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The use of low-dose neuroleptics in the treatment of patients with severe personality disorder: An adjunct to psychotherapy

Progress in psychotherapy can be fostered in some patients with the use of low doses of atypical antipsychotics to improve thought processes, affect regulation, and impulse control.

ABSTRACT: Some patients with personality disorders suffer from disturbances in the form or content of their thinking, in their affect regulation, or in their capacity to contain impulses. These disturbances can be significant enough to interfere with progress in various forms of psychotherapy. Case data from patients in a psychiatry treatment program at the University of Alberta Hospital in Edmonton suggest that small doses of atypical neuroleptics can help to relieve the symptoms of these patients and allow them to benefit from group psychotherapy. Further research is needed to determine whether this benefit will succeed in other modalities of psychotherapy and in patients being supported by family practitioners. Research is also needed to determine to what degree improvement is due to medication and to psychotherapy, and whether at some point after completing psychotherapy patients might stop taking neuroleptics without experiencing symptomatic relapse. It is important for clinical and medicolegal reasons to review the serious side effects of neuroleptic medications with patients and to monitor patients for side effect symptoms.

Patients in a partial hospitalization program were found to benefit from the addition of small doses of atypical neuroleptic medications during their treatment in an 18-week group psychotherapy program offered by the Psychodynamic Psychiatry Service of the Department of Psychiatry at the University of Alberta Hospital in Edmonton.[1] The psychiatric day treatment program (DTP) consists of both unstructured psychotherapy groups and semi-structured groups in which an activity is used to introduce a theme about which the patients may do psychotherapeutic work. The theoretical emphasis of the program is psychodynamic, with a strong emphasis on confrontation, limit setting, and interpretation.

At any one time the DTP has approximately 35 patients. While none of the patients are floridly psychotic, between one and four individuals have a disturbance in the form or content of their thinking, in their affect regulation, and/or in their capacity to contain their impulses. These disturbances are significant enough to interfere with the patients' progress in therapy, and are often difficult to categorize using current diagnostic terminology.[2] These symptoms do not represent a brief psychotic episode, such as is described in some patients with borderline personality disorder, although many of our patients receive that diagnosis. The disturbance of thinking does not appear to be a transient reaction to stressful events, but rather represents the individual's characteristic mode of thinking, feeling, or impulse control, although the disturbance may become more pronounced when the individual is under stress. Frequently accompanying the disturbance in thinking is a disturbance in affect regulation; these individuals may become intensely angry and even paranoid, or be overcome by sadness and weep uncontrollably. Both of these affective responses make it difficult for these individuals to remain involved in the psychotherapeutic process. These patients do not experience other psychotic symptomatology, such as delusions, hallucinations, or Schneiderian criteria[3] for schizophrenia. None of these patients have ever had an acute psychotic

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episode or required hospitalization for acute psychiatric symptoms. While these patients' symptoms suggest schizotypal personality disorder, the patients are not odd or eccentric in other ways, do not usually demonstrate other schizotypal traits, and have not received such a diagnosis prior to admission to the DTP.

Case data from these patients in the DTP suggest that low-dose neuroleptic treatment can allow such patients to benefit from involvement in group psychotherapy. Although no literature was found describing the use of neuroleptic medications as an adjunct to group psychotherapy, or to psychotherapy in general, there *is* such evidence for the treatment of psychotic patients.

Frosch[4] describes the nature of psychotic defences, the state of the ego in its functions, and the ego's position vis-à-vis reality. He also describes approaches to the psychoanalytic treatment of psychosis. Beitman[5] addresses the integration of pharmacotherapy and psychotherapy, raising questions regarding individual diagnoses, looking at studies involving psychotherapy during randomized controlled medication trials, considering psychotherapeutic aspects of pharmacotherapy, addressing the meaning of medications during psychotherapy, and dealing with the neurology of psychotherapy. Several authors describe using a combination of psychotherapy and medication when treating schizophrenic patients.[6-8]

Case data

(Demographic details in the case data have been altered to preserve patient confidentiality.)

Violet is a 31-year-old cleaner who has been living in a common-law relationship for 1 year. Although well educated and relatively articulate in speech, she tended to go off on tangents, leaving the subject being discussed in groups to consider her own associations. At times she would make inappropriate and bizarre comments that were completely unrelated to the topic being discussed. She seemed to have no insight into the effect on others of what she said. For example, when she was angry, she would tell the other members of the group, "I feel like killing you all" in a not particularly angry tone of voice. She mentioned having impulses to mutilate people in public places, then showed no awareness of how this admission might affect other members of the group. When she did say something untoward, it appeared to be unconsciously provocative.

Violet was treated with olanzapine (5 mg q.h.s). This produced a considerable improvement in the organization of her thinking. Her tangential associations almost disappeared, and she only infrequently made comments that seemed unrelated to the subject at hand. She stopped making bizarre and upsetting comments. Violet was able to do psychotherapeutic work on her tendency to be provocative and on what motivated it, which she appeared unable to do before taking the olanzapine.

Adam, a married 33-year-old middle manager in a large corporation, is an especially articulate and intelligent individual with a diagnosis of narcissistic personality disorder. Although there was no indication of a diagnosis of bipolar disorder, there was an unmistakable grandiosity in his manner of presenting himself. He found it very difficult to tolerate confrontations in therapy, which frequently resulted in his becoming not only angry but paranoid, expressing unrealistic suspicions regarding the motivations and behavior of many people, including other group members. At these times he would often become angry enough to walk out of the room in the middle of a group. He would return the next day calmed down, but unwilling to discuss the events that resulted in his leaving.

Adam was treated with risperidone (1 mg q.h.s). This was followed by a complete cessation of his paranoid reactions, and an improved ability to contain himself when he was angry and to discuss what made him angry.

Hazel is a 47-year-old married librarian who displayed a variety of disruptive behaviors and intensely expressed affects in the group. At one point in an interview she began pulling

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her shirt off, exposing her chest, and became intensely angry regarding the therapist's response to this behavior. When sad she would weep uncontrollably in the group, disrupting her own work and that of the group. At times her anger would have a paranoid flavor, and it would be difficult or impossible to reason with her. Hazel's thinking also became quite tangential when she was discussing anxiety-provoking material. At times she appeared to have some difficulty distinguishing fantasy from reality. She sometimes presented material in a disorganized manner.

Hazel was treated with quetiapine (25 mg q.h.s). This was followed by a rapid modulation of her affects, to the extent that she was no longer overwhelmed by either sadness or anger. Her work in groups was no longer interrupted by uncontrollable affects. Her thinking became more organized and her speech completely coherent and goal-directed. Paranoid ideation was no longer evident. Hazel completed the day treatment program having made excellent use of the groups, and continued on the quetiapine upon discharge.

Discussion

Attempts to use psychodynamic psychotherapy and psychoanalysis to treat severely disturbed individuals, including individuals with psychotic illness, are well documented.[4,9-11] These treatments make considerable demands on the patient to integrate a combination of secondary process and creative primary process thinking, which is challenging work for anyone.[12] It is particularly difficult for these patients, with their sometimes limited capacity to recognize reality, to maintain an integrated sense of their own identity and to contain their uncomfortable affects and impulses. A significant number of our DTP patients appear so stressed by the psychodynamic approach or to suffer from symptoms so severe that their ability to benefit from group therapy at times appears compromised. A small dose of neuroleptic medication enables them to function better in psychotherapy and to derive more benefit from it.

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These patients appear to have a borderline or psychotic personality organization[13,14] and to have been given a variety of diagnoses, none of which adequately describe the disturbances we are referring to. They may be overwhelmed by intense affect such as rage, sadness, or guilt, which paralyzes them in their psychotherapeutic work. They may have a disorder of their thought processes. This could mean they engage in tangential thinking or experience a transient or persistent disturbance of thought content, such as paranoid tendencies that make them litigious when threatened, or that they have a tendency to speak and behave impulsively or destructively to ward off painful affect. Small doses of atypical neuroleptics, such as 1.25 to 5 mg olanzapine, 6.25 to 25 mg quetiapine, or 1 to 2 mg risperidone, effect a significant change in these patients' mental status, and appear to enable them to persist in therapeutic work, which they seem unable to do without this medication. These patients do not exhibit florid psychotic symptoms and do not need, and often appear not to tolerate, higher doses of these antipsychotic medications. Often the patients' symptoms and tendencies are not identified in the 1 1/2-hour intake session on which admission to the DTP is based. The tendency to thought disorder usually shows up on Rorschach testing if it is undertaken while patients are in the program.

Research possibilities

The observations represented by the case data discussed here have implications for psychotherapeutic treatment of patients with severe personality disorders in all forms of psychotherapy and, we believe, for patients displaying these symptoms who are not receiving psychotherapeutic treatment. A small dose of neuroleptic seems to enable patients with the difficulties described to engage more productively in any modality of psychotherapy based on any theoretical approach, including a system-based family therapy, a cognitive-behavioral individual or group therapy, or a psychodynamic

individual therapy. The ability of these patients to be actively involved in psychotherapeutic treatment in general is improved with the prescription of low-dose neuroleptic medication. The functioning of these patients outside the day treatment program setting appears to have improved by small doses of neuroleptic medication, unrelated to the therapeutic benefits of psychotherapy.

Experience raises a question regarding to what extent psychotherapy helped these patients, and to what extent the patients' improvements could be attributed to the antipsychotic medication. Future research regarding this might compare the results of psychotherapy alone with the results of neuroleptic medication alone, and the results of combined treatment. Clinical experience suggests that combined treatment is the most beneficial. It seems unlikely that treatment with the neuroleptic medication alone would be as effective as treatment with psychotherapy alone in this population. It seems likely that some disturbances of thinking, of affect regulation, and of impulsive behavior would improve with medications alone. However, the interpersonal learning and the improvement in and development of the capacity for abstract thinking that can take place in a psychotherapeutic day treatment program would not occur, and the patients' improvement would be symptomatic only. There is no reason to believe that this improvement would be maintained if the neuroleptic medication were withdrawn. While it is possible that the environment might positively reinforce the more constructive behavior demonstrated while patients are taking neuroleptic medication, it appears more likely that this would be the case were the patient also to undergo psychotherapy. Ideally, patients who benefitted from their psychotherapy would build on their experience in a psychotherapy program and continue to learn in interpersonal situations with or without more psychotherapy, and might find that eventually the neuroleptic medication could be withdrawn without a relapse of the symptoms prompting its prescription.

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In the clinical situations described here, patients are not followed after discharge. Instead, they are referred back to their referral sources, usually a family physician, a psychiatrist, or a practitioner of another mental health discipline. If the patient of a family physician requires continuing treatment by a mental health professional, an appropriate referral is recommended to the family physician. Similarly, if a patient upon discharge requires ongoing consultation with a psychiatrist, that is recommended to the family physician or mental health professional. Research following patients after discharge from a day treatment program could prove valuable in determining progress in these different circumstances.

Informed consent

Patients must be well advised regarding the potentially serious side effects of neuroleptic medication, such as the development of diabetes mellitus, hyperlipidemia, and weight gain, as well as tardive dyskinesia, parkisonism, and neuroleptic malignant syndrome, although the latter side effects may be less common in atypical neuroleptics than in their forebears.[3] It is important to obtain informed consent from patients when prescribing neuroleptics, and to document that a discussion of risks took place. When patients are on neuroleptic medications on a long-term basis, the prescribing physician should periodically review with them the potential benefits and risks of remaining on the medication and of discontinuing it. In the DTP, the approach is to discuss the side effects and expected therapeutic effects with the patient, and to try to help the patient find a balance between the potential risks and benefits. Many patients are reluctant to use these medications when they hear about the side effects. Most, however, end up willing to try the neuroleptics and often wish to remain on the medication once they experience the speedy improvement in the organization of their thinking, the improved regulation of disturbing affects, the improved capacity to contain their

impulses, and the reduction of disturbing thoughts. Patients are advised to follow up with a psychiatrist after discharge regarding the question of how long they should remain on the neuroleptic medication. The kind of patient described here can benefit from being on neuroleptic medication for a considerable length of time (perhaps indefinitely). For both clinical and medicolegal reasons, family physicians and other non-psychiatric physicians should have these patients consult a psychiatrist every 6 to 12 months if they remain on low-dose neuroleptic medication. Patients with pre-existing diabetes should be monitored regularly for worsening glucose control. Patients with risk factors for diabetes should have a fasting blood glucose test at baseline and then periodically during treatment. All patients initiated on atypical antipsychotics should be monitored for symptoms of hyperglycemia (polydipsia, polyuria, polyphagia, and weakness). Patients who develop symptoms of hyperglycemia should have a serum fasting glucose test. In addition, all patients on atypical neuroleptics should be monitored for weight (baseline, 4 weeks, 8 weeks, 12 weeks, and quarterly), waist circumference (baseline and every 5 years), blood pressure, fasting plasma glucose, and fasting lipid profile (all at baseline, 12 weeks, and every 5 years).

Summary

In some patients with personality disorders who suffer from disturbances in the form or content of their thinking, in their affect regulation, or in their capacity to contain impulses, these disturbances may be severe enough to interfere with progress in various forms of psychotherapy. These patients are not floridly psychotic and do not readily fit into our current diagnostic terminology. Small doses of atypical neuroleptics may help relieve their symptoms so that they can benefit from psychodynamic group psychotherapy in a day treatment program. This treatment may also be beneficial in other modalities of psychotherapy and in patients being supported by family practitioners. Research is needed to determine whether this is the case and whether patient improvement is due largely to the medication or the psychotherapy. In any situation where neuroleptic medications are used, it is important for both clinical and medicolegal reasons to review the potentially serious side effects of those medications with patients and to monitor patients for side effect symptoms.

Competing interests

None declared.

Acknowledgments

I would like to acknowledge the assistance of Dr Nancy McWilliams, Dr John Ogrodniczuk, Ms Jeanette Buckingham, and Ms Lisa Nelson in the preparation of this paper.

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