RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER

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BPD PSYCHOPHARM: IMMEDIATE ISSUES

- No medications carry a specific indication for use in treatment of personality disorders
- Thus "off label" (though that is not uncommon)
- Medications for BPD are less effective for symptom or symptom complex than when used in other disorders
- BPD patients seem exquisitely sensitive to side effects
- Thus the cost-benefit ratio is different

TRANSFERENCE-COUNTERTRANSFERENCE REACTIONS

- **Being a psychopharmacologist does not protect one against transference/ countertransference reactions**
- **Patient wonders why the psychopharmacologist should be different from all the others who have denied and withheld from them and frustrated them**
- **No psychopharmacological treatment is ever purely psychopharmacological**

HOW TO PROCEED - I

- **Is it time to try medication?**
- **Why? Why now?**
- **What symptom or symptom complex are you trying to target?**
- **Would the "target" respond in "pure" axis I? Though too often these patients do NOT respond in the manner that a pure axis I patient would respond.**
- **How would you track improvement?**
- **No response for emptiness, loneliness, abandonment fears**

HOW TO PROCEED - II

- **Do not get distracted by crises and other things re following the progress of the "target" symptom.**
- **If you are the psychopharmacologist and another is the therapist, make sure there is collaboration and understanding**
- **Remember that medications at best are adjunctive**
- **Might be more useful to think in terms of dimensions (next slide) than symptoms or symptom complexes**

TRAITS TO CONSIDER IN PERSONALITY DISORDERS

- **Affective Instability: abandonment, affective instability, capacity for pleasure, depression, emptiness, euphoria/ mania, identify disturbance, interpersonal sensitivity, irritability, rejection sensitivity, suicidality**
- **Cognitive perceptual: paranoid ideation, perceptual distortion, psychoticism-schizotypy**
- **Impulsivity/Aggression: aggression, anger, hostility, impulsiveness**
- **Anxiety inhibition: general anxiety, obsessive-compulsive score, phobic anxiety, somatization**

Adapted from: Siever & Davis (1991). "A psychobiological perspective on the personality disorders." Am J Psychiatry 148(12): 1647-58.

TRAITS OR SYMPTOMS: WHICH MEDICATIONS TO USE?

	Afft/Instb	Agg/Imp ^	CogPer	Anx/In	Glob
Binks (Coch)	(AD)	(AD)	AP	NA	(AP)
Lieb (Coch)	MS (AP)	MS (AP)	AP	NA	
Nosè	AD/MS	AP	NA	NA	(AP)
WFSBP	AD	AP/MS	AP	AD	
Duggan	NA	MS	AP	NA	
Toronto	AP/MS	MS	---	----	
Ingenhoven	MS	MS/AP	AP	MS	MS
SUMMARY	MS (AD*)	MS/AP	AP	(AD)	AP

* If concurrently depressed
^including anger

HOW TO PROCEED-III

- **Need to emphasize the limitations of the medications *prior* to prescribing them, in fact need to discuss how you prescribe**
- **One at a time.**
- **Prefer to stop and switch rather than augment**
- **Long enough trial to have an appreciation of drug's effectiveness**
- **Try to avoid making major psychopharm decisions during crisis**
- **Careful with benzos (very short term but can disinhibit)**
- **Move slowly (usually). It took them a long time to arrive at where they are and it will not be solved overnight**
- **Be patient. Do not allow the patient's impatience to make you impatient**

DON'T BE FOOLED BY CHEMICAL IMBALANCE CLAIMS

- **Patients claim they have it**
- **Patients want a quick fix**

- **Popular literature**
- **Advertisements (direct to public in USA)**
- **The "drugs can cure everything" culture**
- **They may have been treated previously by an overenthusiastic psychopharmacologist**

- **"All of what we feel and do are mediated by chemicals. But chemicals (alone) have not been or been only minimally helpful"**

GETTING ON AND OFF MEDICATIONS

- Not easy to get on
  - Highly sensitive to side effects
  - Highly sensitive to weight gain

- Not easy to get off
  - They can get attached to the medication as rapidly as they do to people
  - They can use the medications as transitional objects

IT IS EASY TO ARRIVE AT POLYPHARMACY

- **Especially with BPD**
  - **Criterion 4 – Impulsivity and anger → SSRI**
  - **Criterion 6 – Affective instability → Mood stabilizer**
  - **Criterion 7 – Emptiness as depression – Augment**
  - **Criterion 9 – Paranoid under stress – Antipsychotic**
  - **And something to sleep**

IT IS EASY TO ARRIVE AT POLYPHARMACY

- **Patients are on all these medications and then they have a crisis or they still feel badly.**
  - **They want more meds**
  - **They want new meds**
  - **They want different meds**
  - **They want you to fix it**

  - **What we can guarantee is weight gain and drug-drug interactions!**

HOW TO PROCEED - IV

- **Use medications one at a time**
- **Do not add a second until you think there is a response to the first**
- **Be careful about "augmenting" when there is such a tendency to use multiple medications**
- **Do not make medication changes during crises.**
- **Choose the safest medication in a group if you have a choice**

DO MEDICATIONS WORK HERE?

- They are non-specific in their response
- There is a high placebo response rate in clinical trials
- Some times we can't appreciate that the medications are working until we experience the patient in the absence of the medication
- No long-term studies
- No continuation studies