SPEAKER NOTES

Ask the Psychiatrist

Summarized by Thomas T. Thomas

A practicing psychiatrist with offices in Berkeley and Orinda, **Jerry Gelbart, MD,** spoke and answered audience questions at our September 25 meeting. He is also the Medical Director of Foresight Mental Health, which uses technology to advance mental health care. Dr. Gelbart is also the author of *The Potent Mind: A Program for Psychological Wellness and Effectiveness*.[1]

His experience is primarily with bipolar disorder, depression, trauma, schizophrenia, and anxiety disorders including eating disorders and obsessive-compulsive disorder (OCD). His treatments include medications along with cognitive behavioral therapy (CBT) or dialectical behavioral therapy (DBT). He uses cutting-edge technologies, such as genetic and neuropsychological testing to differentiate mental illness from biological impairments and to assist in medication decision-making, and he works with new approaches to treatment-resistant depression (TRD) such as transcranial magnetic stimulation (TMS) and the recently approved medication Spravato.

Jerry Gelbart, MD

Q. My stepson, 38, has severe schizophrenia. He can acknowledge his illness but is paranoid and won't take his medication, see a therapist, or join a support group. Should we do an intervention and force him to express and confront his emotions?

A. First, don't ever lose hope. It's sad, but people with mental illness often lack insight, and young people even less insight. The question is how much to confront him. Try to avoid direct intervention. But if you do it, get an intervention specialist, and have a plan where to take your stepson and what to do next.

Look for ways to approach him without forcing the issue of schizophrenia. For example, does he have problems with sleeping or appetite? A primary care physician can suggest medications for that which also address his psychotic symptoms. We are training family care physicians—especially in a program at John Muir Hospital—to deal with mental illness.

Be careful, though, not to become codependent: facilitating his resistance to treatment. Sometimes it's necessary to let the system work and have your loved one go to the hospital for treatment.

Q. My son has been through six cycles of withdrawing from his medication. Can an intervention, even with a specialist, work when it goes against a person's will?

[1] Based on his blogs and currently out of print.

A. Generally, no. But you can recruit family members and set up a treatment plan ahead of time. Interventions are a carrot and stick approach—and again, try a softer alternative, working from the fringes, like treating sleep and appetite disorders.

Q. My daughter has previously been hospitalized with a 5150. She has anosognosia, is paranoid, and suspicious of everything. She won't get a prescription, but I bought some lithium carbonate over the counter. Can I give it to her? Also, what about flower or herbal medications?

A. You have to be careful of dosing with lithium. Treatment requires blood-level monitoring, because this medication can cause kidney damage. So it's not a good idea to slip it into her food.

As to herbal medications, there is a lot of evidence that they can be good for anxiety, but they have not been shown to treat psychotic tendencies. They may not be good for bipolar mania.

Q. My daughter has been diagnosed with both bipolar and schizophrenia. She has been admitted to the hospital but refuses medication.

A. Schizophrenia is characterized by acute psychotic symptoms (i.e., hallucinations, delusions, paranoia) but without mood swings or depression. Bipolar is generally characterized by mood swings from depression to mania, but without psychotic symptoms in the middle state. The combination of both symptoms is known as schizoaffective disorder, and it's harder to treat.

Most people on medication learn over time that, when they go off their meds, things don't work so well. One way to help with compliance is injectable medications like Abilify. You can tell your daughter it's all about the convenience: she won't have to remember to take a pill.

Another recourse to medication refusal is Laura's Law, or court-ordered assisted outpatient treatment (AOT). To qualify for the program, however, a person must have a serious mental illness and a recent history of psychiatric hospitalizations.

It can be difficult to get AOT involved with your case. One alternative is in-home outpatient treatment (IHOT), where a team composed of an unrelated family member, a consumer advocate, and a social worker come to your home and work with your family and your daughter to engage her in treatment.

You should contact the Alameda County Behavioral Health Care Services ACCESS Program at 1-800-491-9099,[2] which is staffed by licensed clinicians. Note that the county program only serves people who don't have private medical insurance.

Q. What are the risks of taking antipsychotic medications for years? What are the effects on the brain?

A. Most medications offer no long-term risks. Some of the older, or "typical," antipsychotics such as Haldol have a higher risk of side effects centered in the brain's motor control system: tardive dyskinesia (TD), or involuntary movements, similar to Parkinson's disease. The risk has been calculated at approximately 7% per year, so in ten years you would have a 70% risk of contracting the disease. However, we now have medications to treat TD; they are expensive but available.

[2] A similar program exists in Contra Costa County.

Of the newer, or "atypical" antipsychotics such as Risperdal, Zyprexa, or Geodon, the risk of side effects is a tenth of that, or 0.7% per year—but it is still a cumulative effect.

Other than movement disorders, some of the older medications may kill brain cells. But the newer ones actually improve nerve cell growth by promoting brain-derived neutrophic factor (BDNF).

Q. Should someone with depression and psychotic symptoms be put on an antipsychotic?

A. It would be appropriate to treat the psychotic symptoms first, then treat the depression.

Q. I've read that untreated psychosis can kill brain cells. Is this true?

A. Depression can kill brain cells, and antidepressants help protect the brain.

A concept taken from the treatment of seizures, called "kindling," also applies to repeated bouts of depression. Each little seizure, or each episode of depression, makes it more likely for the person to have another seizure or more depression. The first episode makes a repeat 50% more likely, the second 75%, and so on. The same may be true of psychotic episodes.

Q. How do you approach treatment-resistant depression?

A. TRD is defined as a person failing to find relief with two antidepressant medications. Many doctors use as antidepressants one of the selective serotonin reuptake inhibitors (SSRIs) like Paxil or Zoloft or a serotonin norepinephrine reuptake inhibitor (SNRI) like Effexor. Lithium or a mood stabilizer like Lamictal can also help. Doctors can use genetic testing to see what should work.

Other than medication, transcranial magnetic stimulation (TMS) has been found to be effective about 70% of the time—although some practitioners are experimenting with their protocols. (Dr. Gelbart recommends BayTMS as a reliable local provider.) The new antidepressant Spravato is also effective, but it must be administered in the doctor's office.

One caution is that persistent, chronic depression may be confused with dysthymia, which is a psychiatric disorder originating in childhood and best treated with psychotherapy rather than medication.

Q. Is obsessive-compulsive disorder (OCD) related to mental illness?

The rituals and anxieties of OCD differ from the delusions of psychosis. A person with OCD may have habitual activities and anxiety, but they may also have insight into their beliefs and can challenge them. A person with a psychotic delusion usually lacks insight.

In the same way, the autism spectrum and cases of attention deficit disorder (ADD) are separate from mental illness. In these cases, the person is experiencing a cognitive impairment. To establish these conditions as separate diagnoses, the physician does a neuropsychological evaluation.

Dr. Gelbart said he believes in a bio-psycho-social perspective: that illness is the presence of symptoms, and health their absence—but beyond that is *wellness*. And wellness involves self-care routines that include healthy eating, sleeping, time management, self-esteem, and other aspects of a life well lived.