Schizophrenia in Children and Adolescents At A Glance*

General medical causes of psychotic symptoms should be ruled out. Potential organic conditions that need to be considered include acute intoxication, delirium, CNS lesions, tumors or infections, metabolic disorders, and seizure disorders. A thorough physical examination is needed.

A diagnosis of schizophrenia is made when the prerequisite *DSM-IV* (or *ICD-10*) symptoms are present for the required duration, and other disorders have been adequately ruled out . The differential diagnosis includes mood disorders (especially psychotic symptoms associated with mania or mixed episodes of bipolar disorder), pervasive developmental disorders, nonpsychotic emotional and behavioral disturbances (including posttraumatic stress disorder), and organic conditions (including substance abuse).

Antipsychotic agents are recommended for the treatment of the psychotic symptoms associated with schizophrenia. First-line agents include traditional neuroleptic medications (block dopamine receptors) and the atypical antipsychotic agents (that have a variety of effects, including antagonism of serotonergic receptors). Compared with traditional agents, the atypical antipsychotics are at least as effective for positive symptoms, and they may be more helpful for negative symptoms. Clozapine has documented efficacy for treatment-resistant schizophrenia in adults. However, clozapine is usually not considered a first-line agent because of its significant potential adverse effects, and it is generally used only after therapeutic trials of at least two other antipsychotic medications (one or both of which should be an atypical agent).

The use of antipsychotic agents requires the following

1. Adequate informed consent from the parent/youth (depending on the legal age requirements and/or legal status of the person served).

2. Documentation of target symptoms.

3. Documentation of any required baseline and follow-up laboratory monitoring, dependent on the agent being used.

4. Documentation of treatment response.

5. Documentation of suspected side effects, including monitoring for known side effects (e.g., extrapyramidal side effects, weight gain, agranulocytosis, and seizures with clozapine).

6. Adequate therapeutic trials, which generally require the use of sufficient dosages over a period of 4 to 6 weeks.

7. Long-term monitoring to reassess dosage needs.

Some persons served may benefit from the use of adjunctive agents, including antiparkinsonian agents, mood stabilizers, antidepressants, or benzodiazepines [CG]. These medications are used either to address side effects of the antipsychotic agent or to alleviate associated symptomatology (e.g., agitation, mood instability, dysphoria, explosive outbursts).

The following psychosocial interventions are recommended:

1. Psychoeducational therapy for the person served, including ongoing education about the illness, treatment options, social skills training, relapse prevention, basic life skills training, and problem-solving skills and strategies.

2. Psychoeducational therapy for the family to increase their understanding of the illness, treatment options, and prognosis and for developing strategies to cope with the symptoms of the person served.

There are case reports of electroconvulsive therapy (ECT) being used for youth with treatment-refractory schizophrenia. However, ECT does not appear to be as effective for schizophrenia as it is for mood disorders. The use of ECT should be reserved for those cases in which several trials of medication therapy (including a trial of clozapine) have failed. ECT may also be considered for catatonic states [OP].

The diagnosis in children and adolescents is made using the same criteria as in adults.

* Adapted from *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Schizophrenia*. J. Am. Acad. Child Adolesc. Psychiatry, 40:7 Supplement, July 2001.