged below 25 years (Chen, 2004) due to limited resources. It was not until more recently, through increased mental health funding, that early intervention services became available to psychotic patients aged 26 or above. The establishment of the Jockey Club Early Psychosis (JCEP) Project in 2009, followed by the EASY extension program in 2010 (Wong et al., 2012), presents the opportunity for a more thorough investigation of the adult-onset cohort. Better understanding of age-related differences at onset will enable a more tailored early intervention and detection program for psychosis, reducing the cost of care and patients' burden in the long run.

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Studies have shown that the early- and adult-onset patients differ across many different aspects. Reviewing more than 30 European literatures between 1913 and 1986, [Harris and Jeste \(1988\)](#) found that adult-onset patients (onset after 40 years) were more likely to be female, characterized by paranoid pathology, schizoid or paranoid traits, and their symptoms were more readily improved by medication. In a chart review study, [Pearlson et al. \(1989\)](#) suggested that adult-onset patients (onset after 45 years) had more pre-morbid schizoid traits and were more likely to have visual, tactile, olfactory hallucinations, and persecutory delusions, but less likely to have thought disorder or affective flattening. A recent meta-analysis, comparing cognitive functioning between the two, found that early-onset patients exhibited larger deficits in arithmetic, executive function, IQ, psychomotor processing speed and verbal memory ([Rajji et al., 2009](#)). While some studies suggested that early-onset patients generally had poorer outcomes than adult-onset patients ([Schmidt et al., 1995](#); [Lay et al., 2000](#)), some found no differences in symptoms and functioning ([Schimmelmann et al., 2007](#); [Langeveld et al., 2012](#)), or even fewer symptoms and superior functioning at long-term follow-up ([Amminger et al., 2011](#)).

The current study compares two large samples of first-episode adolescent-onset and adult-onset psychosis patients in Hong Kong. Differences in their demographic profile, illness presentation, treatment and functional level at baseline were studied.

2. Methods

2.1. Participants

Adolescent-onset psychosis patients were recruited from Hong Kong's Early Assessment Service for Young People with Psychosis (EASY). EASY, covering the entire population of 7 million, provides specialized comprehensive intervention for patients with first-episode psychotic disorders aged between 15 and 25 ([Chen, 2004](#)). A total of 671 patients, consecutively enrolled into EASY between 2001 and 2003, were identified using the hospital psychiatric case registry. Informed consent from individual patients was waived by the institutional review board and ethics committees of the applying sites.

The Jockey Club Early Psychosis (JCEP) Project, established in 2009 in Hong Kong, has been providing specialized intervention service to first-episode patients aged between 26 and 55. During 2009–2011, 747 patients were screened: 198 did not meet inclusion and exclusion criteria, 48 defaulted from service, 141 refused consent when approached by trained research assistants and 360 provided written informed consent for participation. The studies were approved by the relevant institutional review boards, and were carried out in accordance with Good Clinical Practice and the declaration of Helsinki.

In both groups, patients diagnosed with the following disorders according to ICD-10 criteria (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision) were included: schizophrenia, acute and transient psychotic disorders, psychosis not otherwise specified, delusional disorder, bipolar disorder with psychotic symptoms, schizoaffective disorder, and schizophreniform disorder. Patients with drug-induced psychosis, mental retardation and significant organic condition were excluded.

2.2. Assessments

In the adolescent-onset cohort, data were collected retrospectively in 2006 using a standardized procedure of comprehensively reviewing clinical records ([Chen et al., 2011](#)). Both out- and in-patient medical records were retrieved by trained research assistants.

In the adult-onset cohort, data were collected via face-to-face interviews with trained research assistants within a mean of 4 months from patients' first psychotic episode. To ensure a more accurate comparison between the two cohorts, only data that are reliably recorded in clinical records and could be objectively measured were compared in the current study.

Basic demographic information including age, gender, years of education (excluding kindergarten), occupational status (full/part-time, homemaker, student, rehabilitation, or unemployed), smoking habit, place of birth (Hong Kong, China, or elsewhere) were recorded. Date of migration and duration of residency were recorded for patients born outside Hong Kong. Information regarding hospitalization during first episode was collected.

Standardized operational definitions for age of onset, duration of untreated psychosis (DUP), and mode of onset were set for systematic data extraction in the

adolescent-onset cohort. Age of onset refers to the age at which the psychosis starts. DUP was defined as the period between the onset of psychosis (i.e. first emergence of positive symptoms) and the receipt of antipsychotic treatment. Mode of onset refers to the developmental period of the first episode, when a patient progresses from a symptom-free condition to full emergence of positive symptoms. Three modes of illness onset were defined: acute (within one week), sub-acute (2–4 weeks) and insidious (over a month). Research assistants were trained by clinicians in data extraction according to these standardized operational definitions. Weekly consensus meetings among clinicians and research assistants during the period of data collection were held to maintain data quality and to resolve ambiguity in information.

In the adult-onset group, illness onset and presentation were assessed using the Interview for the Retrospective Assessment of the Onset of Schizophrenia (IRAOS) ([Hafner et al., 1992](#)). The same definitions for age of onset, DUP and mode of onset were applied for the early- and late-onset groups. While data for the adolescent-onset patients were extracted from medical records, data for adult-onset patients were collected through face-to-face interviews with patients and collateral sourcing of information from carers or informants, and reviewing medical records.

In the adolescent-onset cohort, the type of antipsychotic medication (conventional and/or atypical) and level of adherence (good/poor) were rated based on medical case notes and drug dispensing records. In the adult-onset cohort, patients filled out an adapted 4-point Medication Adherence Scale ([Thompson et al., 2000](#); [Hui et al., 2006](#)). They were categorized as having good adherence if they answer 1/2 for negative statements and 3/4 for affirmative statements.

Functioning level was measured for the EASY adolescent-onset group and the JCEP early-onset group at baseline with Social and Occupational Functioning Assessment Scale (SOFAS) ([Goldman et al., 1992](#)). The scale assesses social and occupational functioning in psychiatric patients by using a score ranging from 1–100, with higher scores indicating higher functioning level.

2.3. Statistical analysis

Basic demographics and baseline clinical characteristics between the adolescent-onset and the adult-onset groups were compared using SPSS for Windows (Version 20). For continuous, normally-distributed variables, independent *t*-tests and analysis of variance (ANOVA) were used for comparison, and Cohen's *d* was used to calculate the effect sizes. Preliminary analyses of continuous variable distributions indicated that DUP was significantly skewed. Hence, the non-parametric Mann-Whitney test and Rosenthal's *r* were used instead. Chi-squared analysis (χ^2) was applied when the dependent variable was categorical, and Cramer's *V* was used to estimate effect size.

3. Results

Data from 1031 patients were included in the current study: 671 adolescent-onset patients (EASY) and 360 adult-onset patients (JCEP). Mean age of onset was 20.4 years (S.D. 3.3) for adolescent-onset patients and 36.6 years (S.D. 8.7) for adult-onset patients.

3.1. Baseline demographics, functional, clinical and treatment characteristics

[Table 1](#) shows the basic demographics and baseline clinical characteristics of the two samples.

As shown in [Table 1](#), the adult-onset group had fewer smokers than the adolescent-onset group. More adult-onset patients were of non-local birth. Taking into account the percentage of non-local born in the relevant time period and age groups of the general population ([Census and Statistics Department of Hong Kong, 2002, 2012](#)), immigrants were overrepresented in both adolescent and adult-onset groups (EASY: 20.0% vs. 15–24 year-old population (in 2001) 15.6%, $\chi^2(1, N=671)=9.72, p=0.002$; JCEP: 32.5% vs. 25–54 year-old population (in 2011) 25.9%, $\chi^2(1, N=360)=8.20, p=0.004$). Among the immigrants, there were significantly more women than expected in the adult-onset group (JCEP: 71.8% vs. 25–54 year-old non-local born population (in 2011) 61.2%, $\chi^2(1, N=117)=5.51, p=0.019$) but not in the adolescent-onset group (EASY: 53.7% vs. 15–24 year-old non-local born population (in 2001) 47.6%, $\chi^2(1, N=134)=2.0, p=0.16$). Age of arrival and number of years living in Hong Kong were significantly higher in the adult-onset group.

The adult-onset group had more patients working full-time, part-time, and fewer unemployed. Adult-onset patients were

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