

## Serious Mental Illness: symptoms, treatment and causes of relapse

### Bipolar Disorder, Schizophrenia and Schizoaffective Disorder

#### Symptoms and prevalence of bipolar disorder

- Bipolar disorder, formerly known as manic-depression, is a biological disorder of the brain characterized by debilitating mood swings.
- The symptoms of bipolar disorder fall into two broad categories of mania and depression.<sup>1</sup>

| Mania   | Depression   |
|---|--|
| <ul style="list-style-type: none"> <li>○ Euphoric or extremely irritable mood</li> <li>○ Distractibility</li> <li>○ Accelerated and/or delusional thinking</li> <li>○ Decreased inhibitions</li> <li>○ Increased physical activity and risky behaviors</li> </ul> | <ul style="list-style-type: none"> <li>○ Feelings of emptiness, guilt and self-hatred</li> <li>○ Impaired thinking</li> <li>○ Inability to experience joy</li> <li>○ Diminished energy and preoccupation with death</li> </ul> |

- **Bipolar I disorder**, the classic form of the illness, is characterized by recurrent episodes of mania and depression.
- **Bipolar II disorder** is characterized by periods of depression that alternate with milder episodes of **hypomania**, defined as mild to moderate level of mania.<sup>2</sup>
- A **mixed bipolar state** involves concurrent symptoms of mania and depression.<sup>3</sup>
- Twenty-seven million people suffer from bipolar disorder worldwide.<sup>4</sup> Bipolar disorder knows no racial, cultural or economic boundaries.
- An estimated 25 to 50% of individuals with bipolar disorder attempt suicide at least once<sup>5</sup> and completed suicide occurs in 10 to 15% of individuals with Bipolar I Disorder.<sup>6</sup>

#### Symptoms and prevalence of schizophrenia

- Schizophrenia is a debilitating biological disorder of the brain<sup>7</sup> often characterized by acute episodes of delusions (false beliefs that cannot be corrected by reason), hallucinations (usually in the form of non-existent voices) and long-term impairments such as diminished emotion, lack of interest and depressive signs and symptoms.<sup>8</sup>

- Twenty-four million people suffer from schizophrenia worldwide.<sup>9</sup> Like bipolar disorder, schizophrenia knows no racial, cultural or economic boundaries.<sup>10</sup>
- Symptoms of schizophrenia usually appear between the ages of 13 and 25, and have been found to appear earlier in males than females.<sup>11</sup>
- On average, people with schizophrenia die 10 years earlier than the general population.<sup>12</sup> People living with severe and persistent mental illness are more likely than the general population to suffer from heart disease, hypertension, diabetes, obesity, asthma, gastrointestinal disorders, skin infections and acute respiratory disorders.<sup>13</sup> They are also less likely to obtain physical health care services, and when they do, they frequently receive substandard care.<sup>14, 15</sup>
- According to the World Health Organization, schizophrenia is the eighth leading cause of disability worldwide among 15-44 year-olds.<sup>16</sup>
- Approximately 10% of people with schizophrenia commit suicide and between 20% and 40% of people with schizophrenia make at least one suicide attempt in their lifetime.<sup>17</sup>

### Symptoms and prevalence of schizoaffective disorder

- Schizoaffective disorder is one of the more common, chronic, and disabling mental illnesses characterized by a combination of symptoms of schizophrenia and an affective (mood) disorder.<sup>18</sup>
- In order to be diagnosed with schizoaffective disorder, an individual needs to have primary symptoms of schizophrenia such as delusions, hallucinations, disorganized speech, disorganized behavior along with a period of time when he or she also has symptoms of major depression or a manic episode.<sup>19</sup>
- Differentiating schizoaffective disorder from schizophrenia and from mood disorder can be difficult. The mood symptoms in schizoaffective disorder are more prominent, and last for a substantially longer time than those in schizophrenia. In contrast to individuals with mood disorder, delusions or hallucinations must be present in persons with schizoaffective disorder for at least two weeks in the absence of prominent mood symptoms. The diagnosis of a person with schizophrenia or mood disorder may change later to that of schizoaffective disorder, or vice versa.<sup>20</sup>
- Although its exact prevalence is not clear, schizoaffective disorder may range from 0.2% to 0.5% and may account for 25% or 30% of all individuals with schizophrenia.<sup>21</sup>
- Between 30-40% of people with schizoaffective disorder will attempt suicide during their lifetimes and 10% of them will commit suicide.<sup>22</sup>

## Treatment of bipolar disorder, schizophrenia and schizoaffective disorder

- Individuals with bipolar disorder, schizophrenia and schizoaffective disorder can lead productive and fulfilling lives and have successful relationships and meaningful jobs when these illnesses are effectively treated.<sup>23, 24</sup>
- Proper treatment can relieve symptoms, prevent or delay relapse and break the “revolving door” cycle.<sup>25, 26</sup> Proper treatment can also help reduce the frequency and severity of episodes and can help individuals maintain a good quality of life and achieve substantial stabilization of symptoms.<sup>27</sup>
- Treatment for bipolar disorder, schizophrenia and schizoaffective disorder is possible through medication, which can help relieve symptoms and reduce the risk of relapse,<sup>28</sup> and rehabilitation programs, which can help a person improve their confidence and the skills needed to live a productive and independent life in their community.<sup>29</sup> Education and psychosocial interventions can also help patients and families cope with mental illness and its complications and may help prevent relapse.<sup>30, 31</sup>
- Bipolar disorder, schizophrenia and schizoaffective disorder may be treated with a class of medications called antipsychotics in combination with other forms of treatment. These medications are classified as older “typical” antipsychotics and newer “atypical” antipsychotics.<sup>32, 33</sup> The duration of time between when a patient begins an antipsychotic to when he/she terminates that medication is an index used to measure the effectiveness of treatment options.<sup>34</sup>

## Treatment Discontinuation and Relapse

### Bipolar disorder

- Without treatment, the symptoms of bipolar disorder tend to worsen. Over time, a person may suffer more frequent and more severe manic and depressive episodes than those experienced when their illness first appeared.<sup>35</sup>
- For individuals with bipolar disorder, relapse rates are 50% at one year after a manic episode and 70% at five years after a manic episode.<sup>36</sup>
- To reduce the chance of relapse, it is important for individuals to adhere to the treatment plan prescribed by their physician. However, both doctor and patient should closely monitor progress and recognize when changes to the treatment plan may be needed.<sup>37</sup>

### Schizophrenia

- A majority of schizophrenia patients are likely to have multiple episodes, i.e. relapses, often with increasing impairment.<sup>38</sup>

- The more relapses a person has, the harder it is to recover from them.<sup>39</sup>
- The longer patients experience symptoms of schizophrenia, the more likely they are to suffer lasting impairment.<sup>40</sup>
- Some studies have shown that the longer the duration of untreated psychosis, the slower and less complete recovery can be, with the greater risk for depression and suicide.<sup>41</sup>
- There is conclusive evidence that shows that treatment decreases the illness' duration and chronicity and helps control relapses.<sup>42</sup>
  - Risk of relapse during the first year following an acute episode in patients on antipsychotic medications is reduced to about 20%, in comparison with about 60% on a placebo.<sup>43</sup>
- Sixty to 70% of patients relapse within one year without maintenance treatment and almost 90% relapse within two years without maintenance treatment.<sup>44</sup>
- Discontinuation of medication plays a major role in schizophrenia relapse.
  - Four out of five patients who stop taking their medications after a first episode of schizophrenia will have a relapse.<sup>45</sup>
- Patients who stop taking their medication are more likely to do so because of poor response to treatment compared to side effects or poor tolerability.<sup>46</sup> Poor compliance has also been reported in patients with a lack of insight about their illness, and in those who believe that medication should be taken only when they are feeling ill.<sup>47</sup>
- Poor compliance or noncompliance with treatment is also strongly associated with greater likelihood of hospital admission and a longer duration of hospitalization once admitted and can also negatively impact prognosis, especially in patients recently diagnosed with schizophrenia.<sup>48</sup>

### **Schizoaffective disorder**

- Some individuals with schizoaffective disorder only ever have one episode, but others may experience worsening of symptoms at intervals throughout their life.<sup>49</sup>
- Relapses in individuals with schizoaffective disorder may be severe enough to limit functioning and may make hospitalization necessary.<sup>50</sup>
- In order to reduce the risk of relapses and maintain an appropriate level of functioning and quality of life, most people with schizoaffective disorder require long-term therapy with a combination of medications and psychosocial interventions.<sup>51</sup>
  - Approximately 70% of people with schizophrenia or schizoaffective disorder who are not on antipsychotics relapse over a one-year period, but only 30% treated with medication relapse.<sup>52</sup>

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<sup>1</sup> Bipolar Disorder National Institute of Mental Health. NIH Publication No. 02-3679; Printed 2001, Reprinted September 2002. Available at: <http://www.nimh.nih.gov/publicat/bipolar.cfm>, accessed June 7, 2006.

<sup>2</sup> See reference 1.

<sup>3</sup> See reference 1.

<sup>4</sup> The Global Burden of Disease. World Health Organization, 2003. Available at [http://www.who.int/mip/2003/other\\_documents/en/globalburdenofdisease.pdf](http://www.who.int/mip/2003/other_documents/en/globalburdenofdisease.pdf), accessed January 6, 2006.

<sup>5</sup> Jamison KR. Suicide and Bipolar Disorder. *J Clin Psychiatry* 2000; 61 (Suppl 9): 47-51.

<sup>6</sup> Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Edition DSM-IV-TR, p. 384., American Psychiatric Association, 2000.

<sup>7</sup> Schizophrenia. Canadian Mental Health Association. Available at [http://www.cmha.ca/bins/print\\_page.asp?cid=3-100&lang=1](http://www.cmha.ca/bins/print_page.asp?cid=3-100&lang=1), accessed April 3, 2006.

<sup>8</sup> Weiden P, Scheifler P, Diamond R, et al. *Breakthroughs in Antipsychotic Medications*. New York: W.W. Norton & Company, 1999.

<sup>9</sup> The World Health Report 2001: Mental Health – New Understanding, New Hope. World Health Organization, 2001. Available at <http://www.who.int/whr/2001/chapter3/en/index1.html>, accessed January 6, 2006.

<sup>10</sup> Schizophrenia: What You Need to Know. National Mental Health Association. Available at <http://www.nmha.org/infoctr/factsheets/51.cfm>, accessed November 17, 2005.

<sup>11</sup> See reference 10.

<sup>12</sup> PRODIGY Guidance – Schizophrenia. UK National Health Service. Available at <http://www.prodigy.nhs.uk/guidance.asp?qt=Schizophrenia>, accessed November 18, 2005.

<sup>13</sup> Dickey B, et al. (2002). Medical morbidity, mental illness, and substance use disorders. *Psychiatric Services*, 53(7):861-7.

<sup>14</sup> Craddock-O'Leary J, Young AS, Yano EM, Wang M, Lee ML (2002). Use of general medical services by VA patients with psychiatric disorders. *Psychiatric Services*, 53:874-8.

<sup>15</sup> Koranyi EK (1979). Morbidity and rate of undiagnosed physical illnesses in a psychiatric clinic population abstract. *Archives of General Psychiatry*, 36:414-9.

<sup>16</sup> Chapter 2: Burden of Mental and Behavioral Disorders. World Health Organization, 2001. Available at <http://www.who.int/whr/2001/chapter2/en/print.html>, accessed January 3, 2005.

<sup>17</sup> See reference 6.

<sup>18</sup> Schizoaffective Disorder. National Alliance on Mental Illness. Available at [http://www.nami.org/Template.cfm?Section=By\\_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=11837](http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=11837), accessed June 7, 2006.

<sup>19</sup> See reference 18.

<sup>20</sup> See reference 18.

<sup>21</sup> See reference 18.

<sup>22</sup> Treatment of schizoaffective disorder. Rethink. Updated April 2006. Available at [http://www.rethink.org/about\\_mental\\_illness/mental\\_illnesses\\_and\\_disorders/schizoaffective\\_disorder/treatment\\_for.html](http://www.rethink.org/about_mental_illness/mental_illnesses_and_disorders/schizoaffective_disorder/treatment_for.html), accessed June 7, 2006.

<sup>23</sup> See reference 10.

<sup>24</sup> Bipolar Disorder. National Mental Health Association. Available at: <http://www.nmha.org/infoctr/factsheets/76.cfm>, accessed June 7, 2006.

<sup>25</sup> "Expert Consensus Guideline Series," *J Clin Psychiatry*, 1999:60 (suppl 11).

<sup>26</sup> "The World Health Report 2001: Mental Health – New Understanding, New Hope," Chapter 3. World Health Organization. Available at <http://www.who.int/whr/2001/chapter3/en/index1.html>, accessed November 17, 2005.

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<sup>27</sup> See reference 1.

<sup>28</sup> See reference 26.

<sup>29</sup> See reference 10.

<sup>30</sup> See reference 26.

<sup>31</sup> See reference 18.

<sup>32</sup> Schizophrenia. National Institute of Mental Health. NIH Publication No. 02-3517, 2002. Available at <http://www.nimh.nih.gov/publicat/schizoph.cfm>, accessed 17 November 2005.

<sup>33</sup> See reference 18.

<sup>34</sup> Lieberman JA, Stroup T S, McEvoy JP, Swartz MS, Rosenheck RA, Perkins DO, Keefe R, SE, Davis SM, Davis CE, Lebowitz BD, Severe J, Hsiao JK, the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Investigators. "Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia" *N Engl J Med* 2005; 353:1209-23.

<sup>35</sup> See reference 1.

<sup>36</sup> A Perry, "Randomised controlled trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment," *BMJ* 1999; 318:149-53.

<sup>37</sup> See reference 1.

<sup>38</sup> Siegfried K. "First-Episode Schizophrenia: The Importance of Early Intervention and Subjective Tolerability." *J Clin Psychiatry* 1999; 60 (suppl 23).

<sup>39</sup> See reference 25.

<sup>40</sup> See reference 38.

<sup>41</sup> "Early Psychosis: Detection Assessment and Treatment," Psych Direct, Department of Psychiatry and Behavioral Neurosciences at McMaster University in Hamilton, Ontario. Available at <http://www.psychdirect.com/PrintFriendly/psy-first-pro-print.htm>, accessed January 6, 2006.

<sup>42</sup> See reference 26.

<sup>43</sup> Nations for Mental Health: Schizophrenia and Public Health. World Health Organization, 1996. Available at [http://www.who.int/mental\\_health/media/en/55.pdf](http://www.who.int/mental_health/media/en/55.pdf), accessed November 17, 2005.

<sup>44</sup> Lehman AF, Lieberman JA, Dixon LB, McGlashan TH, Miller AL, Perkins DO, Kreyenbuhl J; American Psychiatric Association; Steering Committee on Practice Guidelines. Practice guideline for the treatment of patients with schizophrenia, second edition. *Am J Psychiatry* 2004 Feb;161(2 Suppl):1-56.

<sup>45</sup> See reference 25.

<sup>46</sup> Kinon B, Liu-Seifert H, Adams D, "Differential Rates of Treatment Discontinuation in Clinical Trials as a Measure of Treatment Effectiveness of Atypical Antipsychotics" presented at APA 6/05.

<sup>47</sup> Perkins DO. Predictors of noncompliance in patients with schizophrenia. *J Clin Psychiatry*. 2002 Dec; 63(12):1121-8.

<sup>48</sup> See reference 47.

<sup>49</sup> Understanding Schizoaffective Disorder. Mind UK. Updated 2003. Available at <http://www.mind.org.uk/Information/Booklets/Understanding/USHAD.htm>, accessed June 7, 2006.

<sup>50</sup> Schizoaffective Disorder. Weill Medical College of Cornell University. Updated 2003. Available at <http://wo-pub2.med.cornell.edu/cgi-bin/WebObjects/PublicA.woa/5/wa/viewHContent?website=wmc+physicians&contentID=4149&wosid=LrLzQzb0cpUQNgbwOeUVng>, accessed June 7, 2006.

<sup>51</sup> See reference 18.

<sup>52</sup> Facts about Antipsychotic Medications. Family Social Support Project. Available at <http://www.npi.ucla.edu/ssg/antipsychotic.htm>, accessed June 7, 2006.