In a managed care environment, a book that emphasizes appropriate and practical medication strategies targeting specific symptoms of patients with severe personality disorders is long overdue. This book offers the clinician hope that disabling symptoms can be controlled by medications so that psychotherapeutic approaches can be more effective and efficient. Medication should be considered as a first line treatment of patients with personality disorders and not as a last resort when psychotherapy fails. Most personality disorders are treatable using the combination of medication and psychotherapy, and with new medications available, options for effective treatment have increased exponentially. The availability of new, exciting antidepressant and antipsychotic medications has changed the outlook for treatment of personality disorders. This book promises that the most intractable of psychiatric disorders can be treated with excellent outcomes at reasonable costs.

Steven S. Sharfstein, MD
President, Medical Director,
and CEO, Sheppard Pratt
Health Systems
Personality Disorders

*New Symptom-Focused Drug Therapy*

S. Joseph, MD, PhD, MPH

HMP
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S. Joseph, MD, PhD, MPH, is a board certified psychiatrist and licensed clinical psychologist in Orlando, Florida. He is also certified in Geriatric Psychiatry and Addiction Psychiatry and possesses professional training in clinical hypnosis. He received his Master’s degree in Public Health from Harvard University and completed his psychiatric specialization at Thomas Jefferson University Hospital in Philadelphia. Dr. Joseph’s educational background spans the North American continent. He completed his medical training at the Universidad de Cuidad Juarez in Mexico, his PhD in clinical psychology at the University of Ottawa in Canada, his clinical clerkship in psychiatry at Massachusetts General Hospital, and part of his public health training at the Massachusetts Institute of Technology. Based on his vast experience as a practitioner of psychiatry and psychology, he believes that medication and psychotherapy are equally important for the optimal psychiatric treatment outcome. His success in managing challenging cases validates this belief. Dr. Joseph is a member of the American Medical Association, the American Psychiatric Association, and the American Psychological Association.
Foreword

Personality disorders are enigmatic. Clinicians the world over search for the Holy Grail of understanding the concept and treatment of the elusive personality disorder category.

Dr. Sonny Joseph unlocks the Gordian Knot of understanding and treating personality disorders. Drug therapy universally prescribed for Axis I clinical disorders, ranging from attention deficit disorders (ADD) to zoophobia, had been a heretofore yet-to-be-discovered “diamond-in-the-rough” treatment approach for personality disorders.

_Personality Disorders_, with the help of snapshot guidelines from the clinician’s diagnostic bible, the APA’s _DSM-IV_, describes and defines personality disorders, but also outlines solid, easily understood, easily remembered, easily applied cookbook-recipe treatment formats for personality disorders.

Whether you are: (1) the novice undergraduate; (2) the newly-arrived-to-the-patient-scene physician or therapist; or (3) the sage expert clinician, _Personality Disorders_ will add vital diagnostic and treatment skills to your armamentarium. Skills that might take years to learn in the usual hunt-and-peck discovery process can be learned quickly through use of _Personality Disorders_.

To better understand the concept of the personality disorder, I would use this analogy: Compare the clinician to an artist who paints a picture and then puts a frame around it. The artist’s goal is to tell a story, put it on canvas, and frame it—analyze, and in a way, diagnose a concept, and give a report of the findings. This is so the viewer will know what the artist knows and feels about the subject. The clinician evaluating a patient with a personality disorder has a similar goal of analyzing, diagnosing, and reporting the findings. The clinician paints a picture and frames the diagnosis. The personality disorder represents a unique and rather complex diagnostic dilemma, and every clinician strives to paint, frame, and correctly diagnose the problem of the personality disorder patient.
The personality disorder is unique in that it is not a clinical disorder, or disease entity. It is an intricate mélange of interwoven personality fabrics, adorned with multiple emotional accoutrements. It represents a collage of diverse and manifold personality traits and patterns forming the very essence of the person’s presentation to the world. It walks with that person, as a shadow, everywhere and every second of the person’s existence. It is that shadow, that collage, that the clinician must label. The personality disorder is enigmatic, and the clinician is put to a great test having to put the correct diagnostic label on the particular personality disorder that appears before him or her.

Indeed, it often takes more than one visit to outline and describe the long-term, lifelong continuum of patterns and traits that characterize the personality disorder. In a room of ten clinicians offering a diagnosis on a patient with a personality disorder, you might get ten different personality disorder labels, including "Deferred," or "No Diagnosis on Axis II," or "Personality Disorder NOS."

Clinicians with good skill, knowledge, education, expertise, training, teaching (mnemonic is SKEETT), can usually hit on target with a reasonably accurate personality disorder diagnosis. Once the objective is reached and a diagnosis is made, the clinician has shown that he or she has the necessary psychic insight into understanding and analyzing the concept behind the patient’s condition. Thus, the clinician has painted and framed the picture.

Dr. Sonny Joseph’s Personality Disorders presents you with a “magic genie assistant” to analyze the enigmatic personality disorder diagnosis and category. Next, Personality Disorders gives you the other half of the story—free! The author gives you a recipe-driven cookbook like the Merck Manual, like the PDR, like Bob Vila’s This Old House, like Outdoorsman’s Fix-It Book, like Hints from Heloise. It is the best “How To” or “Fix-It” book I have ever read in the field of psychiatry.

Dr. Joseph takes you on a full ride—from the crack of the starting gun: (1) beginning at Part I, Chapter 1, (Personality Disorders: General Clinical Concepts); (2) through 12 separate personality disorder chapters (three clusters, an NOS, and personality change due to general medical condition); and (3) breaking through and ending at the double finish line ribbon—Part II, Chapters 14 and 15

Dr. Joseph writes in an easily read fashion and delineates his medication program recipes in a one, two, three style format. He offers the clinician who is evaluating and treating the enigmatic personality disorder and its symptoms an innovative, creative, simple, practical, clinical regimen of medicines that helps to alleviate problem symptoms.

This book is the alpha and omega, the beginning and ending of gaining knowledge about the complex subject of personality disorders. It offers new and compelling insights into making the correct call on the personality disorder diagnosis. Don't go to the office without it!

E. Michael Gutman, MD, Fellow A.P.A. 
Diplomate, Am. Board of Forensic Psychiatry, 
Diplomate, Am. Board of Psychiatry with Added 
on Qualifications in Forensic Psychiatry; 
Past President, Florida Psychiatric Society
Preface

Personality disorders are generally considered difficult to treat at best, and untreatable at worst. In fact, personality disorders represent the closest thing to a “four-letter word” in psychiatry. Experienced mental health clinicians frequently hear personality disorder diagnoses stated with a derogatory connotation. It is no secret that psychiatric nurses, psychiatrists, psychologists, and other mental health specialists approach patients having personality disorders with ambivalence, probably emanating from a sense of frustration and helplessness. For example, statements such as “She’s a borderline; he is antisocial; he is narcissistic,” etc., are commonly used by mental health professionals. It is as if the patients who have personality disorders are contemptible simply because they have them. Generally, treatment of personality disorders is not considered to be as effective as that of Axis I disorders. Traditionally it is held that long-term, psychodynamically oriented, intensive psychotherapy provides the best chance for successful treatment. Relegation of personality disorders to Axis II has perpetuated the notion that personality disorders are less important, and that they are clinical nuisances to be tolerated by clinicians. Primary care physicians particularly have little practical experience in the diagnosis and management of personality disorders.

This book approaches the treatment of personality disorders as if they are Axis I disorders, i.e., with a constructive medical and biological focus. The book analyzes each of the personality disorders in terms of its component symptoms, which are then individually targeted for treatment using selected pharmacological agents. The author had in the past experienced discomfort and frustration when treating patients with symptoms suggestive of personality disorders. Currently, with the conceptualization of these personality disorders in terms of their component symptoms there is now an option that offers hope, direction, and control to a clinician dealing with even the most difficult of personality disorders.
The recent availability of superior medications such as selective serotonin reuptake inhibitors (SSRIs), olanzapine (Zyprexa), risperidone (Risperdal), and clozapine (Clozaril) has been a major factor in this exciting transformation. Medication strategies and dosages are suggested for each of the symptom components that are characteristic of a personality disorder. Clinical techniques for dealing with symptoms that are currently untreatable are also discussed. For instance, there is no medical treatment for defective conscience, one of the features of antisocial personality disorder; yet, there is fairly effective treatment for anger, hostility, irritability, and impulsivity which can be some of the other symptoms of antisocial personality disorder. In this example, the patient, the family, and/or the referring service could then be advised that while there is currently no medical treatment available for a defective conscience and thus none for consequent behaviors such as lying, stealing, and exploiting and hurting others, that treatment can be directed toward other associated specific symptoms. Most other personality disorders are, to a greater or lesser degree, effectively treatable with the balanced use of different medications that address the component symptoms.

Actual clinical cases are presented for all of the personality disorders in order to illustrate the practical applications of the clinical techniques outlined in the book. Most literature to date does not present personality disorders with a detailed focus on the symptoms or with focus on practical pharmacological recommendations. Various clinical presentations discuss the treatable symptoms, including specific medication and dosage recommendations. This emphasis on practical and immediate intervention targeting specific symptoms should have particular applicability in a managed care environment. The clinical cases evoke a "hands-on" feeling in physicians and mental health professionals interested in learning a balanced and correct use of psychotropic medications for the treatment of personality disorders.

Cases were chosen to illustrate various diagnostic and treatment issues including the following:

- Symptom analysis
- Symptom-focused treatment
- Rational use of multiple drugs and dosing strategies
Treatment ranging from simple to complex methods
Suicide risk
Outpatient and inpatient treatment
Treatment failures
Clinical skills for successful patient management

Patient identity is of course disguised to assure confidentiality. Clinical history, treatment course, medication doses, and treatment outcome are real. An uneven distribution of cases among various personality disorders is manifest, for example, because some of the personality disorders such as obsessive-compulsive personality disorder, schizotypal personality disorder, and borderline personality disorder come to clinical attention with much greater frequency than avoidant or narcissistic personality disorders. Hence, there are more cases of obsessive-compulsive personality disorder, borderline personality disorder, and schizotypal personality disorder than some of the other disorders.

Each of the 50 clinical cases includes at least one case of each of the personality disorders described in DSM-IV. The first paragraph of each case summarizes presenting complaints and symptoms derived from the patient interview, collateral history, mental status examination, and in some cases, psychological test results. Since the main themes of the book are symptom-focused treatment and treatment guidelines, detailed historical information and a section on mental status examination are omitted. As patients typically do not describe their symptoms in clinical terms such as paranoia and suspiciousness, labile affect, odd behavior, suicidal ideation, lack of empathy, dissociative episodes, ideas of reference, hypomania, or obsessive-compulsive tendencies unless they have had psychiatric training, these are listed in the patient’s history as conclusions arrived at after studying information from the multiple sources previously listed. In many cases the information summarized in the first paragraph of the case histories was obtained after several patient visits over a period of time. In addition, considerable historical and longitudinal information can be and is obtained from the referring therapist. A unique feature of psychiatric evaluation is that patients sometimes do not divulge all of the information during the first visit. They are more forthcoming with information after they feel comfortable with the clinician. This is particularly true
for patients with Axis II disorders, which require longitudinal history, and for patients who have sensitive symptoms or a history which includes suicidal and homicidal ideation, or physical and sexual abuse.

Each case concludes with a comment section that discusses diagnostic and/or treatment issues which are directly or indirectly related to key concepts highlighted in the case. Nearly all of the comments have a practical clinical focus. On reading the cases cited in this text, one might falsely conclude that personality disorders are easily treated and managed. However, personality disorder patients continue to be among the most challenging to diagnose, treat, and manage. The cases selected were chosen because of their successful outcome. Many patients with personality disorders do not respond to treatment with this degree of success and some do not respond at all.

Since virtually all of the clinical cases were based on patient files that were active for a fairly extended period of time prior to 1996 when some of the new medications such as olanzapine (Zyprexa), mirtazapine (Remeron), and lamotrigine (Lamictal) were not available, they could not be included in the clinical cases as active medications that the patients were prescribed. Among the new medications, the author is particularly impressed with the performance of the new atypical antipsychotic olanzapine (Zyprexa), introduced in October 1996. Olanzapine and risperidone (Risperdal) are currently the preferred first-line antipsychotics due to their significantly improved side effect profiles compared to traditional antipsychotics. Their clinical profiles including advantages and disadvantages are described in detail in Chapter 15.

Since diagnostic and treatment concepts are discussed at a fairly advanced level, familiarity with basic psychiatric diagnosis and psychotropic medications is expected of the reader. This text is written primarily for practicing psychiatrists, psychiatric residents, and primary care physicians. Other mental health professionals such as clinical psychologists, social workers, counselors, psychiatric nurses, and medical students considering psychiatric specialization should also find the book relevant and useful.

The section on new generation antidepressants (SSRIs), risperidone, olanzapine, sertindole, and clozapine was reproduced from a book with a broader scope written by the author titled, *Symptom-Focused Psychiatric Drug Therapy for Managed Care* (1997),
which may be consulted for practical clinical profiles of the other psychotropic medications in current use, their side effects, and the management of side effects. The technique of symptom-focused treatment of personality disorders, medication strategies, and clinical guidelines described in the book are primarily based on the author’s cumulative clinical experience, and might represent clinical art and wisdom, rather than scientifically tested and validated facts. The Bibliography lists sources that were consulted to compile factual information in the book.

Psychotherapy is usually necessary for optimal treatment outcome. It is the author’s belief that the gains from psychotherapy are not only significantly enhanced but at times made possible only when the patient’s symptoms are satisfactorily controlled with medications. Since the text primarily discusses medical/pharmacological management of personality disorders, the benefit of psychotherapeutic approaches is not specifically mentioned with each discussion of a medication treatment. It is understood that psychotherapy has an important role in the comprehensive treatment of all psychiatric disorders including personality disorders.

The clinical cases 4, 11, 13, 25, 26, 27, 28, 29, and 50 were adapted from Symptom-Focused Psychiatric Drug Therapy for Managed Care. The sections on new antidepressants and new antipsychotics are also reproduced from the same source. I am grateful to Anne Carney, MD, Mary Randall, RN, Sandra Houston, PhD, Joseph DeLuca, MD, and Pearline Gardberg, PsyD, for reviewing the manuscript and for offering constructive editorial suggestions. Thanks to Nancy Janisz for preparing the manuscript.

S. Joseph, MD, PhD, MPH
Orlando, Florida
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PART I:
PERSONALITY DISORDERS
AND CASE STUDIES
It is a popular belief among today's mental health community that personality disorders are untreatable except with long-term psychotherapy, and that psychoanalysis, psychoanalytically oriented psychotherapy, and intensive, long-term behavioral restructuring/retraining are the preferred treatment techniques for most personality disorders. With the advent of a variety of new psychopharmacological agents and judicious use of medication combinations, it is the author's belief, based on vast clinical experience, that most of what we now call personality disorders are treatable to varying degrees of success if their component symptoms are deciphered. Once the symptom configuration is understood, the combination of medications that will address specific symptoms can be identified.

Personality disorders are diagnosed under Axis II disorders according to DSM-IV and are typically confusing to other medical professionals. There is an implication that personality disorders are permanent or chronic and that anything other than a structural personality change by means of psychoanalytically oriented psychotherapy or psychoanalysis will not be effective. Such a hopeless attitude toward personality disorders was probably justified several years ago, prior to the advent of new classes of psychiatric medications, such as the SSRIs (selective serotonin reuptake inhibitors), atypical antipsychotics, clomipramine, and others yet to be introduced. The prevalent misinformation in the nonpsychiatric community related to personality disorders is facilitated by the relegation of such disorders to Axis II status. No longer valid is the widely held belief that personality disorders for the most part are untreatable; much of what were thought to be immutable personality characteristics and traits
PERSONALITY DISORDERS

are now modifiable with a variety of medications or combinations of medications.

Psychiatric training must now, to a greater degree, be geared toward understanding our patients' dysfunctional thoughts, feelings, perceptions, and behaviors in terms of symptoms mediated by the brain, rather than as syndromes that exist independently of brain chemistry. Human traits and functions such as character, attitudes, conscience, thinking, perception, and emotions are mediated by the brain. This does not invalidate concepts such as soul, spirit, heart, and mind, which have applicability in the world, but serve only to obscure when goals are medical or psychiatric and not philosophical, religious, poetic, or figurative. Clinicians will attest to the commonness of personality changes that are seen after brain injury. This indicates that changes in anatomic brain structure have an impact on personality; thus, it seems a fair extrapolation to conclude that people with no brain injury are dependent on functional brain characteristics that are alterable with medications which act on the different neurotransmitter systems.

It usually takes years of therapeutic work (and considerable expense) for psychoanalysis to have any chance of success, making the process inefficient, given the human life span as well as the competitive psychotherapy marketplace. The careful use of combinations of medications can make an individual personality less symptomatic, the ultimate goal of psychotherapy. The cost and time associated with pharmacotherapy are also expected to be much less when compared to the psychotherapeutic approach, making the pharmacologic approach much more efficient and thereby more immediately beneficial to the patient in resolving symptoms and saving time. However, as I alluded to in the preface, more than symptoms need to be addressed in providing effective care to patients. Psychological conflicts, lack of insight, poor judgment, relationship issues, social deficiencies, and various other psychosocial issues do not respond to medications, but require psychotherapy for optimal intervention. Therefore, the ideal approach in treating psychiatric disorders—including personality disorders—is primary reliance on the use of medications for the treatment of symptoms and the use of psychotherapy for work related to psychosocial issues and conflicts that can cause symptoms or can be caused by
symptoms. Treatment using either approach alone is likely to be incomplete and less successful.

If a symptom is ingrained by being present since childhood or early adolescence it is described as a trait, and thereby considered a personality characteristic that is fairly resistant to change. Examples are emotional instability, moodiness, obsessiveness, social withdrawal, grandiosity, dependency, exaggerated emotions, suspiciousness, emotional sensitivity, and impulsivity. Every characteristic or symptom probably has its correlate in the brain, with the complexity of the control mechanisms varying depending upon the symptoms. Much of these control mechanisms are not precisely understood at the present time and might be sufficiently complex that they will defy complete characterization.

When disinhibition disrupts the tenuous control due to the effects of alcohol, the results are dramatic and mediated by primary process thinking. For example, consider antisocial personality disorder, generally considered the most untreatable of all personality disorders. Individuals with antisocial personalities are said to have a deficient conscience, impaired morality, and an inability to learn from the negative consequences of their behaviors. Currently, it is believed that concepts such as conscience and morality, which are broad and difficult to define, are primarily cortical functions that are more advanced in humans compared to other animals; one can employ the operational concepts such as internal controls and inhibitions to represent the more abstract concepts of conscience and morality, and thereby make the broader concept less vague and more amenable to interventions. Impairment in learning from experience or consequences, another facet of antisocial personality disorder that probably is a result of yet-unknown functional impairment in the brain, leads to deficiencies in internal controls and in inhibitions. Functional deficiencies in the brain must ultimately have their correlates in the structure composed of billions of neurons and their neurochemical and electrophysiological properties. Functions such as perception, learning, thinking, reasoning, inhibitions, conscience, morality, internal control, identity, affect, and judgment are all controlled by the integrative processes in the brain. Optimal balance of inhibitory and excitatory effects might improve the above functions. In antisocial persons, in whom the inhibitory effects are already weak, a disinhibitory drug such as alcohol or a sedative
lifts the inhibitions to an extent that previously inhibited behaviors then find their full expression. Many heinous crimes are actually carried out under the disinhibiting effects of alcohol or drugs in susceptible individuals. Highly inhibited people find alcohol helpful in relieving some of the inhibitions; alcohol is used either deliberately or unintentionally for this purpose. Alcohol can have disinhibiting effects resulting in behavioral correlates, providing strong logic in support of the potential to develop drugs having the opposite or inhibitory effect, which promote secondary-process thinking. Other commonly abused drugs that have more complex effects on the brain (most of them undesirable) exist, for example, marijuana, cocaine, LSD, and various narcotics. (In this context, it is interesting to note that nicotine, which is probably one of the most addictive and the most commonly used drugs, has, for the most part, beneficial effects on the central nervous system but is considered unhealthy primarily because of its hazardous effects on other organ systems, especially the respiratory system.)

Because this work is not a treatise on the neurochemical, neurophysiological, and behavioral effects of alcohol and other centrally acting drugs, the purpose of this discussion is intended to provide a brief illustration of the gross effects of centrally acting drugs on behavior. Obviously, the relationship between alcohol and behavior mediated by the brain is highly complex.

Clinical experience leads me to conclude that alcohol or other drugs do not alone cause people to engage in criminal behavior, but that alcohol and other centrally acting drugs have the potential to uncover predispositions in susceptible individuals. The legal argument that alcohol or other prescription or nonprescription drugs make people commit crime may be legally acceptable and therefore might be an appropriate legal defense, but it is not psychiatrically valid or acceptable. Such an argument should not be accepted by a clinician as the sole justification for criminal conduct. A similar but quite distinct scenario would be that of criminal conduct in the context of a true delirium, which can be induced by drugs or various illnesses. For example, the medical determination would be a major factor in a case of a fatal hit-and-run auto accident if delirium obscured the person’s very awareness of the victim.

It is clear that our behavior, thoughts, affect, and cognitive processes—even if their patterns are originated in childhood, adoles-
ence—or early adulthood, and are pervasive and stable over time, are controlled by the brain. Thus, if personality is controlled by the brain, interventions that affect brain function have the potential to modify what we describe as personality. Would it not be beneficial to millions (patients and those they affect as well) if there were specific drugs or drug combination therapies that would effectively improve personality characteristics? Clinical experience has convinced me that most personality disorders can at least partially be treated and improved with medication.

In order to successfully treat personality disorders, gross descriptions are useful only in guiding us toward the treatable components. One needs to carefully and systematically elicit and determine individual combinations of symptoms that are present. The goal of psychopharmacologic treatment is to eliminate symptoms that are defined as dysfunctional behaviors, attitudes, perceptions, thoughts, and affects by modifying neurochemical processes in the brain. General diagnostic terms are useful stereotypes, important for communication among professionals, but they lack specificity, making them incapable of determining therapy for individual patients. In order to choose a medication or combination of medications, the most important task is to identify all of the component symptoms the patient is experiencing.

One problem with most personality disorder patients is that it is nearly impossible to get this information from them. In many cases, (1) patients are not cognizant of dysfunctional symptoms; (2) they have forgotten the behaviors; (3) they minimize or deny the symptoms; or (4) since they have had these characteristics or symptoms for so long, they believe that they are part of their inborn personality and therefore are normal or untreatable.

Information from a significant other is beneficial in getting a complete list of symptoms. In the majority of cases, descriptions from a close family member or from someone who knows the patient well are more revealing and can be more valuable than information obtained from the patient. For this reason, when a patient is seen for psychiatric evaluation, it is always helpful to have collateral information from another person who knows the patient well. For example, truly paranoid patients do not have the insight to admit that they are paranoid. When they present to the clinician, typically under coer-
PERSONALITY DISORDERS

cion, their complaints are likely to be anxiety, depressed mood, insomnia, etc. The benefit of obtaining collateral information from a significant other is not limited to the initial psychiatric evaluation, because collateral input is also helpful during subsequent visits, since the physician gets important additional feedback regarding the behavior of the patient.

It is a common observation that the subtle improvement due to medication during the first several weeks is not perceptible to the patient, but is noticed by others. This is especially true of adolescents who are not very revealing during the initial visits, especially if they have paranoid or antisocial tendencies or personality disorder symptoms. I have seen numerous cases of adolescent patients whose parents complained that the physician who saw the patient previously neither obtained information from them nor gave any feedback. I presume this approach is practiced by clinicians for the desirable purpose of establishing and maintaining therapeutic alliance, rapport, and trust between the clinician and the adolescent patient. However, in a symptom-focused intervention, rapport should not be sought at the expense of obtaining detailed, specific, and thorough clinical information. My experience in treating adolescents is that when the patient realizes that a thorough clinical evaluation, with the help of direct information from the patient and collateral information from as many sources as possible has been performed, rapport will usually follow. The therapeutic alliance is strengthened further by the adolescent's awareness that the clinician is not allowing manipulation of the circumstances. Any therapeutic alliance based on misleading or incomplete information is fragile. If a patient is not giving answers, or gives evasive answers, it is important for the clinician to turn to the parent or significant other and obtain as much history as possible, make an assessment, and suggest treatment based on the information obtained. Rapport and cooperation will follow spontaneously in most cases. These clinical principles are applicable to adults as well, particularly in dealing with personality disorder symptoms and antisocial or severely disordered patients. Because most of these patients come to the clinician as a result of pressure from the family, spouse, employer, lawyer, or court, it is not unusual to hear statements such as "I have been like this all my life," implying that the behavior is normal and that treatment is not needed. It is easier to recognize the irrationality when, for example, a hyperten-
sive individual makes the same statement regarding his/her hypertension. Family members also at times reflect the same thinking in statements such as “He/she has always been like this,” or “We are now used to his/her habits.” It is the clinician’s responsibility to educate both patients and families that even long-standing dysfunctional behavior can be satisfactorily improved by clinical intervention.

For most personality disorders, symptoms can be improved using psychotherapy, medications, and legal interventions. The ideal treatment technique is a combination of judicious use of medication, and psychotherapy, which can take various forms such as behavior therapy, cognitive therapy, group therapy, and psychoanalysis.

My primary objective of this book is to describe in detail how the medication component of treatment can help, and to illustrate how medications can be used in the effective treatment of personality disorder symptoms. The emphasis on medication treatment is not intended to imply that pharmacologic treatment is all that is necessary to help patients. All patients will benefit from psychotherapeutic intervention to some degree; it is highly recommended. However, medications are extremely beneficial, even for patients who pursue psychoanalysis. Based on psychological, physiological, and medical principles, as well as the results in my clinical practice, my opinion is that patients are able to benefit more from psychotherapeutic intervention, including psychoanalysis, when their symptoms are improved with medication.

One potential problem associated with medication intervention is that when some patients achieve significant relief from symptoms, they are then not motivated to continue treatment, including psychotherapy. If patients believe that their improvement is attributable to psychotherapy, they are likely to stop medication and vice versa. Since improvement with medication is initially more obvious than the effects of psychotherapy, which typically takes more effort and more time, it is reasonable to expect that if the medication is effective, the drive to pursue psychotherapy will be diminished. There are, in fact, numerous case examples in which patients decided to discontinue psychotherapy after they had achieved significant improvement from medication. It can be deduced that distress creates the main drive to seek or to continue a treatment. If medication is used to ameliorate the distress, the drive to pursue psycho-
therapy decreases fairly rapidly. If psychotherapy is used as the sole treatment modality, the drive to continue treatment (psychotherapy) is likely to remain for a longer period of time compared to the pharmacologic approach, because psychotherapy takes more effort and time to produce results in most cases.

There are some qualitative differences by which the two different therapeutic approaches attempt to achieve symptom resolution. A pharmacologic approach primarily attempts to treat symptoms fairly directly, just as antibiotics treat a bacterial infection, or as aspirin treats pain or fever, without much emphasis on attempting to alter factors that may have precipitated the symptoms or illness, such as (continuing the medical example) poor hygiene, exposure to others with the illness, increased stress, and overwork. Once an illness becomes acute, it is not effective to try to use preventive methods to treat the acute phase of the illness. Additionally, if symptoms are not treated fairly rapidly, they can create other complications, such as an untreated fever potentially causing dehydration, weakness, seizures, and delirium.

After the acute illness is brought under control, preventive techniques are important to forestall further episodes. Psychotherapy improves symptoms more in a longitudinal sense by (1) helping people resolve intrapersonal, interpersonal, or other conflicts; (2) helping people to understand themselves, leading to greater emotional control; and (3) helping people to manage stress by teaching various coping mechanisms. These psychotherapeutic benefits might gradually improve symptoms in a patient with an acute illness (as long as the patient does not deteriorate into a crisis state), and at least theoretically, prevent symptoms from occurring in the future. Psychoanalysis historically attempts to restructure a person's personality dynamics, thereby attempting to change the personality in a more functional and healthy direction, making psychoanalysis much more ambitious and comprehensive. The ultimate goal of structural or functional change in personality by means of psychoanalysis or by other techniques is to treat distressing symptoms. Without symptom resolution, structural or any other change in personality has no value to the patient. The eventual purpose of all treatments ideally is to not only improve distressing symptoms, but also to prevent symptoms from emerging in the future. People do not seek treatment simply for
the sake of treatment, whether pharmacological or psychological. Treatment is sought when patients are in distress or are symptomatic.

Psychoanalysis, while comprehensive in its goal, is beyond the reach of the majority of patients, especially given the current emphasis on brief interventions that favor medication use. Since there are no qualitative differences between the brains of patients who pursue medication treatment compared to those who seek psychotherapy, and since the brain is controlled by the same neurochemical processes, an adjunctive medication is theoretically beneficial to even those who are in psychoanalysis (which could be considered the ultimate form of psychotherapy and which traditionally does not favor medication). The reason for discussing this topic at length is to emphasize to clinicians that the polarized and concrete thinking held by many traditional psychotherapists has no basis in neurochemistry or in actual clinical experience.

The advent in the early 1990s of the medications that have an improved side-effect profile, has made it virtually imperative that clinicians consider medication treatment for every patient presenting with symptoms while providing psychotherapy that can be universally beneficial. The advantage of combining medication and psychotherapy is that symptom resolution is much more efficient and the chances of relapse are less, compared to either technique being used alone. Because of inherent characteristics, differences in onset of action between the pharmacological and psychological techniques occur, with pharmacological techniques relieving symptoms faster than psychological intervention. Based on these clinical observations, it is suggested that medication be started with or prior to the initiation of psychotherapy, and not as a last resort. In view of the improved safety and efficacy of recently available medications, to not consider therapy with medication for a patient might, in the near future, be suggestive of substandard practice just as not considering psychotherapy for a patient could be considered suboptimal treatment. Given the relatively immediate benefits of medications in rapidly relieving symptoms, there may be some primacy favors medication intervention in the initial phase of treatment.

The greater efficacy of medication during the initial phase of treatment does not make medication or psychotherapy more or less important in the overall course of treatment, except that differential
importance can be attributed at various phases of treatment, and in
different diagnoses. To give an extreme example, a patient who is
floridly psychotic would immediately need emergency medication
management rather than psychotherapy, but would eventually bene­
fit from a combination of maintenance medication and psychother­
apy to obtain optimal improvement. Obviously, there is the rare
patient who does well on medication alone, and the rare patient who
does well on psychotherapy alone, but the greater majority of
patients would maximally benefit from an optimal combination of
medication and psychotherapy, with individual variations as noted
above.

Practical considerations may prevent a particular patient from
receiving optimal treatment. For example, medication side effects
in a highly medication-sensitive patient, concurrent medications or
medical problems interacting harmfully with psychopharmacologic
agents, costs, time demands, or poor compliance interfering with
psychotherapy can dictate treatment options. Nevertheless, the
generic statements regarding the synergistic benefits of combina­
tions of pharmacotherapy and psychotherapy are still valid.

If a characteristic is long-standing and is expressed in the matur­
ing years, that is—in and of itself—a strong reason to suspect that the
characteristic in question is primarily constitutional and therefore
biologically mediated, making it amenable to biological interven­
tion. In the case of personality disorders, which are characterized by
chronic but dysfunctional traits (or symptoms), it makes sense to
attempt to treat them as one would treat any symptom that clearly
has a physical basis. For some reason, a myth has been perpetuated
that long-standing symptoms, as those seen in personality disorders,
are not amenable to biological techniques. Therefore, many psychi­
atrists and physicians do not treat personality disorders with
medications. Yet similar symptoms precipitated by psychosocial
stressors are routinely treated with medications. From a purely log­
ical standpoint, if any symptoms are likely to be responsive to
biological approaches, they would be the personality disorder
symptoms (due to their constitutional origins), perhaps even more so
than symptoms precipitated by psychosocial stressors. All symptoms,
if they cause dysfunction, should be treated using whatever approach is
most efficient and most effective.
There is a sense of defeatism among mental health clinicians and psychiatric nursing staff dealing with personality disorder patients. Any clinician who treats psychiatric patients in an inpatient setting knows that patients who are hostile, angry, pessimistic, needy, intrusive, regressed, and complaining are described as having a personality disorder. Similarly, any complicated or difficult patient is also labeled as manifesting a personality disorder. The dysfunctional attitudes and behavior of patients with personality disorders are branded as resistant to improvement; therefore, frequently such behavior is not a focus of treatment. The continued relegation of personality disorders to Axis II status in the *DSM-IV*, besides confusing to non-psychiatric medical specialists, has not helped to dispel the myth that these disorders are difficult to treat at best and to be avoided at worst. The opinion espoused in this book, based on extensive clinical experience, is that most personality disorders are treatable using a combination of medication and psychotherapy, with judicious use of medication playing an increasingly more important role as a greater range of medication options becomes available. The time has come to treat most Axis II disorders as aggressively and as systematically as the Axis I disorders.

Clinical experience suggests that even some of the symptoms comprising the most untreatable of all personality disorders, namely antisocial personality disorder, can be improved with medications. The possible symptom correlates of each personality disorder listed in *DSM-IV* will be discussed, and specific medication combinations including approximate dosages will be suggested. It is understood that psychotherapy is beneficial to most patients receiving psychiatric medications. This can be assumed in the discussion of each of the personality disorders. The focus of the remainder of the text will be on the identification of symptoms and their medication management.

The central theme of this book is to promote diligent conceptualization and identification of symptom correlates of personality characteristics, regardless of the age at which the characteristics appeared and regardless of whether they are typical of the person's long-term functioning. A personality disorder consists of dysfunctional psychological or behavioral patterns that are enduring, pervasive, inflexible, and distressing. Does this mean that these behaviors are not treatable or should not be treated? To give an example from one
nonpsychiatric medical specialty, Would a physical disability go untreated simply because the handicap has been present since birth? The disability would be treated at the time it is discovered if intervention is available, or when intervention becomes available in the future. Until five to six years ago, medication intervention options for personality disorders were limited. The recent availability of exciting new medications has changed this outlook. The aim of this clinical manual is to encourage physicians, psychiatrists, and other clinicians to offer modern medication treatments to improve the lives of our patients suffering from personality disorders.

*DSM-IV* categorizes personality disorders into three clusters, cluster A, B, and C. Cluster A includes paranoid, schizoid, and schizotypal personality disorders. Cluster B consists of antisocial, borderline, narcissistic, and histrionic personality disorders. Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders.

**GENERAL DIAGNOSTIC AND TREATMENT CONCEPTS**

The general diagnostic criteria for a personality disorder according to *DSM-IV* are as follows:*

1. A pattern of thoughts, attitudes, and behavior that are dysfunctional, pervasive, and abnormal exists, as manifested in at least two of the following areas:
   a. Cognitive
   b. Affective
   c. Interpersonal
   d. Impulse Control

2. The pattern is evident by adolescence or early adulthood, and is stable and enduring.

3. The personality pattern is neither due to another mental disorder, nor due to illicit drugs, medications, or a general medical condition.

A review of the major areas of abnormality manifested in personality disorders shows that these are the same areas that are disturbed in various Axis I disorders. For example, psychosis primarily affects cognitive areas and secondarily impairs affective and interpersonal areas, mania affects all of these areas, and Attention Deficit Disorder primarily affects cognition and impulse control. The differences are in the typical age of onset, chronicity, severity, and pervasiveness. Each of these dimensions is briefly discussed below.

**Age of Onset**

Symptoms of personality disorders typically emerge during adolescence and early adulthood. Patients with some personality disorders such as antisocial personality disorder and borderline personality disorder come to clinical attention relatively early, due to disruptive manifestations. In the case of antisocial personality disorder, one of the diagnostic criteria is evidence of the presence of conduct disorder with onset prior to age 15. Conduct disorder (before age 18) and antisocial personality disorder (after age 18) are fairly easily recognized by school psychologists and clinicians. Although their short-term prognosis is poor, early diagnosis enables the school, parents, and social and legal agencies to assist the patient in various ways in an effort to limit the dysfunctional effects of the disorder upon the individual and the society.

The onset of schizophrenia also usually occurs in adolescence and early adulthood. Like the personality disorders, schizophrenia is chronic, enduring, and has pervasive effects. Usual ages of onset of various major disorders are listed in Table 1.1.

Based on age of onset, personality disorders do not present any unique features other than a tendency to manifest the characteristics during adolescence and early adulthood. Table 1.1 shows that there are other major disorders that share the same characteristics. The manifestation of personality disorders fairly early in the life cycle suggests that personality disorders may be more biologically determined than is generally believed. If this is true, pharmacological intervention deserves greater emphasis in the management of personality disorders. If treatment is started early, better results are expected.
TABE 1.1. Age of Onset of Various Psychiatric Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Common Period of Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>personality disorders</td>
<td>adolescence, early adulthood</td>
</tr>
<tr>
<td>schizophrenia</td>
<td>adolescence, early adulthood</td>
</tr>
<tr>
<td>schizoaffective disorder</td>
<td>early adulthood, adulthood</td>
</tr>
<tr>
<td>major depression</td>
<td>adulthood</td>
</tr>
<tr>
<td>dysthymia</td>
<td>adolescence, early adulthood</td>
</tr>
<tr>
<td>bipolar disorder</td>
<td>early adulthood, adulthood</td>
</tr>
<tr>
<td>attention deficit disorder</td>
<td>childhood</td>
</tr>
</tbody>
</table>

Frequently, personality disorders may not come to clinical attention until early adulthood or later when the symptoms exert their cumulative impact on interpersonal, social, academic, occupational, and other important areas of functioning.

**Chronicity**

Personality disorders are chronic patterns of maladaptive feelings, thoughts, and behaviors, by definition. Axis I disorders such as schizophrenia, delusional disorders, and dysthymia, among others, are also chronic conditions. Thus, it is clear that personality disorders are not unique in the chronicity factor. Since chronic conditions usually require long-term treatment, it is logical to expect that personality disorders will need long-term treatment for optimal benefit.

**Severity**

There is marked variation in severity among the different personality disorders. Some patients with Borderline Personality Disorder for example, can present with severe dysfunction that is comparable to some of the most dysfunctional Axis I disorders, i.e., schizophrenia and schizoaffective disorders. However, in general, personality disorders are less acute, less severe, and more equitably comparable to Axis I disorders such as dysthymia, anxiety disorders, eating disorders, attention deficit disorder, and obsessive-compulsive disorder. Personality disorders can present with a spectrum of severity as do Axis I disorders, suggesting that qualitatively, personality
disorders and Axis I disorders follow similar biopsychosocial characteristics. The general treatment implication is that less acute disorders may respond to low doses of fewer medications for optimal control. Figure 1.1 illustrates the linear relationship between severity of symptoms and medication dose needed for response. For instance, mild psychotic symptoms respond well to a low dose of an antipsychotic while severe psychosis requires a relatively high dose for adequate response. This general observation is based on clinical experience.

FIGURE 1.1. The Linear Relationship Between the Severity of Symptoms and Medication Dose
**Pervasiveness**

Personality disorder affects nearly all aspects of the patient’s behavior and relationships. Most Axis I disorders likewise affect a variety of functions in varying degrees. Concerning pervasiveness, personality disorders are more similar than dissimilar to Axis I disorders, which suggest an absence of any qualitative differences.

All of the outlined conclusions imply that the treatment of personality disorders should not be fundamentally or qualitatively different from that of Axis I disorders. Obviously, different disorders within Axis II are variably responsive to treatment due to various factors, such as variations in compliance, potential for insight, and differential response to medications, as is true for Axis I disorders. For instance, factitious disorder, somatoform disorder, and paraphilias, among Axis I disorders, are notoriously difficult to treat.

Several of the personality disorders are more amenable to development of insight and to securing treatment compliance; therefore, they have a better prognosis than other disorders. Table 1.2 shows the prognostic groupings.

<table>
<thead>
<tr>
<th>Fair Treatment Compliance (Better Prognosis)</th>
<th>Poor Treatment Compliance (Worse Prognosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>obsessive-compulsive</td>
<td>antisocial</td>
</tr>
<tr>
<td>dependent</td>
<td>paranoid</td>
</tr>
<tr>
<td>histrionic</td>
<td>narcissistic</td>
</tr>
<tr>
<td>borderline</td>
<td></td>
</tr>
<tr>
<td>schizoid</td>
<td></td>
</tr>
<tr>
<td>avoidant</td>
<td></td>
</tr>
<tr>
<td>schizotypal</td>
<td></td>
</tr>
</tbody>
</table>

Patients with paranoid, antisocial, schizotypal, schizoid, and narcissistic personality disorders seek psychiatric services typically due to external pressure from a family member, employer, or court system. Once the symptoms are well treated, there is the possibility of developing insight and rapport, which can lead to continued treatment compliance even when external pressures are not sus-
tained. Typically this occurs among paranoid, schizotypal, and schizoid personality disorders, and to some extent in narcissistic personality disorder. The chances of true insight and rapport emerging in antisocial personalities are remote. Although schizoid personalities comply with treatment through a family member’s persuasion, treatment effectiveness is modest at best with currently available medication interventions.

SYMPTOM-FOCUSED TREATMENT: THE MEDICAL MODEL

If the physician is able to identify the symptoms that are causing distress to a patient, regardless of the personality disorder diagnosis, treatment should be offered. In some cases, one medication may effectively address multiple symptoms, whereas in other cases, multiple medications are necessary for optimal symptom control. In the former case, a patient with three or four distinct and disparate symptoms can be treated with one medication, whereas in the latter case, a person with three or four different symptoms may need three or four medications from different classes depending upon the specific symptoms. In rare instances multiple medications may be necessary for the optimal control of one symptom. The following simplified hypothetical examples will illustrate this point.

1. A healthy 30-year-old patient presents with depressed mood, obsessive rumination of the fear of dying of cancer, mild compulsive cleaning behavior, anxiety attacks, and anger outbursts. In this example, there are four different target symptoms as follows:

   1. Depressed mood
   2. Obsessive-compulsive features
   3. Anxiety
   4. Anger

   All of the above symptoms might effectively be treated with one medication, for instance with one of the serotonergic antidepres-
sants* such as fluoxetine, sertraline, paroxetine, venlafaxine, mirtazapine, and fluvoxamine, or with clomipramine, or with one of the tricyclic antidepressants (TCAs). The author prefers a first trial on serotonergic antidepressants (SSRIs), then clomipramine, and then TCAs, primarily because of the benign side effect profile of SSRIs. The ideal goal is to treat the symptoms using one medication, which is quite possible if the symptoms are as listed above. However, such an economy is not always possible, as will be seen in the next hypothetical case example.

2. A healthy 30-year-old patient presents with symptoms such as depressed mood, frequent nightmares causing sleep disruption, paranoid ideation, and significant mood swings.

The four different target symptoms are:

1. Depressed mood
2. Nightmares
3. Paranoid ideation
4. Mood swings

This patient also has four different symptom foci; however, adequate resolution of these four symptoms could require the use of medications from four different classes as follows:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>antidepressant, preferably an SSRI</td>
</tr>
<tr>
<td>Nightmares</td>
<td>benzodiazepine at bedtime, or low dose of a TCA at bedtime</td>
</tr>
<tr>
<td>Paranoia</td>
<td>low dose of an antipsychotic</td>
</tr>
<tr>
<td>Clinically significant mood swings</td>
<td>mood stabilizer</td>
</tr>
</tbody>
</table>

3. A healthy 30-year-old patient presents with hostility. The only target symptom is hostility. This patient could require medications from different classes for the best outcome.

**“Serotonergic antidepressants” is used loosely in this context to include all of the new generation antidepressants such as fluoxetine, sertraline, paroxetine, venlafaxine, fluvoxamine, and mirtazapine. Venlafaxine and mirtazapine have both sertonergic and noradrenergic effects.**
The key concept is global improvement via symptom control, through treatment with effective medication for each symptom identified. The patients’ complaints are translated into individual symptoms (no matter how many there might be) that are then targeted for treatment; progress is then followed in an organized and disciplined manner. Drugs that are not effective are eliminated, and drugs that become unnecessary over time are reduced or discontinued. Conversely, a symptom that improves partially may respond to increasing drug doses or addition of other medications as dictated by the clinical problem.

Unfortunately, when dealing with psychiatric problems, many excellent physicians do not think in the same clinically precise manner that they would employ if they were treating a nonpsychiatric illness. Again, a medical example illustrates this idea. A 42-year-old patient presents with symptoms of clear rhinorrhea, dyspnea upon exertion, postprandial bloating, premenstrual cramps, low backache, productive cough, and heartburn. Exam findings indicate a blood pressure of 175/102 and are otherwise consistent with benign etiologies for all of the patient’s complaints. Additional history is a five-year history of borderline hypertension, a family history of essential hypertension, and a cyclic history of seasonal allergies, frequently with reactive airways. The diagnoses then are: seasonal allergies with rhinorrhea; allergic asthma; probable lactose intolerance; essential hypertension; premenstrual syndrome; lumbar strain; bronchitis; and gastritis/reflux esophagitis. The primary care physician will have no hesitation in considering several medications from several classes as follows:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility</td>
<td>SSRI and antipsychotics at low doses (risperidone or olanzapine preferred due to favorable side effect profile)</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>antihistamines, decongestants</td>
</tr>
<tr>
<td>Asthma</td>
<td>bronchodilators, steroids</td>
</tr>
<tr>
<td>Symptom</td>
<td>Medications</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Essential hypertension</td>
<td>diuretics, beta blockers (both undesirable with asthma), calcium channel blockers, ACE inhibitors, alpha-2 agonists, peripheral vasodilators, etc (and physical measures)</td>
</tr>
<tr>
<td>Lactose intolerance</td>
<td>lactase</td>
</tr>
<tr>
<td>Premenstrual cramps</td>
<td>nonsteroidal anti-inflammatory, oral contraceptives, aspirin, acetaminophen</td>
</tr>
<tr>
<td>Lumbar strain</td>
<td>nonsteroidal anti-inflammatory</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>antibiotics</td>
</tr>
<tr>
<td>Gastritis/reflux esophagitis</td>
<td>H₂ blockers, omeprazole, antacids</td>
</tr>
</tbody>
</table>

While this comparison between the medical and psychiatric approaches has its limits (psychiatrists do not generally search for occult diseases as rigorously as medical practitioners look for cancers, for example), it does reinforce the point that when it comes to nonpsychiatric problems, physicians have no difficulty organizing the symptoms and prescribing a medication for each specific target symptom. Returning to the hypothetical case, this patient could be prescribed eight different medications for eight different problems. Fewer than eight medications could be considered suboptimal treatment. Some combinations of medications might be contraindicated, or in another circumstance, one medication will serve for two or more symptoms. It is not at all uncommon to see a medical patient taking three, four, ten, or even more medications from different pharmacologic classes. As in psychiatry, this entire list of medications is not permanent, with medication for acute symptoms being eliminated as soon as the patient's condition allows, with antihypertensives more likely to be a lifelong necessity. Physicians tend to think clearly, logically, and specifically when dealing with nonpsychiatric symptoms. The time has come in psychiatry for psychiatric specialists as well as primary care physicians to apply this same
clinical precision on a more general scale, i.e., to use it in the management of psychiatric problems. The management of personality disorders is no exception.

**RATIONAL POLYPHARMACY: EVOLUTION IN PSYCHIATRIC DRUG THERAPY**

Polypharmacy carries a negative connotation of too many drugs, conflicting drugs, and lack of physician care and attention to the complete drug list so that multiple specialists are together prescribing a mishmash of medications with toxic potential. More precisely, however, the word polypharmacy in its pristine form means "multiple drugs." While the negative connotation indicates too many, the more correct definition—as adhered to in this text—should elicit a positive connotation of only as many drugs as are necessary, each for a specific target symptom, each evaluated individually for efficacy and side effects and adjusted optimally, and each eliminated when no longer necessary.

Some years ago when there were only three or four classes of psychiatric medications available, each with many common side effects and less specific main effects, concurrent use of more than one class of medication was likely to lead to adverse effects. However, in recent years, more and more new psychiatric medications with specific indications and effects have become available, affording use of intelligent drug combinations for optimal symptom control. Inevitable and desirable evolution in psychiatric drug therapy has made it possible to practice rational polypharmacy, which every contemporary psychiatrist must learn to provide the patients with the best care possible in an era of psychopharmacological revolution.


Bibliography


