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Keeping Kids Healthy Month: Early Intervention in Adolescents with Schizophrenia

by Lisa Brauer, PhD

April 18th is National Healthy Kids Day. Although many of the concerns relating to keeping kids healthy relate to physical health, data regarding the prevalence and unmet needs of children with psychiatric disorders are sobering and underscore the importance of keeping kids as healthy as possible in that domain as well.

According to Mental Health America and the Department of Health and Human Services, one out of five young people is affected with a mental health problem at any given time and may have a diagnosable psychiatric disorder. Approximately two-thirds of the estimated 7.7 to 12.8 million children with a mental disorder are not getting appropriate care.¹ Among the myriad mental illnesses that can arise during childhood and adolescence, schizophrenia is of major concern owing to its neurodevelopmental nature and the devastating consequences of long-term untreated psychosis.

Schizophrenia generally has an onset in very late adolescence or early adulthood, but data show that as many as one-third of individuals with schizophrenia or schizoaffective disorder had their first episode during adolescence.² Adolescent-onset schizophrenia can be extremely debilitating both in terms of psychotic symptoms and psychosocial function—its course and prognosis are more severe than later-onset disease.³ Little is known about the phenomenology of schizophrenia in adolescence, and diagnosis can be difficult, sometimes taking up to two years.⁴ Patient and family concerns about the stigma associated with mental illness may delay their coming forward for medical attention until something happens to prompt action (e.g., getting kicked out of school).⁵ As with any mental illness, delay in diagnosis and treatment of any duration can significantly impact outcome.

For the majority of adolescents with schizophrenia, treatment will be lifelong.⁶ Finding the right medication early is important, as there is some evidence that early response predicts better long-term outcome.⁷ Two atypical antipsychotics, risperidone and aripiprazole, are FDA-approved for the treatment of schizophrenia in adolescents. Results of the limited number of controlled trials with both conventional and atypical antipsychotics have shown an overall response rate of 50% or less, which is lower than what is typically observed in clinical trials with adults.^{5,6,8,9} Nevertheless, as a group, adolescents are likely to be more responsive to treatment than adults and to be equally responsive to first- and second-generation agents.⁹ However, given the generally poor prognosis in adolescents with schizophrenia,³ greater medication responsiveness per se may not translate into better long-term function overall.⁵ In addition, functional outcome relies heavily on nonpharmacologic factors as well, including the family environment and dynamic, and the availability of an extended support system.

Adolescents with schizophrenia are also at a relative disadvantage because they may be more prone to experiencing side effects that may impact adherence and/or have lifelong health implications.¹⁰⁻¹² The long-term consequences of some side effects, such as hyperprolactinemia, are still unknown but are likely to have significant impact in pubescent children. Balancing efficacy and adverse effects is critically important in selecting an appropriate treatment regimen. For most adolescents, the “start low, go slow” adage applies; however, there may be some patients with sufficiently acute problems to warrant starting at a higher dose in spite of reduced tolerability.

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Early identification of adolescent-onset schizophrenia may benefit from data demonstrating specific structural brain changes that may underlie or co-occur with the cognitive and other symptoms of schizophrenia.¹³ The identification of early brain changes underscores the importance of the development of neuroprotective therapies that may forestall or slow disease progression. Early treatment becomes important, since the degeneration in schizophrenia does not progress throughout the entire course of the disease. In a 2007 article, Lieberman and colleagues explain that schizophrenia differs from neurodegenerative disease in that patients ultimately reach a stable chronic phase of the disease after which they remain symptomatic but do not experience additional brain deterioration. Research suggests that there is a possibility of forestalling disease progression with early identification and treatment, thereby improving outcomes.¹³

Adolescent schizophrenia is a distinct clinical entity with unique symptoms, outcomes, and challenges. A number of pharmacologic agents are available with which to manage symptoms, but little data exists from controlled trials. Nevertheless, physicians need to balance the known course and prognosis of schizophrenia in adolescents against the short- and long-term efficacy and safety of available medications. In addition, clinicians should consider the possible neuroprotective effects of available agents in order to chose an appropriate treatment to optimize outcomes.

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