
UNIT 4 COURSE AND OUTCOME OF MENTAL DISORDERS

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4.0 INTRODUCTION

Having learnt the classification, epidemiology and clinical features of mental disorders in the previous Units, we shall proceed further to discuss the course and outcome of mental disorders. Before proceeding further, it is important to remember a few essential points regarding the course and outcome of mental disorders:

- i) Mental disorder is a broad rubric, which consists of many individual disorders, each having a different course and outcome. The presence of one psychiatric disorder may alter the course and outcome of other co-morbid disorders.
- ii) The course and outcome discussed in this chapter for individual disorders is the general tendency commonly seen in people with these problems. The course may vary among different people.
- iii) For an individual patient suffering from a particular disorder, the course may be affected by various factors like age at onset, comorbidity pattern etc. (which will be discussed subsequently). Even if we know all the associated factors, it may not be possible to *accurately* predict the likely course and outcome for a particular patient.
- iv) Treatment of these conditions has a significant positive impact on the course and outcome. Hence, the course of both treated and untreated mental disorders are discussed.

Why study course and outcome?

How does studying the course and outcome of mental disorders help us in managing the patients?

- On communicating the diagnosis, patients and their family members often want to know more about their illness. This is usually about the likely outcome of illness,

how much improvement can be expected and regarding the likelihood of having a recurrence of the illness again. Knowing the course and outcome helps us to *educate* the patient and family members on these aspects.

- Knowing the natural course of illness helps because, it helps us to differentiate whether the decrease in symptoms observed is due to natural course of the illness or the treatment given.
- It helps us to estimate which stage of the illness the patient is currently in. Different stages of illness need different treatments. For example, in the acute stage, *treatment* has to be given more aggressively for control of symptoms. While in the later stages, treatment should be geared towards prevention of recurrences and rehabilitation.

With this background we would discuss the course and outcome of important mental disorders in the subsequent sections.

Learning Objectives

After reading this Unit, you will be able to:

- define various terms used to describe the course and outcome of mental disorders;
- describe the course and outcome of important mental disorders; and
- ascertain the relevant factors that may affect the course and outcome of important mental disorders.

4.1 DESCRIPTORS OF COURSE AND OUTCOME

In this Unit, we would be defining the commonly used terms that are used to describe the course and outcome of mental disorders. Since most mental disorders are chronic conditions, similar terms are used to describe the course and outcome of these conditions. As you know, *course of illness* refers to the usual trajectory the disease follows from the moment of exposure to *causal agents* until recovery or death. In mental disorders, where the cause of illness is not known exactly, course is described from the onset of first symptom. The description of course of the disease, which is not manipulated in anyway like treatment etc. is known as *natural history of the disease*. The word *Prognosis* is used to denote the prediction of the probable course and outcome of a disease. As discussed previously, prognosis can be calculated accurately for large populations as a whole, but it is impossible to predict *accurately* how a particular patient's prognosis is likely to be for any disease. But knowledge of the general course and outcome an illness and also the factors affecting course and outcome will give an idea on the likely prognosis of a patient.

Different aspects like how the illness begins, how the illness progresses over time and likely outcome of the illness should be described separately to get a better picture of the overall course of the illness. The terms used to describe each of these aspects are discussed separately.

Terms related to onset of illness

Onset of illness refers to how the symptoms of the disease begin to appear in a patient. Onset is defined as the time span from the beginning of the first symptom to the time of developing a full blown diagnosable psychiatric syndrome.

- 1) Abrupt: The onset is described as abrupt when it occurs within 48 hours

- 2) Acute: It is called acute when it occurs within more than 48 hours but less than two weeks
- 3) Insidious: When the onset of illness is subtle, and the symptoms develop so gradually that it is difficult to ascertain when the onset exactly occurred, it is known as insidious onset

Terms related to progression of illness:

The course of a chronic illness is described as either continuous or episodic.

- 1) **Continuous course:** An illness is considered to be continuous when the symptoms of the illness never disappear completely throughout the course of the illness. It is further divided into
 - a) Waxing and waning course: When the symptoms of the illness increases or decreases, showing a fluctuating level of symptoms, but never reaches the symptom free level.
 - b) Progressive course: When the symptoms of the illness steadily worsen over time, the illness is called a progressive illness.
 - c) Static course: The course is said to be static, when the symptoms have progressed to an extent, and do not show any further deterioration or improvement.

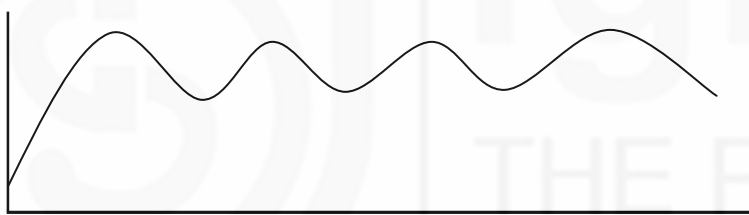


Fig. 1: Waxing and waning course

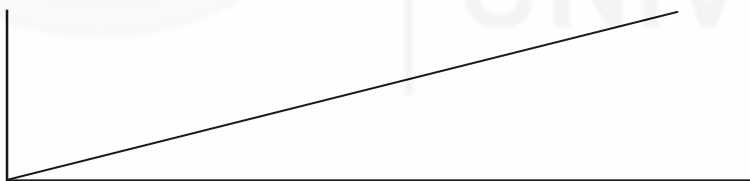


Fig. 2: Progressive course

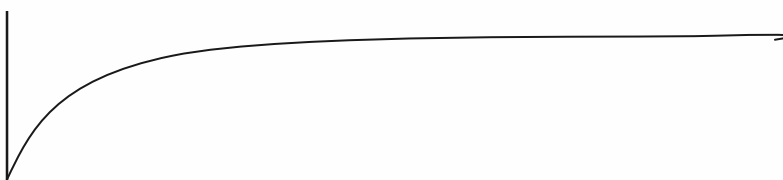


Fig. 3: Static course

- 2) **Episodic Course:** The course of the illness is said to be episodic, if the symptoms disappear completely for varied periods of time, only to reappear again. The period of illness when the symptoms are present i.e. the period between the onset of symptoms to complete disappearance of symptoms is known as an *episode of*

illness. The intervening symptom-free period is known as periods of *remission*. These are illustrated graphically in figure 4.

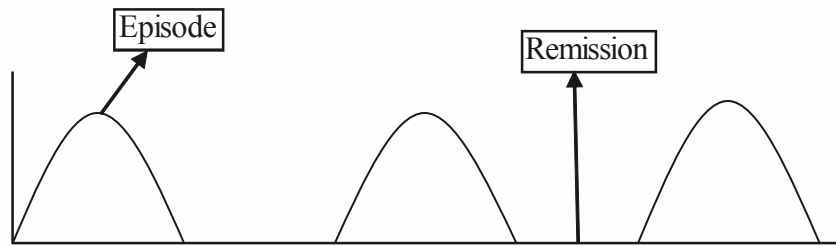


Fig. 4: Episodic course

There are a few other terms used in the description of course of an episodic illness:

- a) **Remission:** This refers to the period in which the symptoms disappear completely.
- b) **Recovery:** When remission is sustained for prolonged periods, i.e. at least 6 months duration, it is known as recovery.
- c) **Relapse:** If the symptoms restart again during periods of remission, it is known as a relapse of symptoms and these symptoms are considered to be of the same episode.
- d) **Recurrence:** When the symptoms restart after recovery i.e. 6 months of sustained remission, it is known as recurrence of a new episode.

Check Your Progress 1

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) How does the study of course and outcome of an illness help us in managing a patient?

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2) What is the difference between acute and insidious onset of illness?

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3) What is the difference between remission and recovery?

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4.2 COURSE OF IMPORTANT PSYCHIATRIC DISORDERS

With this background, we shall now proceed to discuss the course of some important psychiatric disorders. The disorders discussed below are those that are seen commonly in clinical scenario. Those who are interested in the course of other disorders, can refer to the references given in the *further reading* section.

4.2.1 Psychotic Disorders

1) Schizophrenia

As you would have read in the previous Units, schizophrenia is a serious mental illness characterized by three categories of problems, namely positive symptoms, negative symptoms and cognitive impairment. The positive symptoms include delusions, hallucination, formal thought disorder etc. and the negative symptoms include anhedonia, apathy, alogia, avolition and asociality. Different patients have different degrees of these symptoms. Each of these categories follows a different course during the illness. The positive psychotic symptoms usually begin in late adolescence and improve rapidly with treatment. The negative symptoms and cognitive impairment may begin earlier. They are more persistent and resistant to treatment.

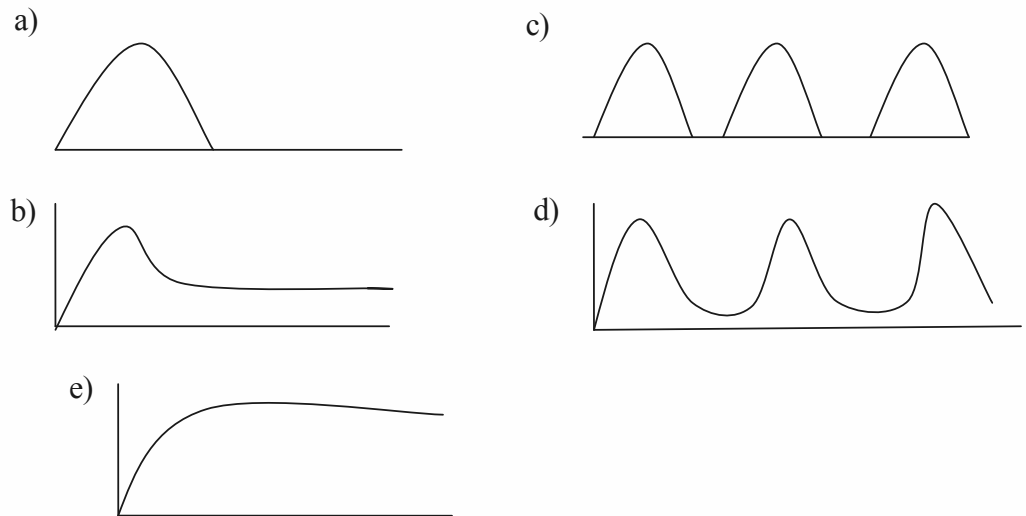
The widely held belief is that schizophrenia being a serious mental illness has a very poor prognosis and has low chance of recovery. But most of the recent research evidence has given contrary evidence suggesting that schizophrenia has a highly variable course and outcome. Further, the recent developments in treatment methods have greatly improved the prognosis of patients suffering from schizophrenia. This would be clearer as we discuss further

- i) **Onset:** As discussed earlier, there is marked variation in the course and outcome of schizophrenia, including the onset of illness. In a majority of patients, the symptoms of schizophrenia start developing in the late adolescence, with most of the patients developing the disease by 30 years of age. It has also been observed that female patients have a slightly later age of onset compared to males. Some female patients develop the illness in their middle age i.e. around menopause.

The illness can be either acute or insidious in onset. In some patients the illness shows a more insidious onset, and starts with negative symptoms like asociality along with vague fearfulness and other behavioural disturbances like agitation, irritability; which slowly progresses to develop clear-cut positive psychotic symptoms like delusions and hallucinations. In other patients the illness starts more acutely starting with positive symptoms like delusions and hallucinations. As will be discussed later, the latter group has a better prognosis compared to the former.

- ii) **Course:** The course of schizophrenia is highly variable. Five patterns of course have been described for schizophrenia namely,
- single psychotic episode followed by complete remission;
 - single psychotic episode followed by incomplete remission;
 - two or more psychotic episodes, with complete remissions between episodes;
 - two or more psychotic episodes, with incomplete remissions between episodes;
 - continuous (unremitting) psychotic illness.

These are illustrated in the figures below:



The course of the illness for an individual patient may follow any of the above described courses. The course of the illness has been markedly altered in recent years due to treatment with antipsychotic patients. Most of the patients show at least some degree of improvement with antipsychotic treatment.

- iii) **Outcome:** Although the outcome of schizophrenic illness is also variable, most of the patients attain at least some degree of symptomatic improvement with antipsychotic medications. The positive psychotic symptoms show better response to antipsychotic medications compared to negative symptoms and cognitive impairment. Despite symptomatic improvement, patients may not be able to reach their previous occupational and social functional status due to the persistence of negative symptoms and cognitive impairment. Hence many patients may need other forms of help like rehabilitation to help them attain their previous socio-occupational functional status.

There is a sizable minority (around 10 to 20%) of patients who develop complete remission of symptoms and regain complete functional status after they develop an episode of schizophrenia. There are other patients who may have longstanding minimal symptoms. They may be able to function adequately, with minimal symptoms and continuous antipsychotic treatment. Taken together, around 30 to 40% of patients have a good prognosis i.e. they are able to lead at least a somewhat normal life. There are some patients who have continuous deteriorating illness who belong to the poor prognosis group. Around 20-35% of patients show such an illness, but as mentioned previously they show at least some degree of improvement (both symptomatically and functionally) with treatment. The remaining patients remain in the intermediate-prognosis group, with moderate improvement and moderate level of functional status. One interesting aspect of the prognosis of schizophrenia is that many patients with schizophrenia in developing countries including India, show a good prognosis compared to those of the developed countries. This has been attributed to the good family support in developing countries which has shown to foster improvement.

The attainment of good functional status in a patient with schizophrenia with continuing psychotic symptoms is excellently demonstrated in the 2001 Hollywood movie “A Beautiful Mind”!

- iv) **Mortality:** Another aspect of schizophrenia outcome that deserves attention is the mortality. It has been seen that people suffering from schizophrenia live on an average 12 to 15 years lesser than the general population. One important cause of premature death in schizophrenia is suicide. People with schizophrenia are 10 to 20 times more likely than the general population to commit suicide. Schizophrenic patients may have suicidal thoughts when they are acutely ill i.e. when they are suffering from florid positive psychotic symptoms like delusions and hallucinations. Some patients also get distressed and attempt suicide immediately after they improve from a psychotic episode, when they come to terms with how the illness has affected their lives. Hence patients with schizophrenia should be actively monitored throughout the course of their illness for the presence of suicidal thoughts and plans.

But the major cause of death in people with schizophrenia is due to physical conditions like heart diseases. The prevalence of physical illness and early death due to physical illness is found to be elevated in people with schizophrenia when compared to the general population. Risk factors for cardiovascular mortality like poor diet, inadequate exercise, sedentary lifestyle, obesity and smoking is higher in people with schizophrenia. Some newer antipsychotic medicines also increase the risk for diabetes and high cholesterol levels, further increasing the risk factor for cardiovascular diseases. Due to the presence of negative symptoms like amotivation, apathy and asociality, people with schizophrenia do not seek treatment even when they have symptoms of medical illness. Further, they are ostracized in the society and their medical needs are not given priority. Hence in people with schizophrenia, it is important to actively monitor for medical illness and relevant risk factors to prevent premature mortality.

- v) **Factors affecting course and outcome of schizophrenia:** The course and outcome of schizophrenia have been found to be affected by various factors, which are given in table 1. The knowledge of these factors can give an idea of how the likely prognosis may be, but we may not be able to accurately predict the course for a particular patient. Not all of these factors can be modified with intervention (e.g. Gender). But other factors (like delay in starting treatment) can be modified through education and community intervention.

Table 1: Factors that affect the course and outcome of schizophrenia

Good prognostic factors	Bad prognostic factors
Good premorbid social and work histories	Poor premorbid social, and work histories
Female gender	Male gender
Late age of onset	Early age of onset
Acute onset	Insidious onset
Stressful events preceding onset	No obvious stressful events
Predominantly positive symptoms	Predominantly negative symptoms
Good social support	Poor social support
Married	Single, divorced, widowed
Early initiation of treatment	Delay in initiation of treatment

2) Acute and transient psychotic disorders

This group of psychotic disorder is by definition characterized by acute or abrupt onset of symptoms and rapid remission of symptoms within 1-3 months. The disorder has an onset characteristically in young adults aged between 20 and 30 years, more commonly seen in females. After remission, which usually occurs within days or weeks, the patients

do not have any residual symptoms unlike schizophrenia. Many patients experience recurrence of such episodes, which too recover completely. Some of these patients have been shown to be re-diagnosed as either schizophrenia or mood disorder in follow-up. In the acute phase, many disorders present with agitation and excitement, which may be misdiagnosed as acute and transient psychotic disorder. By and large this disorder is a good prognosis condition, with most patients achieving full functional recovery in long term.

3) Persistent delusional disorder

This is a relatively uncommon condition characterized by the presence of a single or a set of related delusions, in the absence of other psychotic or mood symptoms. This disorder usually starts in the 30s with an insidious onset. But some people develop this disorder even at a later age. It usually remains stable and does not progress, unlike schizophrenia. In many patients, the delusion affect only those aspects of life related to the delusion. For example, in a person with a delusion that his wife is not faithful to him, his family life will be affected to a great extent. But he may be functioning normally in his occupational life and other aspects. The presence of a precipitating factor before the onset of illness and persecutory delusions are good prognostic factors. The presence of comorbid disorders like depression is a poor prognostic sign. The major difficulty in these patients is that they do not come for treatment despite years of illness, due to the well preserved functioning in at least certain aspects of life and poor insight into the illness.

4) Schizoaffective disorder

Schizoaffective disorder is characterized by both mood (depressive or manic) and psychotic symptoms in the same episode of illness. The disorder usually runs an episodic course and the prognosis is intermediate i.e. better than schizophrenia and worse than mood disorders. It depends on which group of symptoms predominates.

Check Your Progress 2

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the various patterns of course described in schizophrenia?

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2) Enumerate the factors that indicate a good prognosis in schizophrenia.

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4.2.2 Mood Disorders

1) Depressive disorder

- i) **Onset:** Depressive disorder can occur at any age from childhood to old age. It usually starts in middle age, more commonly in 30s. The onset of depressive disorder is usually gradual or insidious. Depression occurring as a part of depressive disorder has more of a gradual onset compared to those that occur in bipolar disorder. But patients who develop a depressive disorder after a stressful life event can have an acute onset of depressive disorder. The initial episodes are usually precipitated by stressful life events, but later episodes start occurring without any obvious precipitating event.
- ii) **Course:** Depressive disorder characteristically runs an episodic course, with complete remission of symptoms in between the episodes. Variations do occur. For example, around 10 to 15% of patients just have a single episode of illness with no further episodes. Another 10% of patients also have chronic stable course of depressive disorder. But majority of the patients have an episodic course, each untreated episode lasting 6 to 13 months. The treated episode usually lasts for an average of 3 months, depending on when the treatment was initiated. As the course of the disorder progresses, patients tend to have more frequent episodes that last longer. Studies have shown that patients develop an average of 5-6 episodes, when followed up for a period of 20 years. One particular type of depressive disorder known as seasonal affective disorder follows a particular pattern of illness characterized by recurrence of episodes in a particular season of the year, usually in winter.
- iii) **Outcome:** Although recurrent depressive disorder improves with treatment, it runs a chronic episodic course. But the incidence of further episodes is decreased in people taking prophylactic antidepressant medicines. Recently, it has been seen that many patients may have some minor symptoms in-between the episodes, and the presence of such symptoms, increases the chance of further episodes. Further, stopping of treatment before complete remission of symptoms could lead to heightened chance of recurrence. It is recommended that people having recurrent episodes of depression should take antidepressants for longer periods to prevent further development of episodes.
- iv) **Mortality:** Mortality seems to be higher in people with depressive disorder when compared to the general population. Suicide is an important cause of increased mortality in this population. More than half of people who commit or attempt suicide suffer from depressive disorder. Severity of depression, past history of suicidal attempts, comorbid personality disorders, anxiety and substance use increase the risk of suicide in these patients. Other causes of mortality like accidents and physical illness have also seen to be increased in patients with depressive disorder. This occurs due to factors like altered physiological status in people suffering from depressive disorders, substance use and unhealthy eating habits.
- v) **Factors affecting course and outcome:** Certain factors predict the course and outcome of depressive disorders. For example, presence of comorbid substance use disorder, ongoing stress and personality disorder is associated with worse outcome of depressive disorders. Onset of depression at old age is associated with longer duration of illness, although the severity may be less severe. The presence of multiple previous episodes of depression, longer episodes in past and persistence of residual symptoms predict a poorer outcome of the current episode of illness.

2) **Bipolar affective disorder**

- i) **Onset:** Bipolar disorder has an earlier age of onset compared to unipolar depressive disorder with an onset usually around 20 years of age. Male patients have a slightly earlier age of onset compared to female patients. People with a variant of bipolar disorder known as bipolar disorder-II (who do not develop severe manic episodes and present only with depressive episodes and hypomanic episodes) have a slightly later age of onset compared to bipolar-I disorder. The illness usually starts with a depressive episode in most patients. Onset of symptoms appears to be more acute in bipolar disorder compared to depressive disorder.
- ii) **Course:** The illness characteristically runs an episodic course with almost complete remission of symptoms in between the episodes. A minority of patients (around 10%) do not develop further episodes after their first manic episode. Around 10-20% of patients develop only recurrent manic episodes with no depressive episodes. But majority of patients have recurrent episodes, which are either of manic or depressive in nature. Each manic episode lasts for an average duration of around 4 to 6 months. Depressive episodes are also more acute in onset and shorter in duration in bipolar disorders compared to unipolar depression. The recurrences tend to occur more frequently as the illness progresses and the periods of remission decreases and stabilize after a certain time period. On an average, patients develop one episode every 2-3 years. But this estimate is just an average and the frequency of episodes varies greatly among different individuals. During the course of their illness, some people suffer from very frequent episodes i.e. four or more episodes in a year. This phase is known as *rapid cycling* bipolar affective disorder and is usually difficult to treat.
- iii) **Outcome:** The outcome of bipolar disorder is worse than unipolar depression, characterized by more frequent recurrences. Some patients have some minor symptoms in-between the episodes, and the presence of such symptoms, increases the chance of further episodes. The recurrence of manic symptoms greatly affects the occupational status of the patients due to their impaired judgment during the episodes leading to occupational errors. Further, the stigma associated with the presence of a mental illness and breaks in the occupational career also contribute to their decreased functional status. The severity of the episodes and the risk of recurrences can be greatly controlled by treatment with continuous treatment with medications.
- iv) **Mortality:** The risk of mortality in bipolar disorder is higher than that in the general population. Suicide risk is found to be high in this population. Other medical causes of mortality like heart diseases and stroke are also found to be higher in bipolar patients. Treatment with lithium has shown to decrease suicide in patients with bipolar disorder.
- v) **Factors affecting course and outcome:** Poor premorbid occupational status, alcohol dependence, psychotic symptoms, inter-episode depressive features and male gender are associated with a poor prognosis. Short duration of manic episodes, advanced age of onset, few suicidal thoughts, and few coexisting psychiatric or medical problems predict a better outcome. Long term regular treatment also improves the outcome of patients with bipolar affective disorder.

3) **Dysthymia**

Dysthymia is characterized by low grade depressive symptoms which are present for long periods. This disorder has an early age of onset. Around 50% of patients have an

onset before the age of 25 years. Onset is usually insidious. The disorder tends to run a chronic course and usually patients seek treatment after a decade of illness. The prognosis improves with treatment. Some patients may develop either a depressive disorder or bipolar disorder over long term.

Check Your Progress 3

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What is the usual age of onset of depressive disorder and bipolar affective disorder?

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2) What is rapid cycling bipolar disorder?

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4.2.3 Anxiety Disorders

Anxiety disorders are the most common psychiatric disorders seen in the community. They usually share the common features of early age of onset and a chronic waxing and waning course. Individual anxiety disorders have different age of onset and course. For example the peak age of onset common anxiety disorders are as follows: Specific phobias in middle childhood; social phobia in middle adolescence; panic disorder in late adolescence; generalised anxiety disorder in young adulthood; and Obsessive compulsive disorder in early adulthood. Earlier anxiety disorders were considered to be relatively mild conditions. But recent research findings show that they are associated with significant disability and functional impairment. Many of these patients may not seek treatment due to poor awareness of the availability of treatment options for these conditions. The course of some anxiety disorders are discussed briefly.

Generalised anxiety disorder starts at an early age, at around 20 years of age and tends to run a chronic course with fluctuating severity and symptom patterns. Periods of sustained remission are rare without treatment. Patients usually have other comorbidities like depression and other anxiety disorders. Early age of onset, untreated status and presence of comorbidities is associated with poor outcome.

Panic disorder usually has its onset in late adolescence, but can occur at any age. People with panic disorder may develop fear of going to crowded places and travelling secondary to fear of having another panic attack. This latter condition known as *agoraphobia* increases the disability associated with panic disorder. Other psychiatric disorders like depression, substance use may also coexist. They are also prone to have increased risk of suicide. This disorder tends to run a chronic course, but it may remit completely in some people. Most of the patients have good response to treatment, which has to be continued for adequately long duration to prevent recurrence of attacks.

Social phobia begins in middle adolescence and runs a chronic course. It causes marked impairment in academic and occupational functioning. It may persist into adulthood if not treated adequately. Specific phobia has an earlier age of onset and it too persists into adulthood. Specific phobia causes dysfunction only in circumstance the person has to face the feared stimuli.

Obsessive compulsive disorder (OCD) usually starts by around 20 years of age, but for some people it may also have its onset in early childhood. The disorder can have an acute or insidious onset. Usually people suffering from this disorder delay seeking treatment due to unawareness and shame about the symptoms. OCD usually runs a chronic course with fluctuating level of symptoms. Some people may show improvement in symptoms and may remit completely without any treatment. But a majority of patients need long term treatment to improve their condition. Comorbidities including both psychiatric and physical illnesses, are commonly seen in patients suffering from obsessive compulsive disorder.

4.2.4 Substance Use Disorders

People with substance use disorders like alcohol dependence, nicotine dependence (e.g. cigarette smoking) etc. show a characteristic pattern of substance use behaviour which leads to significant dysfunction and health risks. This pattern generally follows a similar course, irrespective of the substances used. The use of such substances usually has an onset in adolescence period. People usually start by using commonly and legally available substances like cigarette and alcohol. Some people who are predisposed to develop substance use disorders, continue using these substances in a more regular basis and in a few years become dependent (or addicted) to these substances. They are not able to quit them even though they experience harmful effects due to these substances. After a few years they develop significant health problems due to these substances and also other financial and social problems. Some people also start using illegal substances like cannabis and heroin and they become dependent on these substances on due course.

At the peak of their dependence some people may succumb to death due to physical complications of these substances or overdose. Some people develop depression and suicidal ideations and they may die of suicide. They may also meet with accidents under intoxication. Significant familial problems like separation, divorce, disowning by family members may occur. At this stage many of them may be willing to quit the substances, but they may not be able to do so. Substance dependence is a chronic disorder which follows a waxing and waning course. By employing various methods, some people quit substances but they may relapse in future following a stressful event, craving or pressure from peers. Adequate treatment may help these patients in decreasing the physical and social complications as well as decreasing the relapses and helping to maintain abstinence.

Check Your Progress 4

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What is the usual age of onset of various anxiety disorders?

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2) What are the common causes of premature death in substance use disorders?

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3) How do mental disorders predispose to physical illness?

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4.3 LET US SUM UP

From the above discussion, you would have understood that mental disorders include a broad rubric, containing various individual disorders, each having a different course and prognosis. Many mental disorders are chronic illnesses, which have an onset in early age. Nevertheless they may begin at any age and their course is variable. The course is often characterized by either remission-relapses or by fluctuations in the level of symptoms. They cause significant impairment in the patient's lives. Some patients have a good prognosis and remit completely with treatment. There are some disorders like acute and transient psychotic disorders which are short lasting and have a good prognosis.

Mental disorders may sometimes be comorbid with each other. Such comorbidity worsens the prognosis of either disorder. Due to unhealthy lifestyle and decreased access to treatment, people with mental disorders are more prone to develop physical illness. Mental disorders may also lead to death due to suicide, accidents or increased risk of physical illness. There are various factors which affect the course and prognosis of mental disorders. Some of them like early initiation of treatment, continuous treatment and social support are modifiable. These factors have to be targeted with interventions like screening for mental disorders, early initiation of treatment, education of the family members and the general population to improve the prognosis of mental disorders.

4.4 GLOSSARY

- 1) **Course:** Course of an illness refers to the usual trajectory the disease follows from the moment of exposure to *causal agents* until recovery or death
- 2) **Prognosis:** Prognosis refers to the prediction of the probable course and outcome of a disease.
- 3) **Onset:** The time from the beginning of the first symptom to a full blown diagnosable psychiatric syndrome.

- a) **Abrupt:** The onset is described as abrupt when it occurs within 48 hours
 - b) **Acute:** It is called acute when it occurs within more than 48 hours but less than two weeks
 - c) **Insidious:** When the onset of illness is subtle, that it is imperceptible when the onset exactly occurred, it is known as insidious onset
- 4) **Continuous course:** An illness is considered to be continuous when the symptoms of the illness never disappear completely throughout the course of the illness. It is of three types
- a) **Waxing and waning:** When the symptoms of the illness increases or decreases, showing a fluctuating level of symptoms, but never reaches the baseline i.e. symptom free level.
 - b) **Progressive:** When the symptoms of the illness steadily worsen over time, the illness is called a progressive illness.
 - c) **Static:** The course is said to be static, when the symptoms have progressed to an extent, and do not show any further deterioration or improvement
- 5) **Episodic Course:** The course of the illness is said to be episodic, if the symptoms disappear completely for varied periods of time, only to reappear again.
- 6) **Remission:** This refers to the period in which the symptoms disappear completely
- 7) **Recovery:** When remission is sustained for prolonged periods, i.e. at least 6 months duration, it is known as recovery
- 8) **Relapse:** If the symptoms restart again during periods of remission, it is known as a relapse of symptoms and these symptoms are considered to be of the same episode.
- 9) **Recurrence:** When the symptoms restart after recovery i.e. 6 months of sustained remission, it is known as Recurrence of a new episode.
- 10) **Mortality:** Deaths occurring in patients suffering from a disorder.

4.5 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

- 1) How does the study of course and outcome of an illness help us in managing a patient?
Studying the course and outcome helps us to:
 - 1) educate the patient and family members on what to expect when one is suffering from a particular disorder
 - 2) know how much the treatment given has helped the patient
 - 3) adjust treatment according to the stage of illness
- 2) The onset is described acute when it occurs within more than 48 hours but less than two weeks. When the onset of illness is subtle, and the symptoms develop so gradually that it is difficult to ascertain when the onset exactly occurred, it is known as insidious onset

- 3) Remission refers to the period in which the symptoms disappear completely. When remission is sustained for prolonged periods, i.e. at least 6 months duration, it is known as recovery.

Check Your Progress 2

- 1) Five patterns of course have been described for schizophrenia namely,
 - a) single psychotic episode followed by complete remission;
 - b) single psychotic episode followed by incomplete remission;
 - c) two or more psychotic episodes, with complete remissions between episodes;
 - d) two or more psychotic episodes, with incomplete remissions between episodes;
 - e) continuous (unremitting) psychotic illness.
- 2) Refer to Table 1.

Check Your Progress 3

- 1) Both disorders can occur at any age. Bipolar affective disorder starts at the age of around 20. Depressive disorder starts at a later age at around 30 years of age.
- 2) Rapid cycling bipolar disorder is characterised by frequent occurrences of manic or depressive episodes i.e. 4 or more episodes within a year.

Check Your Progress 4

- 1) Specific phobias in middle childhood; social phobia in middle adolescence; panic disorder in late adolescence; generalised anxiety disorder in young adulthood; and Obsessive compulsive disorder in early adulthood.
- 2) Premature death can occur in substance use disorder due to
 - 1) Physical complications of the substances
 - 2) Suicide
 - 3) Accident
 - 4) Overdose of the substances taken.
- 3) Mental disorders can predispose to physical illness due to:
 - 1) Sedentary lifestyle
 - 2) Poor eating habits
 - 3) Substance use
 - 4) Side-effects of treatment

4.6 UNIT END QUESTIONS

- 1) What are the different types of course of chronic mental disorders?
- 2) Describe the course and outcome of schizophrenia.
- 3) How does the course of depressive disorder differ from that of bipolar affective disorder?
- 4) Discuss the course and outcome of various anxiety disorders.
- 5) What are the various factors associated with mortality in mental disorders?

4.7 SUGGESTED READINGS AND REFERENCES

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