

*Improving
the long-term
outcome
of patients
with serious
mental
disorders*

Depression and Suicide in Schizophrenia

Patients with schizophrenia frequently suffer from more than one psychiatric disorder. More than half will experience some form of depression during their lifetime. This combination is often associated with impaired social adjustment, treatment non-compliance, multiple hospitalizations and relapse for psychosis. The rate of suicide among individuals with schizophrenia is about 10 percent, highlighting the importance of recognizing and treating depression associated with schizophrenia.

Is it Depression?

The incidence of depression during or immediately following an acute psychotic episode is very high, occurring in about 25% of patients with schizophrenia. Depressive symptoms may also appear just before a psychotic relapse. Negative symptoms of schizophrenia (inability to experience pleasure, lack of energy and motivation, social withdrawal, and impaired abstract thinking) can have a significant overlap with symptoms of depression making it difficult to recognize. Also, some depressive symptoms may be confused with side effects of antipsychotic medications such as akinesia, (apathy and diminished spontaneous movement and speech) or akathisia, (motor restlessness) which can produce dysphoria (negative moods). Additionally, a depressed mood is often seen in persons who are abusing or withdrawing from drugs or alcohol as well as in medical conditions, such as thyroid disorders. Deficits in perception, cognition, and communication skills in patients with schizophrenia often interfere with the detection of depression and risk for suicide.

Paul, a 33 year old male veteran with schizophrenia was able to function in social relationships but unable to work. Divorced with a young daughter, Paul was doing quite well on antipsychotic medication until his ex-wife moved to another state, taking his daughter, who he saw on weekends. At first, Paul spent his weekends with his mother, helping her with yard work. Gradually, he began to spend less and less time with his mother and more and more time at his own home watching television. Whenever his mother suggested that he telephone or write to his daughter, Paul would reply, "What's the use?" Paul began to neglect his grooming and began to hear voices again. At his mother's urging, Paul sought professional help and was

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MIRECC Funds Pilot Health Services Study of Veterans Released From Los Angeles County Jail by Jim McGuire

Veterans in jail have received increasing attention by the VA. In 1996, veterans were estimated to be 12%, or 69,300 of the U.S. jail population, and 83% of these veterans were eligible for VA services. While it is VA policy not to offer treatment services in jail or prison unless covered by special agreement, jail release outreach services providing linkage to VA and community treatment have grown.

Locally, about 7,500 veterans pass

through the Los Angeles County Jail annually. The VA Greater Los Angeles Health Care System Comprehensive Homeless Program has taken leadership in linking veterans to VA medical, psychiatric and substance abuse services for many years.

In the past year, LA County Sheriff Lee Baca has created a Community Transition Unit (CTU). The mission of the CTU is to "enhance (inmate) participation in educational, vocational, and

other life skills training programs, and to assist (inmates) with successful reintegration into the community", accomplishing this through partnership with community and other public agencies, such as the VA. The existence of the CTU has led to expanded access to incarcerated veterans and a need to develop effective programs based on data about this population.

Health services research studies health care accessibility, use, costs, quality, and outcomes, in order to improve health care services. An essential first step in health services

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Stephen R. Marder

Depression, Suicide, Incarceration and Homelessness: Serious Issues for Our Patient Population

Individuals with schizophrenia are vulnerable to a number of problems that can undermine the quality of their lives. This issue focuses on some of the most tragic outcomes that are associated with the disease. These include depression during the course of the illness; suicide that is related to depression or psychosis; incarceration; and homelessness. Other problems that could be added to this list are violent or aggressive behaviors and substance abuse.

The management of depression is an everyday issue for patients with schizophrenia and the clinicians who treat them. At any given time, as many as 25% of these patients will describe themselves as depressed. Depression can occur when patients are experiencing an acute relapse of their illness or when an individual's psychosis has been stabilized on medication. However, the approach to depression in these different phases will differ. When depression emerges during an acute psychotic episode, the focus of drug treatment should be on the psychosis itself. In the great majority of cases, the individual's depression will improve as the psychotic symptoms improve. Patients who become depressed while psychosis is stable will often benefit from the addition of an antidepressant medication.

As noted in this newsletter, as many as 10% of individuals with schizophrenia will end their own life. Some of these suicides are related to the same factors that are associated with suicide in individuals who do not have schizophrenia. That is, there is an increase in the

likelihood of suicide when patients are depressed, when they are living alone, and when they are drinking excessively. Other suicides are more directly related to the illness itself. Patients who are experiencing command hallucinations or frightening delusions may attempt suicide. Others may become hopeless or demoralized when they realize that they are suffering from a serious and chronic illness. All of these potential causes of suicide can be addressed by family members and clinicians when they are aware of them. Unfortunately, some patients with schizophrenia are poor describers of their internal experience. They can suffer silently since they are unable to articulate the pain that they are experiencing.

Issues such as incarceration and homelessness are more difficult for clinicians to address. The extraordinary number of seriously ill patients in our prisons is probably a relatively new phenomenon. As noted in this issue, incarceration, substance abuse, and homelessness are problems that tend to occur in the same individuals. Unfortunately, relatively little is known about the characteristics of these individuals. As a result, Jim McQuire from this MIRECC and Robert Rosenheck from the MIRECC in New England are studying the needs of seriously mentally ill patients in jail. The goal of this work is to develop new strategies for improving the lives of this growing population of patients. ♦

Pilot Studies Incarcerated Veterans *contd. from Page 1*



Raul Espinosa (inset) of the Community Transition Unit at the LA County Jail Twin Towers

1,676 veterans contacted and assessed by jail outreach workers to 6,560 homeless veterans contacted in the community. Some initial findings are:



While it was not clear how many of the incarcerated veterans were subsequently released from jail, this profile suggests high social and clinical need for the incarcerated veterans, particularly in employment and psychiatric and substance abuse treatment. That current use of drugs and alcohol was lower for the inmate group suggests that the time of outreach may present a window of opportunity for linkage to and engagement with post-release community treatment.

An upcoming MIRECC-funded study will complete the second phase of the research. It will obtain data from the criminal justice system 1) to determine the needs of "released veterans", 2) to draw a much clearer picture of specific clinical problems and the extent to which veterans released from jail with these problems receive appropriate VA treatment and, 3) to determine if there is any association between receiving VA services and remaining out of jail. Dr. Jim Mintz (VISN22 MIRECC Director, Data Evaluation Unit) will provide statistical and data support and, along with Dr. Alex Young (VISN22 MIRECC Director of Health Services Research), consultation with analysis of study results.

While cause-effect relationships cannot be established by this type of study, data from this research will be needed to inform development and testing of various interventions currently under consideration by the VA West Los Angeles Healthcare Center and the Los Angeles County Sheriff's Department. These initiatives range from development of scheduled releases allowing for systematic linkage to community program for employment and mental health services to intensive community re-entry residential care programs. ♦

research is to establish the nature and extent of the problems experienced by health care consumers. There is virtually no information currently available about the needs or use of services of incarcerated veterans. Accordingly, a two-phase study has recently been launched by Dr. Jim McGuire, Director of VA's CHALENG Program Evaluation for the Northeast Program Evaluation Center (NEPEC). This study examines data collected through outreach assessments over a three-year period from 1997-1999.

Dr. McGuire and Dr. Robert Rosenheck, Director of the NEPEC, collaborated on the first phase of the research which compared

diagnosed with depression. He was placed on an older, often called "typical" antipsychotic medication.

Although the medication controlled the voices he heard it left Paul feeling tired and lethargic most of the time. Paul was sleeping or watching television large amounts of the day. Paul's mother noticed the changes in his activities and wondered if Paul was depressed. Paul's psychiatrist determined that Paul's behavior was a result of the side effects from the anti-psychotic medication, not depression because Paul did not feel particularly sad or hopeless. He prescribed one of the newer, atypical antipsychotic medications and Paul began to feel more like himself again.

One symptom that can differentiate a depressive episode from negative symptoms of schizophrenia is sadness. People with clinical depression frequently experience sadness, whereas people with negative symptoms of schizophrenia do not. Those who develop persistent depressive symptoms not related to psychotic episodes are more likely to have clinical depression. Clinical depression is a psychiatric disorder in which a person has a persistent (greater than 2 weeks) sad mood and/or an inability to derive pleasure from previously enjoyable activities. Changes in appetite, energy levels, and sleeping patterns are common, as are feelings of guilt, worthlessness, and hopelessness. People with clinical depression may have thoughts about death and suicide. Whether it is depression concomitant to a psychotic episode or a more persistent clinical depression, it is important to obtain a thorough evaluation by a mental health professional to determine the causative factors of these symptoms and how best to treat them.

Suicide

Untreated depression is a major risk factor for suicide, the eighth leading cause of death in the US. Suicide claims the lives of 30,000 Americans per year, outnumbering the murder rate by 3:2. Suicide impacts more than 180,000 persons in the US each year taking into account the effect a suicide has on the surviving family members.

Paul's ex-wife returned with their daughter, they were getting along well and discussing reconciliation. Suddenly, Paul's ex-wife changed her mind and decided to move out of state once again. This second loss sent Paul spiraling into depression. He lost 10 pounds in one month, spent most of his days sleeping, and most of his nights crying or pacing. Paul felt hopeless, worthless and began to wonder if life was worth living. He quit taking his antipsychotic

medication and began to hear voices again. One morning, after drinking a few beers in front of the television, Paul ingested a lethal dose of medication. Fortunately, his mother found him, unconscious but still alive, and he was successfully treated for the overdose of medication. During his hospital stay Paul was stabilized on antipsychotic and antidepressant medication and began participating in a psychotherapy group where he learned how to cope with feelings of sadness, worthlessness, and hopelessness. The group helped him to change his thinking patterns. Paul has not heard voices or felt depressed for several months now and is currently also participating in a vocational rehabilitation program where he is learning how to cope with feelings of sadness, worthlessness, and hopelessness. The group helped him to change his thinking patterns. Paul has not heard voices or felt depressed for several months now and is currently also participating in a vocational rehabilitation program.

The highest risk of suicide occurs in the presence of multiple co-existing conditions, particularly combinations of mood or psychotic disorders with alcohol or drugs. Substance and alcohol abuse alone or in combination with psychiatric disorders are found in 25% of suicides. Major depressive disorder and bipolar disorder are associated with about half of all suicides. Patients with depression and schizophrenia are nearly three times more likely to attempt suicide than people with clinical depression alone and may be less likely to communicate suicidal intent to health care professionals. They are also more likely to use highly lethal methods in their suicide

attempts. To date, there are no definitive measures to predict suicide. Researchers have identified factors that place individuals at higher risk for suicide, but as with suicide in general, the progression to suicide among people with schizophrenia is complex.

In general, the risk of suicide rises with advanced age, especially after the age of 60. By the age of 75, the risk for suicide doubles. This increase may be related to factors such as retirement, widowhood, social isolation, declining vigor and health, and other losses.

Suicide Prevention

Researchers believe that both depression and suicidal behavior can be linked to decreases in the neurotransmitter serotonin in the brain. Low levels of this brain chemical have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and also in postmortem brains of suicide victims. This has led to the use of a group of antidepressants called SSRIs (selective serotonin reuptake inhibitors) to treat depression in people with and without schizophrenia. The newer antipsychotic medications may also relieve some depressive symptoms in people with depression and schizophrenia. Psychotherapy, such as cognitive-behavioral therapy, in conjunction with medication, has also been found to be an effective treatment for depression. MIRECC researchers are currently conducting studies to test the effectiveness of medications and psychotherapies for depression in people with schizophrenia. ♦

Risk and Protective Factors for Suicide

Protective Factors	General Risk Factors	Schizophrenia-Related Risk Factors
Intact social supports, marriage	Young and elderly men	Long-term illness with many relapses
Active religious affiliation or faith	Native American or Caucasian	Symptoms and poor functioning upon discharge
Presence of dependent young children	Self-reported hopelessness	Awareness of illness, fear of deterioration
Ongoing supportive relationship with a caregiver	Deteriorating health	Excessive dependence or loss of faith in treatment
Absence of depression or substance abuse	Significant loss (emotional, social, physical, or financial security)	Depressed mood, hopelessness, hostility
Living close to medical and mental health resources	Current or past substance abuse	Prominent positive symptoms
Awareness that suicide is a product of illness	Family History of suicide	
Proven problem-solving and coping skills	Easy access to a firearm	

THE FACES OF MIRECC

Stephen R. Marder, M.D.



Dr. Stephen Marder, M.D., Director of the VISN22 MIRECC and Chief of Psychiatry Services at the West Los Angeles VAMC has been a faculty member in the School of Medicine at UCLA since 1977 where he is currently Professor

Stephen R. Marder in Residence and Vice Chair of the Department of Psychiatry and Biobehavioral Sciences. He recently received the Exemplary Psychiatrist Award (2000) from NAMI. Dr. Marder serves on the Behavioral, Psychiatric, and Addictive Disorders Medical Research Advisory Group for Department of Veterans Affairs and is co-chair of the Committee on VA guidelines for Diagnosis and Treatment of Schizophrenia. Dr. Marder's research focuses on treatment for schizophrenia, both pharmacological and psychosocial therapies.

Dr. Marder was born and raised in New York, NY and received his BA from University of Pennsylvania and his MD from the State University of New York, Buffalo. He is the author of more than 150 journal

articles and 50 book chapters. In his leisure time, he enjoys classical music and plays golf and tennis. He lives in LA with his wife.

How did you get interested in schizophrenia?

I've been interested in schizophrenia practically my whole adult life. My interest in biological and clinical psychiatry led me to study schizophrenia, which was undertreated in the 70's, when I began my research career.

For two decades you have been investigating treatments for schizophrenia? How have treatments changed?

Psychosocial treatment 20 years ago was based on individual psychotherapy with an emphasis on psychodynamic theory. This treatment was not effective in treating schizophrenia. Subsequently, there was a shift in the conceptualization of psychosocial treatment of schizophrenia such that illness-based psychopathology was addressed. Social skills were taught and cognitive and behavioral ther-

apy to reduce the distress caused by symptoms of schizophrenia, to prevent relapse, and to promote treatment adherence. More recently, psychosocial treatment efforts have begun to focus on rehabilitation, especially vocational training.

Pharmacological treatment of schizophrenia has changed in that the new antipsychotic medications have fewer side effects, and may be even more effective in treating negative symptoms. These pharmacological improvements have made treatment more attractive. More people are complying with their prescribed medication regimes and consequently, more people with schizophrenia are functioning better. Treatment for schizophrenia has become more than reducing troublesome symptoms, such as hallucinations and delusions; it has become improving the quality of life of people with schizophrenia. ♦

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