First Episode Psychosis
Update on treatment options and research progress

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Workshop at NAMI 2012 Conference - Stronger Together: Partners for the Future
Learning Objective

- What is prodrome vs. first episode of psychotic break?
- Challenges facing patients and families experiencing the first psychosis episode
- Treatment options and limitations
- Update on current research progress
MPRC’s First Episode Clinic

The Maryland Psychiatric Research Center (MPRC)

A part of the

University of Maryland
School of Medicine,
Department of Psychiatry
Disease Course of Schizophrenia

Prodrome Stage

First Break of Psychosis

Early Stage of Schizophrenia

Later Stage of Schizophrenia
Prodrome

- Prodrome phase is defined by changes in behavior and function before full episode of psychosis emerges.
- Typically a few months to 1-2 years before psychosis.
- Can be absent in some cases, or prolonged (many years).
Prodrome

Arrow points: 1 = patient first notices some change in self, 2 = family or friends first notice some change in patient, 3 = patient first notices psychotic symptoms in self, 4 = family or friends first notice psychotic symptoms in patient, 5 = first psychotic intervention. See text for amplification.
Prodrome

- Two of the most common complaints:
  1. Change in social interaction, social withdrawal
  2. Deteriorated functions at school or work

- Can be difficult to detect.

- Very important to detect because emergent evidence of potential treatment options to delay or even stop psychosis onset
Prodrome

Other common prodrome symptoms

- Attenuated positive symptoms: distorted perceptions, strange thoughts, subtle communication difficulty

- Brief intermittent psychotic symptoms: subtle paranoia and hallucination, occur for a short period of time

- Some subtle functional decline in school or work and odd behavior
Kurt Snyder’s Personal Experience with Schizophrenia

Kurt Snyder\textsuperscript{1,2}

\textsuperscript{2}Website: www.kurtsnyder.net/Schizophrenia.html.

My name is Kurt Snyder, and I have paranoid schizophrenia. I live in Arnold, Maryland, just outside Annapolis, in the United States. I developed schizophrenia gradually over a period of nine years, with the most severe symptoms appearing when I was twenty-eight years old. For most of those years, my family, friends, and colleagues were unaware that I was experiencing any mental problems.

My illness, as is true with all mental illnesses, started in the privacy of my own mind. My thoughts slowly wandered away from the normal range—I began to think less and less about daily life and more about a fantasy created in my mind. I cannot think of anything physical or psychological that could have triggered a change in my mental state. I had wonderful, supportive parents, relatives, and friends, and I had a wonderful childhood.

people about them. I was paranoid that so would solve the riddle first if I provided the

At about the age of twenty-two, I had my icant paranoid episodes. The first episode when I was on vacation with my girlfriend, r and his wife in the mountains. We had rented gether. For some reason, I started to think at from horror movies where an insane man bre house and kills everyone. I actually started to was going to happen to us. I created a fantasy that we were very vulnerable and helpless, and one was going to kill us. It did not occur to r scenario was unlikely. The more I thought a more I believed it was going to happen. I rem I tried to reinforce the doors of the cabin v Everyone else seemed bewildered by my beha tually, however, I calmed down and went to Later that year, I had two more minor pa sodes. The first one happened when I hurt
First Episode Psychosis

- When it occurs, everyone knows something is wrong.

- Hallucinations are sensory perceptions in the absence of an external stimulus. The auditory type is common.

- False beliefs, seemed fixed and held tight by the individual: persecutory, grandiose, reference types.

- Disorganized thinking and behavior.

- Lack of motivation and interests, and isolation.
First Episode Psychosis

- A traumatic and stressful experience to the person
- Confusion, difficult to understand and manage for the family
- Severe disruption of schooling and work
- Disruption of social relationship, isolating patients from friends and people around him/her
At the age of twenty-eight, I suddenly started to become psychotic. I am using the word *psychotic* to mean that my understanding and perception of the real world diverged sharply from reality. I could no longer work. At one point, I wondered whether my whole existence and everything I experienced was manufactured by a virtual reality machine and whether my whole life was spent in a laboratory run by some type of alien creatures. This initial psychotic episode lasted for a few days.
First Episode and Early Stage

Once started, long-term active psychosis can become a major cause of severe disability in society

Ranked #3 of all medical conditions globally by WHO survey

<table>
<thead>
<tr>
<th>Health condition</th>
<th>Overall rank</th>
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<tbody>
<tr>
<td>Quadriplegia</td>
<td>1</td>
</tr>
<tr>
<td>Dementia</td>
<td>2</td>
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<tr>
<td>Active psychosis</td>
<td>3</td>
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<tr>
<td>Paraplegia</td>
<td>4</td>
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<tr>
<td>Blindness</td>
<td>5</td>
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<tr>
<td>Major depression</td>
<td>6</td>
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<tr>
<td>Drug dependence</td>
<td>7</td>
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<tr>
<td>HIV infection</td>
<td>8</td>
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<td>Alcoholism</td>
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<tr>
<td>Total deafness</td>
<td>10</td>
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<tr>
<td>Mild mental retardation</td>
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</tr>
<tr>
<td>Incontinence</td>
<td>12</td>
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<tr>
<td>Amputation below the knee</td>
<td>13</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
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<tr>
<td>Severe migraines</td>
<td>15</td>
</tr>
<tr>
<td>Infertility</td>
<td>16</td>
</tr>
<tr>
<td>Vitiligo on face</td>
<td>17</td>
</tr>
</tbody>
</table>

Ustun et al 1999 Lancet
Early Years after First Psychosis

- Medication vs. no medication
- Therapy vs. no therapy
- Will it improve?
- Will it relapse
- Work and school
Directions of treatment research

Clinical trials are used to find out whether a particular treatment helps prodrome or early stage psychosis. They target one of the two goals:
Directions of treatment research

- Clinical trials to prevent the onset of psychosis
- Clinical trials to improve the outcome of first-episode psychosis
Therapy to prevent conversion to psychosis - one small study, needs replication

- Supportive counseling (SC)
- Integrated psychological intervention (IPI): combining cognitive-behavioral therapy, group skills training, cognitive remediation and multifamily psychoeducation on prevention of psychosis

Bechdolf et al 2012 Br J Psychiatry
Therapy to prevent conversion to psychosis - one small study, needs replication

- Specialized cognitive behavioral therapy (CBT) that focuses on normalization of unusual experience and awareness of cognitive biases showed a favorable effect on preventing transition to psychosis and reduction of subclinical psychotic symptoms

van der Gaag et al 2012 Schizophrenia Bulletin
Dietary supplement for prevention of conversion to psychosis – small study, needs replication

- Long chain omega-3 polyunsaturated fatty acid vs. placebo

- 2 of 41 individuals (4.9%) in the treatment group and 11 of 40 (27.5%) in the placebo has a first episode

Amminger et al 2010 Arch Gen Psychiatry
Can drug and therapy help for preventing conversion to psychosis?

- There are reports of encouraging examples of success
- However, most of these reports await replication
- Analysis in combination of available data, show that the evidence of success by various intervention is far from convincing (Marshall et al 2011)
- Even if they will reduce conversion to psychosis, for the foreseeable future, most individuals prone to have psychosis will still develop psychosis

Pharmacological treatment is most important and most cost-effective to control psychosis and to prevent relapse.

Meta-analysis showed that first – generation and second – generation antipsychotics are almost equally effective.*

Drawbacks are side effects - benefit outweighs risk in most cases.
Should patients stop medication after the first episode is treated or recovered?

- Maintenance treatment is more effective in preventing relapse.
- Deterioration (up to 57% vs 4%, P < .001) were much higher if no maintenance treatment in one year, could be worse for longer.

Gaebel et al 2011 J Clinical Psychiatry
Should patients stop medication after the first episode is treated?

- No – not in principle
- Do patients listen? Often not, unfortunately
- An important area for clinicians managing patients who are determined to give stopping medication a try
Should patients stop medication after the first episode is treated?

- Patient autonomy vs. evidence-based assertive treatment recommendation
- Built strong alliance with patients and family regardless patients current decision
- Because most patients who decided to stop medication eventually will need more treatment
Treatment to prevent relapse after first episode - what is more important

- Relapse prevention therapy (RPT) by individual and family cognitive behavior therapy

- Specialist treatment for first episode (TAU)

- Short-term: less relapse but worse psychosocial functioning in RPT

- No long-term difference

- Both better than non-specialist management (relapse can otherwise be 50-70% in 2 years)

Gleeson et al 2011 Schizophrenia Bulletin
What Matter Most in First Episode Management
Two basic principles most experts agree

- Sooner the treatment begins after the first psychosis, shorter the duration of untreated psychosis, better the outcome

- More comprehensive, higher quality pharmacology, therapy and psychosocial intervention, better the recovery
First principle – Reducing the duration of untreated psychosis

- Meta-analysis of 43 publications on the issue *

- Shorter the duration, greater the response to antipsychotic treatment

- Longer the untreated psychosis, more severe in negative symptoms

- The duration is not related to the severity of positive symptoms, or global brain morphology or cognitive function impairment.

Second principle – Comprehensive, sustained treatment and therapy

- Antipsychotic medications reduce symptoms, reduce disability associated with symptoms, and reduce chance of relapse.

- Comprehensive therapy and psychosocial support improve recovery, reduce disability associated with symptoms and improve family, social, and employment success.

- Many of our patients return to school and obtain full-time employment after first break of psychosis.

- Long term management of side effects of antipsychotic medications is required in most patients.
since switched my medication to Zyprexa, and the akathisia gradually diminished. I have now been taking Zyprexa for three years, and it seems to be working beautifully, except for the extra twenty pounds of fat I’m carrying around. However, I wouldn’t change it for anything. I have continued to notice steady improvement in my condition over the last three years, both for positive and negative symptoms. I now believe that I have fully recovered from schizophrenia, and I realize that my recovery is owed entirely to medication. I now experience no delusions, no paranoia, and I do not have bizarre thoughts. To get better, I did not perform any mental gymnastics.
MPRC’s First Episode Clinic

The Maryland Psychiatric Research Center (MPRC)

A part of the
University of Maryland
School of Medicine,
Department of Psychiatry
Our Mission

- To provide the highest quality of care available in order to:
  - Reduce the symptoms that are interrupting your life
  - Prevent lengthy and expensive hospital stays
  - Find the correct diagnosis so that we can treat you in the best way possible
  - Improve your social and work-related functioning
  - Increase your ability to live your life the way you want to
Therapy

- Patients are generally seen once a week initially by their therapist. Additional appointments can be scheduled for family sessions and other patient needs. Regular visits are reduced as you become stable. Visits can be reduced up to every 1 to 3 months.
Psychiatric Care

- A psychiatrist sees patients on an as-needed basis, generally starting at one visit every one or two weeks. Visits can be reduced to every month for some patients and even longer for most patients after they are stable.
Group Sessions

- **Group therapy sessions** are optional and offered to most clinic patients.
- **Family group therapy sessions**
Other Benefits

- We involve families, caregivers, and/or other significant persons in the initial evaluation process to allow for the best possible results.
- Costs are subsidized through state and research funding.
- No insurance is OK
Examples of Our Current Research Projects

**Family Imaging Study:**
Using cutting-edge fMRI to study genetics and family history and the brain changes associated with first break.

**Smoking Study:**
Why do individuals with psychosis or schizophrenia smoke more?
Conclusions

- Finding better treatment for psychosis is a top priority for NIH and many research institutions.

- Rapid progress is making in finding the cause and treatment, but lacking new treatment with novel mechanisms.

- Available drug and therapy are effective for improving symptoms and reducing disability, when appropriately managed.
Conclusions

- Early detection and early treatment make a difference
- Community awareness is key to bring a patient in for treatment
- Drug treatment plus high quality therapies
- Individual psychotherapy, cognitive behavioral therapy, family therapy, group therapy, proactive community engagement
Who Can You Call?

For more information, or to schedule an intake appointment, call or email:

Judy Liu (FEP Clinic Director)

410-402-6832
jliu@mprc.umaryland.edu