

Suicide and Schizophrenia

In 2017, 10.6 million adults in the United States had serious thoughts of committing suicide, 2.8 million made suicide plans, 1.3 million attempted suicide and 47,173 died by suicide as reported by the National Institutes of Mental Health (NIMH). The World Health Organization estimates that 1 million people across the world die by suicide each year at a rate of 3 people every 2 minutes.

Death by suicide in those with schizophrenia occurs at a rate much higher than that of the general population, sometimes reported as high as 13,000 per 100,000 people with this disorder compared to 13 per 100,000 in the general population. It is the largest cause of premature death in this population. The risk of death by suicide is highest in the first 2 years after the onset of schizophrenia and occurs more often in males, those with co-occurring depression and substance use disorders as well as those with a history of suicide attempts. So often, the focus of treatment in schizophrenia is reduction in hallucinations and delusions, but clearly, an important part of any treatment plan involves suicide prevention strategies.

Prevention of suicide in schizophrenia requires breaking down barriers around the stigma of mental illness and bringing discussions of this topic into the light, whether with clinicians, family members or support groups. This is a challenging task given the stigma that already exists, even amongst those affected by this brain disorder. It has been reported that most people who commit suicide give definite warnings about their intentions and often do so in ample time before an attempt. Additionally, a majority of people who are suicidal are ambivalent about death. This



Stephen Rush, MD
Associate Professor of Clinical Psychiatry

contradicts stigma that suicide occurs in people who never discuss it, without warning and who are intent on ending their lives. The high risk of suicide in persons with schizophrenia mandates that we must discuss this topic openly, without bias and without fear of negative consequences. Increased awareness of suicidal thinking is, in fact, associated with decreasing the risk of completed suicide.

Universal prevention strategies must include dissemination of accurate information through media outlets and dispelling inaccurate and biased information that marginalizes individuals with a predilection toward suicide. Restricted access to highly lethal means of suicide (such as guns) has been shown to

reduce the incidence of suicide and requires that, as a society, we advocate for laws and regulations that protect our vulnerable citizens, even in the face of sharp criticism from opposition.

Selective strategies must target those at risk for suicide and require broad screening of these populations; having frank and open discussions about suicide. We must educate and train all members of society to manage issues of suicide in the same vein as interventions such as Cardiopulmonary Resuscitation (CPR), a widely known treatment for cardiac arrest with education provided in many sectors of society not limited to health care professionals. Imagine if raising suicide awareness is established as a requirement in the same way various occupations and activities require CPR training and what this could do to reduce completed suicide.

Individual strategies involving patients with schizophrenia must include family, community and physician involvement. Psychiatrists must be educated about the clear benefits of clozapine in reducing suicide risk in those with schizophrenia (Meltzer et al, 2003) as studies demonstrate this treatment is widely underutilized. Community collaboration, in which multidisciplinary teams are available to provide a range of supports for those with schizophrenia, such as Assertive Community Treatment (ACT) should be standard of care and more easily accessible to all segments of society. Family education, social skills training and cognitive behavioral treatments, were they easily accessible to all patients, regardless of insurance and ability to pay, would similarly have a significant impact on suicide prevention.

Continues on Page 4

CureSZ Foundation Editorial Board

Bethany Yeiser, BS,
Editor-In-Chief

Henry A. Nasrallah, MD

Karen S. Yeiser, RN

David E. Yeiser, M. Div

Louis B. Cady, MD, FAPA

Mary Beth De Bord, JD

Erik Messamore, MD, PhD

Stephen Rush, MD

Craig Chepke, MD, FAPA

Peirce Johnston, MD

James A. Hunt, JD

Jonathan M. Meyer, MD

Carol North, MD, MPE

WhatSZ IN THIS EDITION

CURESZ Friendsz: Rebecca Schaper Pg 2

**Tardive Dyskinesia –
Impact on Patients' Lives** Pg 3

**Treatment Advances in
Schizophrenia: Secuado** Pg 3

Suicide and Schizophrenia (cont.) Pg 4

Video Highlight Pg 4

CURESZ FRIENDSZ



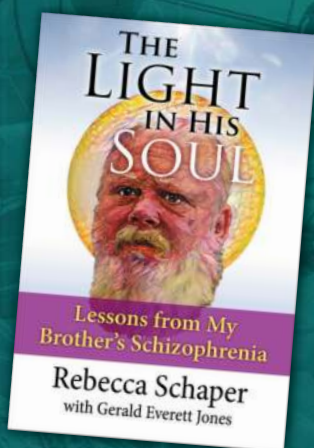
Rebecca Schaper

The Light in His Soul

Lessons from My Brother's Schizophrenia



Rebecca Schaper,
Author of *The Light in His Soul: Lessons from My Brother's Schizophrenia*



In 1977, Call Richmond suddenly disappeared from his home in Greenville, South Carolina. Call was in his late twenties at the time. Since college, he had slowly become more reclusive and depressed. His family heard from him occasionally on holidays such as Thanksgiving and Christmas when he would phone. His sister Rebecca was especially fond of Call and tried unsuccessfully to find him.

In 1997, after being missing for twenty years, Call arrived unannounced at Rebecca's mother-in-law's house, saying simply "I'm Call." Rebecca became Call's primary caregiver. When Rebecca first met her brother after twenty years, she could tell something was very wrong. He was hallucinating and unable to carry on a normal, coherent conversation with Rebecca. Rebecca took Call to see a psychiatrist, and he was diagnosed with schizophrenia.

Call's road to recovery was not easy. His psychiatrist initially prescribed Haldol, which left him with a flat affect and unmotivated. Rebecca persevered to find better options for her brother. She frequently drove two hours from Atlanta to Greenville to see Call. She helped him work with a doctor to finally find an effective medication with fewer side effects. Rebecca also took Call to get a haircut, to be fitted for dentures and to buy new clothes. She helped Call find a social worker who met regularly with him and helped him find his own apartment. His social worker taught him how to clean, cook, and buy groceries.

During Call's recovery, Call shared his memories of the onset of his illness. Just a few months before Call was supposed to graduate from Presbyterian College, he dropped out of school and moved into a dirty cabin in the woods of Greenville, South Carolina, alone. Wanting no one to know how far he had fallen, he got on a train and traveled across America, working various odd jobs all over the country.

Through Call's recovery process, Rebecca learned of the history of schizophrenia and depression in her family. Although her family seemed "picture perfect" (her mother Mary had been a debutante, they lived in a lovely home and their father was well employed at a textile firm), her mother struggled with a psychiatric illness.

Rebecca remembered spending the night at a friend's house when she was young. At the time Rebecca was unaware that her mother Mary suffered from a psychiatric illness. Her parents had kept Mary's psychiatric illness a secret. Mary was also abusing medications and drinking to cope. Mary suffered from extreme anxiety, and soon began to experience hallucinations. Rebecca remembers her mother talking with imaginary people on her back porch. Mary had two suicide attempts at the beginning of her marriage and in her 40's. She was committed four times to a local psychiatric ward, Marshall Pickens. Mary died of an overdose in 1977 when Rebecca was 23.

In 2006, Call became very depressed and relapsed. His constant need for Rebecca's time was difficult on her family. At the time, Rebecca's daughter was also in a facility undergoing treatment for anorexia. It was tough for Rebecca to divide her attention between her brother and her daughter.

Call passed away in 2012 of colon cancer at 61 years old. In 2007, Rebecca asked him what advice he would offer to someone who had his illness. He said "Go see a psychiatrist and get started on medication." Call had finally learned that the key to his recovery was participating in treatment, and for many years, he was able to live a happy, meaningful life.

Today, Rebecca's daughter Kim is recovered and a thriving entrepreneur helping other women empower themselves with self-image, balancing hormones and body issues. Rebecca is grateful that she was able to support and assist in Call and Kim's recoveries. She is also thankful that others in her family provided support to her so that she could provide the caregiving necessary to Call and Kim. Rebecca's daughter Lauren, Lauren's husband, Gabe, and Rebecca's husband, Jim were especially supportive during the challenging times with Call and Kim.

Her hope is that those who suffer from mental illness will find caregivers to support them in their recovery. She hopes that by sharing her story, others may find resources to recover from schizophrenia and that caregivers will find a path to balance the need to care for those struggling with schizophrenia with the need to care for themselves.

TARDIVE DYSKINESIA

IMPACT ON PATIENTS' LIVES



Dr. Craig Chepke, Member, Board of Directors, The CURESZ Foundation, Private Practice Psychiatrist, and Adjunct Assistant Professor of Psychiatry, University of North Carolina School of Medicine

I was teaching a psychiatric physician assistant about Tardive Dyskinesia (TD) recently, and he told me his clinical supervisor, a seasoned psychiatrist near retirement, had expressed the sentiment, *"I don't know why everyone gets so worked up over TD — it's nowhere near as bad as I used to see it in the state hospital. You young people just have too much of an emotional reaction to things."* America has recently struggled with a long-overdue reckoning with social injustice, and I hope that the medical field can also change how it responds to the suffering people with TD endure as well.

There are profound social and occupational consequences that people with TD face.

One of my patients is a smart, hardworking 49-year-old woman who works in an office setting. She'd long felt she was hitting *"the glass ceiling"* trying to climb the corporate ladder as a woman in a male-dominated profession. When she developed TD, she was

terrified it would be yet another barrier to her superiors and coworkers taking her seriously. She was so self-conscious that she might be having involuntary facial movements without her noticing it, she set up her smartphone at her desk to record her face all day long. She would scrub through the video at lunch or after work, and at any sign of movement, she'd begin crying and despair that she'd never achieve her career goals.

She remarked that she felt lucky that she had a good job when she developed TD because she didn't think anyone would hire her for even an entry-level position with TD. I have had other patients with TD feel discriminated against when applying for both blue and white-collar jobs, and a recent clinical trial studied this situation.¹ Actors were filmed participating in a scripted interview that had two versions: one in which the actor imitated facial movements consistent with those that occur in mild to moderate TD and another in which he did not. 800 people were evenly randomized to either watch the imitated TD version or the non-TD version, and all participants were asked questions about their impressions of the interviewee in regards to employment, friendship, or dating.

The study's results were disheartening, if not surprising. While about 65% of people shown the non-TD version felt the interviewee would be suitable for a client-facing job, just 25% of people who watched the same actor say the same words in the same way — but with apparent mild to moderate involuntary facial movements — thought he would be appropriate for the same job. The study also showed the participants perceived the actors mimicking TD as significantly less interesting, less friendly, and less favorable dating partners.

The 65 years that preceded the approval of VMAT2 inhibitors were filled with futility in treating TD, until minimizing or ignoring it became a habit. Like any suffering we turn a blind eye to, there are consequences we don't perceive until a light is shined upon them. Healthcare providers cannot give our patients with TD a job. Still, with safe and effective treatments now available, there is at least one more of social injustice we can remedy far more easily than most of those our society currently faces.



Treatment Advances in Schizophrenia

Secuado. (transdermal asenapine)

by Craig Chepke, MD

Asenapine is an established treatment for schizophrenia, achieving FDA approval with the brand name Saphris in 2009. Despite having favorable results for some, two factors limited its widespread usage. The body cannot absorb asenapine well when swallowed, so it was given as a dissolving tablet that had to be held under the tongue ("sublingual") for 10 minutes twice a day. It had an unpleasant taste, and a common side effect was irritation or numbness of the mouth. But a new formulation of asenapine developed by Noven Therapeutics may help overcome those limitations. It is a transdermal patch worn on the skin that's changed once a day and keeps the amount of medication in the body consistent for all 24 hours. Some may experience skin irritation from the patch but otherwise, rates of potential side effects are similar to the sublingual form, and may include motor abnormalities and weight or metabolic changes. The FDA approved transdermal asenapine on 10/11/19.

Reference: 1. Ayyagari, et al. "115 An Experimental Study to Assess the Professional and Social Consequences of Mild-to-Moderate Tardive Dyskinesia." *CNS Spectrums* 25.2 (2020): 275-275.

Suicide and Schizophrenia

(continued from Page 1)

In summary, we must, as a society, recognize the high risk of suicide among those in our communities living with schizophrenia as a first step toward prevention. We must reduce stigma surrounding this brain disorder and suicide and be aware of risk factors. We must advocate for legislation and healthcare reform. Perhaps most of all, we must act as a community to surround this sect of our population with support and increase access to effective care.

References:

1. Association of timely outpatient mental health services for youths after psychiatric hospitalization with risk of death by suicide. Fontanella et al; JAMA Netw Open. 2020;3(8):e2012887.
2. Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT). Meltzer et al; International Suicide Prevention Trial Study Group. Arch Gen Psychiatry. 2003. Jan;60(1):82-91
3. Predictors of suicide at time of diagnosis in schizophrenia spectrum disorder: A 20-year total population study in Ontario, Canada. Zaheer et al (In Press); Schizophr Res. <https://doi.org/10.1016/j.schres.2020.04.025>
4. Preventing Suicide. Sher, L. QJM. 2004. Oct;97(10): 677-680.
5. Awareness of Disorder and Suicide Risk in the Treatment of Schizophrenia: Results of the International Suicide Prevention Trial. Bourgeois M et al. Am. J Psychiatry. 2004. 161:1494-1496
6. Managing Suicide Risk in Patients with Schizophrenia. Kasckow J, Felmet K and Zisook S. CNS Drugs. 2011;25(2): 129-143
7. Suicide. (2020, September). Retrieved from https://www.nimh.nih.gov/health/statistics/suicide.shtml#part_154969

VIDEO HIGHLIGHT

Scan QR code with smartphone to view video.



Cognitive Impairment in Schizophrenia and Related Disorders

Dr. Henry Nasrallah (professor, University of Cincinnati, and CURESZ Foundation Scientific Director) interviews Dr. Philip Harvey (professor, University of Miami), a national expert on cognition, about how various cognitive functions are impaired in schizophrenia and other psychiatric brain disorders.

There are two types of cognition: **neurocognition** which refers to many mental processes that enable understanding, learning, remembering, planning ahead, decision-making and using information, while **social cognition** includes empathy and the ability to read facial expressions. Both types of cognitive functions are needed for holding a job or appropriate interactions with others.

Cognitive deficits in schizophrenia led Dr. Kraepelin a century ago to call it Dementia Praecox (early dementia) but Dr. Bleuler later renamed it schizophrenia (disconnected thinking). Many experts in schizophrenia regard cognitive deficits as the core feature of this brain disorder.

Although many medications were developed since the 1950s for psychosis (delusions and hallucinations), there is no pharmacological treatment for cognitive impairment in schizophrenia, which can be disabling.

Types of cognition include 1) **processing speed**, which is the ability to process information efficiently or rapidly to keep up with the conversation, 2) **working memory** is the ability to hold information in mind such as remembering a phone number or driving directions, 3) **episodic memory** involves remembering items (such as lists of words) 4) **sustained attention**, and 5) **executive functions**, which include problem solving, planning ahead, the ability to adapt to changing requirements.

Other psychiatric disorders such as bipolar disorder and major depression are also associated with cognitive problems.

Please consider making a donation to the CURESZ Foundation online at CURESZ.org

Your contribution will help provide education and referrals to persons with schizophrenia, their families, and those who work with the seriously mentally ill. CURESZ informs the general public to better understand this serious brain disorder, and to provide scientific advances showing that there is hope for recovery, and a return to a fulfilling and normal life. The CURESZ Foundation is a 501(c)(3) nonprofit organization. All contributions are tax deductible.

"We are committed to helping individuals to cope with and recover from schizophrenia."

You can now also support the CURESZ Foundation by signing up with Kroger Community Rewards and Amazon Smile.

