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ANTIPSYCHOTIC SIDE-EFFECT – POTENTIAL RISK OF PATIENTS REJECTING THEIR TREATMENTS

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SUMMARY

Antipsychotics side-effects pose an enormous problem in psychiatric treatment. The choice of antipsychotics is a crucial issue in the treatment as both patients' cooperation and compliance often depend upon it. Severe side-effects might sometimes cause the treatment interruption, to which each patient is entitled. Schizotypal personality disorder (SPD) features include social and interpersonal deficits, discomfort with close relationships, as well as cognitive and perceptual distortions and eccentricities of behaviour. Dominant symptoms often determine psycho pharmacotherapy and therefore antipsychotic treatment is possible. A 23 year-old man was treated for 4 months due to disturbances typical for SPD. Since the patient did not respond well to haloperidol, zuclopenthixol was advised. The latter medication produced severe, life-threatening side-effects which caused urgent hospitalisation. Althouth zuclopenthixol was instantly retracted from the therapy, the patient and his family rejected any further psychiatric treatment. In spite the fact that hetero-data obtained from his mother a few months later, revealed disturbances which greatly affected the patient's live, the patient showed resistance to further psychiatric treatment because of his negative experience with this medication.

Key words: *schizotypal personality disorder – zuclopenthixol - side-effect*

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INTRODUCTION

Personality traits represent a long-lasting model of perception, relations and reasoning about the environment and oneself, which is manifested through a range of social and personal situations (Pervin & John, 1996; Larsen & Buss, 2007). Whenever the traits are non-flexible, non-adaptive and cause significantly damaged functioning, the diagnosis is a Personality disorder (Matthews et al. 2003). Personality disorder represents a long-lasting model of internal experiencing and behaviour, which significantly deviates from what is expected and socially acceptable (APA 2000, Pervin & John 1996, Larsen & Buss 2007).

The schizotypal personality (SPD) disorder features, according to the DSM-IV and the ICD-10 do not differ significantly. However, DSM-IV (APA 2000) classifies this disorder as the Personality disorder, while the ICD-10 (WHO 1992) assigns such disorder to the Schizophrenia and the schizophrenia alike disorders group. The incidence of SPD in general population is around 3%, only a lower number acquiring a schizophrenia characteristic or that of other psychotic disorders (APA 2000). Individuals with SPD manifest a disturbed reasoning and communication and often develop ideas of relations which differ from the delusional ideas of relations. Superstition and obsession with paranormal phenomena are quite frequently present, as well as unusual perceptual experiences, bizarre reasoning and speech. Moreover, such individuals might generally be suspicious, and can have an inadequate and limited affect. The behaviour or appearance such people is often peculiar or even eccentric. Social anxiety is pronounced and such individuals have no, or just few close friends, the reason being the aforesaid personality characteristics. Such individuals are not able to express a full range of emotions in interpersonal relations which makes them rigid and difficult to adapt (APA 2000, Raine et al. 1994, Jacobsberg et al. 1986, Bornstein et al. 2006).

CASE REPORT

A 23 year old student asked for psychiatric assistance for his anxiety, lowered mood and sleep disturbance, also confirmed by his mother. Although the young man was quite reluctant to talk, the session revealed that the symptoms persisted for two years. His academic achievement was above the satisfactory level, however he didn't

have any friends or social life with his peers. He also confirmed not having any friendships or social company in the past. He thought his spare time was excessive, and stated that he occasionally spent some on hobbies (cards fortune telling, attempts of performing clairvoyance). He said the main reasons he decided to ask for help are sleep disturbance and anxiety. His speech abounded metaphors and he manifested suspicion and scepticism towards the psychiatrist's professional skills. The patient rejected the advised medication therapy but he agreed to join supportive psychotherapy. A routine analysis was conducted (laboratory blood and urine report and EEG showed no irregularities) but he refused the psychological testing. He did not attend his first psychotherapeutic session and he later apologized and justified his absence. He unwillingly agreed to pharmacotherapy.

A low dose of haloperidol was introduced (3mg), but two days after, the patient arrived and stated he had read the contraindications list and decided not to take haloperidol any longer. The psychiatrist put a great effort into persuading the patient to accept the suggested medication but the patient still rejected the latter. Lower alprazolam (0.75 mg/per day) and promazine (25 mg in the evening) doses were introduced. This therapy regulated sleep but only reduced anxiety. The patient did not attend his scheduled appointments with psychiatrists for two months but he would always call, apologise and justify his absence.

After a short period of time, the patient came without previous notice, stating even more intense anxiety and insomnia. A prolonged colloquy revealed paranoid thoughts towards his student colleagues with whom he actually didn't have any close contacts. According to the patient, the latter wanted to „set him up“, and he believed them to have the power to control his future. He claimed experiencing certain body changes and supplied exhaustive descriptions and precise details. In the meantime he managed to graduate, but had no desire to obtain employment. Again, haloperidol was advised and rejected by the patient. Still, the psychiatrist succeeded in convincing the patient to accept zuclopenthixol (2x5 mg) with alprazolam (3x0.5). A week after such therapy was introduced, the patient paid a sudden and unscheduled visit during which he was extremely tense, almost agitated and hostile. He shouted and brought accusation that the psychiatrist intended to kill him and acted against him and he therefore refused any further communication with the specialist.

Considering the patient's anger outbreak, a family GP doctor was contacted, who revealed that the patient had developed tachycardia, tongue oedema, suffocation, face numbness, a body rash similar to nettle-rash soon after the first dose of zuclopenthixol. The aforesaid disturbances were the reason why his family called the First aid intervention which resulted in hospitalisation. During the 18-hour permanence in hospital the patient was examined by a cardiologist and an anaesthesiologist and a psychiatrist was consulted too. Medical documentation gave evidence the psychiatrist prescribed infusion containing diazepam and verapamil, and after the main symptoms (tachycardia, tongue oedema, suffocation) had been taken care of, biperiden chloride (one single dose 5 mg IM) and biperiden chloride (4 mg oral dose per day) were administered, while zuclopenthixol was removed from the therapy. The psychiatrist advised a check-up after the discharge, but the patient never attended it.

Nine months later, the patient's mother came to ask for the expert’s advice and she revealed the patient still rejected both the psychiatric treatment and the medications available. He was still unemployed and did not show any interest in finding employment. He did not develop any friendships, was still convinced he could foresee future events and was engaged with the paranormal. He was excessively detailed in communication and anxious during social contacts, which both obstructed his relationships and troubled him very much. His mother was advised and she never established any contact afterwars.

CONCLUSION

The choice of antipsychotics in the treatment of psychiatric illnesses and disorders, as well as the SPD, is a rather demanding process for each psychiatrist. It is crucial to be acquainted with possible side-effects and clinical and personal experience in the administration and antipsychotic treatment. At first the patient’s hostile reaction towards the psychiatrist did not reveal that such reaction was caused by his negative experience with the side-effects of the medicament. Only the analysis of additional information supplied by the family GP and medical documentation, lead to conclusion that the patient experienced zuclopenthixol side-effects which were reported to the relevant institutions. Unfortunately, these severe side-effects were the main cause of the interruption of psychiatric treatment. Such

unpleasant experience is the reason why the psychiatrist feels both insecure and afraid of side-effects when prescribing zuclopenthixol.

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