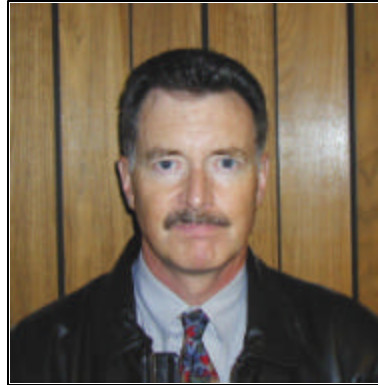


Update on Treatments and Medications for Schizophrenia and Schizo-Affective Disorders

Summarized by Thomas T. Thomas

As we have learned over the past decade or so, new medications are becoming ever more effective in managing brain disorders. At our November 17 speaker meeting, **Stephen Sturges, MD**, discussed his treatment philosophy and the currently available medications that can help with schizophrenia and bipolar disorder. Dr. Sturges is a Berkeley psychiatrist affiliated with Alta Bates/Herrick Psychiatric Hospital. He works mostly with adolescents and young adults and understands the problems our members face, because he also has several family members with schizophrenia and bipolar disorder.



STEPHEN STURGES, MD

“It’s a lot more fun to be a psychiatrist these days,” Dr. Sturges said, “because we have better medications with fewer side effects. And we also have a better understanding of how to work with patients’ families—not so much in terms of therapy as education. They can help us learn what the disease is like in their family member and tell us what works and what doesn’t.”

People with severe mental illness have a problem with judgment, Dr. Sturges said. So it helps to have a supportive family. Patients with families tend to do better and not lose function over time as much as patients who are alone. “However,” he said, “offering this kind of support can be stressful for the family. So you need to care for yourself and not get too worn out.”

Dr. Sturges briefly reviewed the history of psychotropic medications. In the early 1950s a French hospital which was treating allergy patients with antihistamines discovered that Stelazine (generic name: trifluoperazine) and Thorazine (generic: chlorpromazine) also had an effect on psychosis. Most such medications work by blocking the dopamine and norepinephrine receptors in the brain. Neuroleptics like Thorazine help with the positive symptoms of schizophrenia—hallucinations, delusions, and general acting out.

Clozaril (generic: clozapine), one of the atypical neuroleptics, was introduced about 15 years ago and was the first medication to treat schizophrenia’s negative symptoms—loss of energy, loss of interest, and social withdrawal. Other medications of this class are Risperdal (generic: risperidone) and Zyprexa (generic: olanzapine). The modern drugs have fewer side effects like tardive dyskinesia (involuntary facial movements) and dystonia (muscular tightness, which often shortens the patient’s gait to a shuffling walk). Although these medications can be

expensive—for example, olanzapine costs \$7 to \$8 per tablet—this is offset by overall reduction in costs for hospital care and treatment.

Dr. Sturges then opened the meeting to questions from the audience.

When you work with a patient, how do you decide what medications to start with?

“A lot of this is trial and error,” he said. “Although it’s not so hard with schizophrenia. I like to use olanzapine first, but that can take weeks to be effective, so I use Haldol [generic: haloperidol] to get a faster effect. Also, olanzapine does not always work.

“With depression and bipolar disorder, there is more guesswork,” he said. Twenty to thirty percent of bipolar disorders respond to mood stabilizers like Depakote (generic: divalproex sodium). In schizo-affective disorder, which is a hybrid of schizophrenia and bipolar, Dr. Sturges tries to treat the delusions and hallucinations with bipolar medications and then, if they don’t work, goes on to an antipsychotic like olanzapine.

With olanzapine, the patient may begin responding in two to four weeks, show improvement in three months, and then demonstrate some further improvement over two to three years. Psychiatrists have found that, with bipolar disorder, patients remain healthier and have a better sense of who they are—especially if the patient is young and still developing emotionally and socially—if they can avoid having psychotic episodes.

What is the difference between psychosis and schizophrenia?

While psychosis and schizophrenia used to be thought the same thing, a person can be psychotic without being schizophrenic. “Although sometimes it can be hard to tell a paranoid schizophrenic apart from a bipolar patient,” Dr. Sturges said. “That’s where family histories are important, because bipolar has a strong genetic relationship.”

In schizophrenia, over the patient’s lifespan, he said, there is a gradual deterioration of function, especially without medication. A bipolar patient, on the other hand, will return to normal levels of functioning between episodes.

Do all these medications have a sedative effect? Is it common for a person taking them to sleep 16 hours a day?

Extended sleep is fairly common, Dr. Sturges said. There has been some clinical work on using stimulants like Ritalin (generic: methylphenidate) to counter this effect. “Caffeine can be used, too,” he said.

Why do people with schizophrenia seem to have similar ideas—the hyper-religiosity, say, or the idea that they’re getting messages from the electrical wires?

A major part of schizophrenia is perceptual disturbance. The patient cannot interpret sights, sounds, or social cues, in a reliable way. So he believes he has a better explanation of what he sees and hears than those around him: it’s all the work of demons, or God, or the FBI.

How can we help a young person deal with their own development while coping with a mental disease?

“Families can remind the young person of his or her capabilities,” Dr. Sturges said. “Young people need to address low self-esteem and be told that they

are not worthless. Family members can help them work on the future and reinforce their efforts with support.”

What is the onset age for schizophrenia and bipolar disorder?

Schizophrenia has a fairly narrow range, typically from 17 to 24 years. Some patients develop the disease as early as 12, and some as late as 30. Incidence of bipolar, on the other hand, spreads across a lifetime. Some patients develop it as young as two to three years, and some not until their eighties.

Have you ever diagnosed schizophrenia in a really young child, like a toddler?

Not so far, and not so that we can predict the onset of schizophrenia ahead of time. However, because genetics plays some role in these illnesses, advances in genetics may one day help with diagnosis.

What are the effects of street drugs on these diseases? And how can a person get clean?

“This has not been studied in any controlled way,” Dr. Sturges said, “not in terms of people who have used drugs versus those who haven’t. But we do see people in hospitals with psychotic episodes after using street drugs. When someone is already prone to psychosis due to illness, the perceptual distortion that these drugs cause can bring on a crisis sooner than expected.

“People have different brain chemistries,” he said. “It’s our most unique characteristic—represented by our differences in personality. No two people respond in exactly the same way to the same medications.”

However, psychiatrists have established four things about mood disorders like bipolar. In general, the more episodes you have, then the longer the episodes tend to last, the worse they become, the time between them shortens, and the medications to treat them work less effectively.

Can a patient who is doing well on a medication such as olanzapine decrease the dosage to zero in six months?

“No. Medications only work if you take them,” Dr. Sturges said. “These medications are not like penicillin. They are not a cure for mental illness.”

Instead, he said, they replace a chemical that the brain once made and now no longer makes. If a person stops taking the medication, the symptoms will come back.

Should a person who is taking olanzapine switch to Clozaril?

Prescribing medication is a matter of trial and error, Dr. Sturges said. “We don’t have any kind of blood test for the brain to tell in advance what will work and what won’t. If a patient is doing well on olanzapine, then stay with it.”

Do these medications lose effectiveness over time?

“With some patients—about ten percent of cases—the medications can work well at first and then lose effectiveness. Then it’s the time to raise the dose or switch medications,” he said.

All medications are metabolized, or broken down, in the liver. Sometimes the liver function improves and makes more enzymes, and that breaks the medications down faster.

“Because we don’t have blood tests that work at the synaptic level in the brain—and brain scans are not clinically significant yet—we have to deal with the

patient's symptoms. When they come back, we increase the dose or try something else."

What about medical cocktails, like Clozaril with Risperdal and Zyprexa?

"They can work together," Dr. Sturges said. "If there are no toxic side effects, then stay with it."

Outside of medications, what else works?

"We have found that social therapies seem to help patients," he said. "Getting them involved with activities—group therapy, art therapy, exercise therapy—is always a good thing. And, of course, family involvement and support is important, too."