

# Case Report: Treatment of Schizophrenia

Bradford Weeks, M.D.<sup>1</sup>

The patient, a 17-year-old girl with a two-year history of drug-resistant mood and thought disorders beginning at age 15, had been diagnosed variously as schizophrenia, schizoaffective disorder, bipolar and manic depression. The patient's mother's friend had been a patient of mine and they self-referred to my clinic (against their doctor's advice) for a second opinion to learn about how orthomolecular medicine and psychiatry might offer some benefit.

Prior to her breakdown, the patient had been quite active in high school. In addition to being an honors student, she swam on her school team and lifeguarded to earn extra money. She was a cheerleader and also played basketball. Other hobbies included various artistic pursuits, as she was an accomplished sketcher and learning photography. She was from a healthy and supportive home, ate a mostly vegetarian diet and attended her church on a daily basis. The patient had no prior need for medical or psychiatric care. Before beginning the prescribed anti-psychotic medication she had been a fit 15-year-old high-school sophomore, 5'5" tall and weighing 120 pounds.

The history revealed that her first encounter with the psychiatric profession occurred 18 months prior to our first office visit. The mother attributed this schizophrenic break to stress from being an over-achiever. She had "crashed" after a period of sleep deprivation and, upon being taken out of school, demonstrated confusion, poor judgment, paranoia, as well as grandiosity and hyper-religiosity. Over the next 18 months, the family doctor gave the patient many medications each of which reportedly offered more negative side effects than positive symptom alleviation. Zoloft was her first drug and was used for five months but it left the patient so tired and

stuporous that she was switched to Welbutrin. Unfortunately, this drug, in turn, worsened the patient's sense of paranoia and also created a comatose-like state where the mother claimed she was obtunded: "You could not wake her up in the mornings." The family physician thought the patient was swinging to bipolar mania and, understandably, referred to a local psychiatrist who prescribed the following flurry of medicines over the next 12 months, bringing new side-effects: Respidol (weight gain and nausea); Prozac (agitation and anxiety); Seroquel (stuporous and poor concentration); Clonazepam (too sedating, poor concentration); Lorazepam (too sedating); Lithium carbonate (stuporous); Neurontin (headaches and rash); Depakote (headache and nausea) Lamictal (headaches); Effexor (sleep disruption and paranoid); Paxil (stress, paranoia); Zoloft (anxiety and jitters); Celexa (ominous sense of doom and sleep disruption). These medication trials culminated in an emergency psychiatric hospitalization over Easter, 2002, for three days due to paranoid and suicide ideation. The patient was fixated on the thought that "things were eating me from the inside out." At the time of hospitalization, the patient was taking Respidol, Lithium, Celexa, Neurontin and Depakote with laboratory values significant for anemia and elevated liver transaminases. The drug levels were tested and found to be within therapeutic levels. Medications were tapered in the hospital over three weeks and at discharge she was off medications and symptom free for the first time in 12 months. Inexplicably, once the patient was discharged from the hospital, her psychiatrist started her on Effexor, Clonazepam and Seroquel despite her having no symptoms. Within 2 months, the psychiatrist again switched the protocol to Mellaril and Topomax.

1. The Weeks Clinic, Consultants for Orthomolecular Medicine and Psychiatry. 6456 S. Central Ave., Clinton, WA 98236

The patient who ultimately was brought to our office by her mother was mostly mute with rigid and highly guarded mannerisms. Most impressively and quite tragically, however, she weighed 260 pounds having gained 140 pounds over the past 18 months. She appeared profoundly obese with Cushingoid features and a stunned and sad affect. She seemed to follow the discussion with a mixture of trepidation and despair. She had the appearance of being a defeated soul as if she had survived constant teasing and bullying in the playground.

Her presenting symptoms were poor ability to concentrate, inability to keep up with her home-schooling program, depressed mood, helplessness, hopelessness and worthlessness. Dizziness and heartburn were constant. Her pre-menstrual tension was worse than it had ever been and she had experienced no periods in a year. The medications she presented with were Mellaril, 100 mg, and Topamax, 50 mg, and the only benefit the patient and her mother could attribute to the medications was a reduction of mood swings. She reported significant disruption of most vegetative parameters: poor sleep, loss of appetite, profound anhedonia, low libido, frequent crying spells, low energy, and feeling helpless, hopeless, worthless about every getting back to school and her prior life.

Objectively, the patient and her mother brought no laboratory data but reported a recent MRI of the head was normal and that “lots of blood work had been done”. Physical examination showed elevated blood pressure (160/102) with a rapid pulse of 96 and normal neurological examination save for a bilateral tremor and leg tics. The most remarkable sign was morbid obesity. She was a strong flusher as per the niacin skin test (Horrobin) and she rapidly absorbed the iodine patch suggesting some form of hypothyroidism.

The initial Mental Status Exam revealed a young lady with grossly obese ap-

pearance but with appropriate grooming and hygiene. Her affect was weary, guarded and resigned as well as being devoid of any spark of vitality. All this combined to cause her to appear to me as older than her stated age. She avoided eye contact as if she had grown wary of psychiatrists. Her speech was soft and she spoke somewhat guardedly but at a normal rate. Her thought process was logical and her thought content was significant for depressed ideation, none of the following: preoccupation, obsessions, ideas of reference, delusions, magical thinking, grandiosity, religiosity, thought broadcasting. Thought form was normal and coherent with no evidence of circumstantial thinking, flight of ideas, tangential process or looseness of associations. Perceptions were normal in that she denied auditory and visual hallucinations. Her insight and judgment were adequate and she was fully oriented.

My initial diagnosis included a complex assortment of biochemical imbalances including: 1) phospholipid membrane disorder; 2) secondary hypothyroidism; 3) hypoglycemia as a component of the mood instability; 4) pharmaceutical drug overdose reaction; 5) obesity secondary to pharmaceutical drug overdose. We easily tapered the patient off her medications while adding an orthomolecular protocol.

We addressed the weight with a dietary approach which simply was “eat only things you see in nature” otherwise said, “shop only the periphery of the supermarket” where you find the meat/fish and produce sections. Refined foods like sugar and flour also are unnatural and were avoided. Mood instability was addressed by controlling blood sugar fluctuations through the avoidance of probable problem foods (dairy and wheat, artificial sweeteners) while focusing on low glycemic foods (no pasta, grain, cereal, and bread), more organic protein (chicken, fish, eggs, turkey), and nutrient dense “stick to your ribs, slow-burning” foods and foods like

bee pollen, rice bran extract, raw organic seeds and nuts. Finally, a socially enjoyable exercise programming of swimming and gentle weight training was begun.

We addressed the secondary hypothyroidism with tyrosine, L-phenylalanine and Westhroid and an increased movement/exercise program as well as restricting soy foods.

We addressed the manic depression, EFA deficiency and adrenochrome toxicity with the above dietary changes. We also began a medication taper which relied on the patient and family calling me at any sign of problems (all my patients have my work and home telephone numbers). Supplements added were as follows: a broad-spectrum multi-vitamin, multi-mineral; an omega 3 EFA product; IM vitamin B<sub>12</sub>, folic acid, B complex and B<sub>6</sub> shots; vitamin C, 3 g, 3x per day; GABA 500 mg as needed for agitation or sleep; Homeopathic drainage remedies.

We reduced Topamax immediately from the initial 50 mg to 25 mg a day for three days then 25 mg every other day for one week then stop. We reduced Mellaril immediately from the initial 100mg in my office to 50 mg/day for one week then 25 mg a day for one week then 25 mg every other day then stop.

It should be noted this is "medicine by Braille" meaning it is not a standard taper but rather it was tailored to the patient's individual capacity. She left the office with instruction to follow some common sense health tips called the Prescription for Vitality (see [www.weeksmd.com](http://www.weeksmd.com)) and to return to the Clinic in one month but to feel free to call in the interim.

In one month at her follow up visit, the patient was completely off her medications and feeling much better. Her temperature was increased and her ION test revealed low essential fatty acids (EFA), low essential amino acids (EAA) and a various enzymatic and nutritional deficiencies. The most striking issue was her feeling victim-

ized by her mother who refused to let her see her other psychiatrist any more. The mother felt that the other psychiatrist was failing her daughter in that she believed and told the patient that her illness was incurable; she tried to turn the daughter against the mother; she refused to consider biochemical etiologies of the mental illness even when shown the ION test results;

Over the next two months, I saw the patient and her mother four times. The process was relatively uneventful with the exception of her former psychiatrist undermining the process by predicting catastrophe if she continued to taper off medicines. Nonetheless, within one month of starting the orthomolecular protocol, the patient was off all prescription medications and stable on a maintenance dose of omega 3 EFA, B vitamins and sensible nutritional choices. She completed her home-schooling class work over the summer with honors and re-entered her high school as a senior in September, 2002, with her old class. Having learned something about the principles of health, the young lady now felt empowered to titrate her nutrients in response to anticipated stress and was feeling stable and focused in her life.

As of the February, 2003, when I last heard from her and her mother, the patient had maintained honor-roll status throughout her senior year and had been accepted on early decision to the college of her choice after scoring a GPA of 3.89. She has never gone back to her former psychiatrist and wonders now how she let herself believe that her illness, which after all came out of nowhere to strike down an otherwise healthy 15-year-old, was incurable. I was delighted to learn that she had lost 78 pounds and was enjoying life again. The only troubling news was that she now plans to go to medical school after college and to become an orthomolecular doctor. Fortunately, she knows that she may need extra B vitamins and other nutrients to follow that stressful but very rewarding path.