Early Intervention for Psychosis in the United States: Tailoring Services to Improve Care for Women

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Specialty team–based services for first-episode psychosis (FEP) have the potential to transform the course of schizophrenia spectrum disorders (1). Gender differences in the epidemiology, presentation, and course of schizophrenia have been well described (2); however, less is known about possible gender-based disparities in care. We acknowledge that both men and women have specific service needs for FEP, and in this this Viewpoint we focus on women with FEP, because a smaller proportion of these women receive services for FEP, and their service needs are hence at risk for being overlooked.

We briefly consider seven factors that might disadvantage women in terms of both access to and quality of care in FEP services. We hope that awareness of these specific needs will inform service refinements within an ongoing nationwide rollout of FEP services across the United States (1).

Factors That Can Affect Access to Care for Women With FEP

Age at onset. Many FEP services target transition-age youths or young adults. Although this focus allows programming tailored to the developmental needs of this particular age group, it risks excluding those women who experience psychosis onset later in life (3). A large-cohort study in Europe (the EUropean network of national schizophrenia networks studying Gene-Environment Interactions, N=2,774) reported both an older median age for women at first contact with FEP services (age 34 vs. age 28 for men) and a second peak in the incidence of psychosis for women in their fifties (3). Therefore, there is a dilemma between designing psychosocial interventions to coherently address a set of needs for educational and employment support for younger individuals and the needs of women across the lifespan. Options to tackle this challenge include flexibility in setting the maximum age of admission to FEP services. In this regard, the national effort in the United Kingdom to widen inclusion in these services to age 65 may offer some useful lessons for the United States (4). Preliminary reports suggest a 25% increase in total referrals to services, with those older than 35 representing one-third of the total FEP sample (5). Of note, FEP in this specific age group results in higher care complexity, requiring more intensive care planning, as well as sustained social worker support for child care, involvement with child protective services, and consideration of economic needs (5).

Clinical presentation. Compared with men, women tend to present with more mood symptoms and may be more likely to receive a misdiagnosis of psychosis due to a primary affective disorder (2), which is often a criterion for exclusion from FEP services. Additionally, women tend to have better overall functioning at symptom onset (2), which may result in an underestimation of their needs that delays entry into FEP services. Gender stereotypes can also impair access, with women's efforts to seek help being mischaracterized as attention seeking. In response to these presentation characteristics, FEP services may more strongly consider including women with concomitant psychosis and mood symptoms, reevaluating diagnoses, and referring women to other services only after preliminary treatment and several months of careful longitudinal assessment.

Pathways to care. For both patients and families, urgent help seeking often includes involuntary admission and involvement with the criminal justice system in the United States, experiences that can jeopardize engagement with psychiatric services. Paradoxically, women with FEP who are less likely to display disorganized or threatening behavior due to the psychosis (2) may be less likely to be identified by these referral pathways and may experience longer delays in receiving care. Accordingly, FEP services should be sensitive to these gender differences and target outpatient health facilities (e.g., primary care and obstetric and gynecologic clinics) where women with underrecognized psychosis may be found.

Gender roles. Across different societies, women spend more time in informal caregiving for infants and elderly relatives than do men and thus may not adequately prioritize their own need for care. To increase the likelihood that caregiving women will access and accept care, services should integrate their outreach and engagement activities to settings where relevant services (e.g., social services and child care) are colocated and readily available.

Factors Affecting Quality of Specialized Care for Women With FEP

Sexual and reproductive health. Psychosis usually manifests during the period of greatest fertility for women. Young women carrying the added burden of psychotic symptoms

may need more support to manage personal contraception or to negotiate condom use with male sexual partners. FEP services should routinely provide education to help prevent sexually transmitted diseases and unintended pregnancies. Shared decision making around family planning is also critical when medications with potential teratogenic risks are prescribed. Particular sensitivity to asking patients about any adverse effects of medications and managing the impact of these effects on, for example, gendered societal expectations (e.g., weight gain and hair loss) or on reproductive health (e.g., secondary amenorrhea due to hyperprolactinemia) can ameliorate the often-unpleasant experience of taking antipsychotic medications.

Women have a unique risk for developing psychosis in the peripartum period; patients who have a history of psychosis or are experiencing a current psychotic episode should receive tailored care when they are pregnant or planning a pregnancy. FEP services may facilitate ad hoc consultations with other services (e.g., pediatric, primary care, and obstetrics) or more systematic interagency collaborations that make it easier for FEP patients to get best practice reproductive care during the peripartum period for themselves and access to pediatric care for their infants.

Preventive medicine. Compared with women without a severe mental illness, women with schizophrenia are less likely to receive Pap test screening for cervical cancer and are half as likely as the general population to receive mammography screening for breast cancer (6). Possible explanations for these disparities among women with schizophrenia include a lack of awareness of these available health screenings, fewer invitations by primary care physicians to access the screening, fear of the procedures, and economic constraints. FEP services should consider providing education and care coordination to facilitate appropriate access to preventive measures (e.g., human papillomavirus vaccination, breast self-examination, and diagnostic imaging).

Trauma. Growing evidence has associated exposure to traumatic events in childhood with an increased risk for psychosis. Moreover, intimate partner violence, which victimizes more women than men, is linked to an increase in psychotic experiences, especially in cases of multiple victimizations. Although most controlled trials of psychotherapy for posttraumatic stress disorder have excluded patients with psychotic disorders, FEP services should consider offering trauma-focused psychological interventions as part of the services provided.

Conclusions

In summary, women with FEP have specific needs that can be proactively addressed to refine the current expansion of FEP services in the United States. The historical underrepresentation of women in using these services may have diminished the incentive to implement some of the refinements we have suggested here; hence, we are presenting a dual focus on access and care within a comprehensive approach that envisions pathways to *and* through specialty care for women with FEP.

These recommendations may be difficult for U.S.-based FEP services to implement. In this country, both access pathways and care provision are fragmented across multiple agencies and payment systems, which can impede systematic approaches. We have articulated a population health framework to guide service design (7). This framework includes a commitment to measure outcomes relevant to all stakeholders and may reduce subgroup disparities that arise from demographic, geographic, and other structural factors. Specific attention to women's voices and needs as part of this focus on population health can both widen and deepen the impact of emerging FEP services across the United States.

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