SPEAKER NOTES

Ask the Doctor…

Summarized by Thomas T. Thomas

Our members got the rare opportunity to pick the brains of a practicing psychiatrist—free of charge—at our meeting on November 16. **Richard A. Shadoan, MD,** is Clinical Professor of Psychiatry at the University of California, San Francisco's Langley Porter Psychiatric Institute. He has also served as medical director of UCSF's Aftercare Program and has a private practice in San Francisco.

As a preface, Dr. Shadoan discussed his long-time relationship with AMI. He gave our group credit for educating the psychiatric profession and doing away with the notion of "schizo-genic" mothers and families. "You didn't cause your family member's illness," he said.

The doctor also praised AMI's work in the political arena, noting that it's far more effective to approach an elected official with a family member and a psychiatrist working together than for either to go separately.

Here then are a sampling of members' questions and Dr. Shadoan's answers.

Is there a better term to describe this illness than "schizophrenia"? And is it now considered a disease?

The brain has many different functions—thought processing, memory, and mood. Schizophrenia, rather than a mood disorder, is actually a thinking or cognitive disorder. The client's mood changes may have much to do with his or her frustration at the effects of disabled thinking.

As to whether schizophrenia is a disease or a disorder, it probably should be considered a disease. That approach would help us treat it like any other of the body's illnesses. But that battle has been waged—and lost—with the latest edition of the psychiatrist's diagnostic manual, *DSM IV*. They call it a disorder, and physicians have to use that language because *DSM IV* governs insurance payments.

My son was having mild success with his medication, then tried Haldol and deteriorated with it. Now he's trying Risperidone. What's the story on that drug?

Risperidone (sold as Risperdal) is a new drug that's supposed to work like Clozaril. These are both neuraleptics, which seem to be effective with the positive symptoms of schizophrenia.

Positive symptoms are hallucinations, delusions, and wildly disordered thinking. Negative symptoms are more subtle—such as passivity, loss of motivation, and flat emotional response.

Clozaril is costly, $9,000 and up per year, and requires weekly blood analysis because it lowers the white cell count. That can make the client susceptible to infections. But Clozaril enables the client to get back into the community.

Risperidone seems to treat both positive and negative symptoms, and does not require the blood work of Clozaril. It also has a narrow therapeutic window—

that is, dosages can be effective with as low as 5 or 6 milligrams. Risperidone doesn't seem to promote motor-control problems such as tardive dyskinesia.

My son is on medication and has trouble with clumsiness and rigid fingers. What would happen if we took him off all medications? How much worse could he get?

Some people don't get any benefit from neuraleptics. But some people need them if they become violent or suicidal.

A recent article in the *New York Times* discussed an economist who had his break, or became schizophrenic, when he was thirty. His family and his employer, Princeton University, provided a supportive, noncritical environment where he could live as naturally as possible and without medications, which they felt had not helped him. Over the years, he gradually became better.

If the family members are not being abused, and the family life is not itself in disarray, then this can be a good environment for the client. Some schizophrenics simply cannot cope with independence.

I've seen patients do well with one medication, then take Clozaril. Can memory and thinking be improved even more?

The guideline with Clozaril is to use it if nothing else is working. If other medications are doing well, then don't change.

My sister has been diagnosed variously with schizophrenia and schizo-affective disorder. The psychiatrist wants to lower her Stelazine dose. She hasn't been sleeping well, averaging three hours a night. She took Restoril and now Clonazepam.

These are anti-anxiety medications, and they're all addictive. I would be careful with them over the long term. Clonazepam is probably the safest.

With Stelazine, an anti-psychotic medication, you must worry about tardive dyskinesia. So you should try to get the dosage as low as possible.

My son is on Clozaril and is getting better. He's well groomed now. But he still takes Navane because he hears voices.

It's okay to use both medications—Clozaril to treat the negative symptoms, Navane for positive symptoms like the voices.

They're taking a "serum level" on his Clozaril. Why do they do that?

Everyone absorbs medication at a different rate, often *very* differently. Also, people's livers metabolize the drugs differently, and their kidneys excrete them at different rates. So measuring the dosage is not always a true indicator of how much is getting into the system.

Serum levels measure the body's absorption more effectively than dosage levels. But doctors haven't been doing as much serum-level work with the neuraleptics.

My son is getting better. Now he's asking me what he was like as a child, compared to his siblings. How much should I say?

This is a case of family relationships rather than purely medical advice. Apparently, your son wants to know more about his disease, which could mean he's trying to gauge his potential for development down the road. The danger lies in being too optimistic. But you also don't want to dash his hopes.

Schizophrenia is an information-processing disease. Your son will probably have to work harder than people who are without it. Things are just going to be harder for him—it's a handicap.

Our son is like he has no skin: everything goes in, and he responds so strongly to it. Talking with him can be grand, but then he will overreact. Something extraneous will happen, and he's gone. It takes so much energy for him to maintain himself in the world.

This is another effect of the disease—and that's a very good way to put it, "no skin." His stimulus barrier is gone, and so he can't screen out stimuli that most of us would ignore.

My son has been under medication for three years now. He's been on Risperdal for five months and seems to be improving. But the better he gets, the more depressed he gets. We tried an antidepressant, but Risperdal doesn't work with it.

Unfortunately, when people's symptoms get better they can see how much of a useful life they've lost—and they do get depressed.

The newest anti-depressant, Effexor, should help. It so works on serotonin and norepinephrine in a balanced way.

Do you have any patients that lose the ability to talk? My son has been on Clozaril, Risperidone, etc. and he seems to have trouble talking.

That could be an effect of depression. Long-term medication does not seem to upset the speech centers.

I work with children. Do you know of any behaviors, in little children, that might be a red flag for later schizophrenia?

No. There are so many different stories… bright kids who have a break, or shy children who were always "different," or the ones who turn to street drugs—apparently in an attempt at self-medication. There doesn't seem to be a pattern.

Some studies have indicated soft neurological signs—clumsiness, motor problems, poor muscle tone, eye-tracking problems—as a sign or precursor of schizophrenia. Other studies have indicated through MRI (Magnetic Resonance Imaging, a form of scanning) that large ventricles in the brain and shrunken cortices may be a sign.

The research in this area is not conclusive yet. It would be wonderful—or terrible—if we had a way to spot this disease in young children. Maybe we could do remedial work with them…. But we're not there yet.