Medications for Borderline Personality Disorder

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Skills Not Pills

(0:23-1:30)
Core Features of BPD

- Rapid mood fluctuations
- Unstable self-image
- Unstable interpersonal relationships
- Transient psychotic symptoms
- Impulsive behavior
- Suicidal ideation and self-harm with high risk of completed suicide
Epidemiology

- About 1% of the population
- Women present for services more than men
- Most common in early adulthood
- Variable course with higher rates of remission than previously thought
- Social and interpersonal difficulties may be persistent even after treatment
Etiology

- Childhood abuse and neglect
  - Not just sexual abuse
  - DBT: “invalidating environment”
  - MBT: insecure attachment leading to “failure of mentalization”
- There may be a biological predisposition
  - Strongest evidence for substance abuse and ASPD
  - Bipolar spectrum?
Some reasons you might want to use pills...
- Patient not yet DBT-G! (not in therapy or in early stages)
- Severe suffering/high-risk behaviors
- Comorbid Axis I disorders
What would we be trying to treat?

- Most neuroimaging studies take limbic-prefrontal circuits as the a priori area of interest.
Wise mind

Attempts to synthesize and compromise between the logical mind and emotional mind. Uses deepest aspirations to determine the best course.

Emotional mind
Uses energy level, feelings, and deep psychological need to guide the individual.

Logical mind
Use logic and cause-and-effect reasoning to guide the individual.
What would we be trying to treat?

- Disagreement between neuroimaging studies
  - Most include common comorbidities
  - Small sample sizes
  - Technical issues in interpretation
Limbic-Prefrontal Circuits

- PET:
  - Hypermetabolism of limbic structures
  - Hypometabolism of prefrontal cortex
- MRI:
  - Reduced volume in the frontal lobe and bilateral hippocampus/amygdala
  - May reflect loss of inhibitory neurons
  - Reduced volume appears to be correlated with hypermetabolism
- Unclear if:
  - Limbic overreactivity overwhelms the frontal cortex
  - Absence of frontal cortex restraint leads to an overactive amygdala
KEEP CALM AND USE WISE MIND
Could pills do this?

- Limbic-prefrontal pathways
  - Implies a (potential) role for medications that regulate dopamine, glutamate and/or Ach
- Limbic system impacts the autonomic nervous system
  - Implies a (potential) role for medications that regulate the stress response
MEDICATIONS FOR BPD: THREE APPROACHES

- There is some evidence that medications are helpful for BPD
- There is little evidence that medications are helpful for BPD
- Even if we can’t medicate BPD, we can treat comorbidities
Some Evidence for Medications in BPD

  - Based on an older generation of research
  - SSRI’s + Klonipin for affective dysregulation
    - Avoid TCA’s due to high lethality in overdose
  - Low-dose antipsychotics for cognitive-perceptual symptoms
- “Drug Treatment for Borderline Personality Disorder,” Cochrane Review 2010
  - Meta-analysis of 28 studies with 1742 participants
Some Evidence for Medications in BPD

- **2010 Cochrane Review:**
  - “Total BPD severity was not influenced by any drug”
    - Some benefit from: second-generation antipsychotics, mood stabilizers and omega-three fatty acids
    - Marginal benefit from: antidepressants and first-generation antipsychotics
      - Possible increase in self-harm with olanzapine
    - No drugs for chronic feelings of emptiness, fear of abandonment or identity disturbance
  - Positive findings mostly based on single study effect estimates
    - “Current findings of trials and this review are not robust and can easily be changed by future research endeavors”
Gunderson’s “Algorithm for Medications for Borderline Personality Disorder”
Summary: Medications by Core BPD Symptoms

- Some providers use BPD symptom checklists to identify medication targets
- Affective dysregulation/impulse control/interpersonal conflicts
  - mood stabilizers
  - non-maleficence: topiramate/lamotrigine
- Cognitive-perceptual disturbances (transient paranoia, identity disturbance)
  - atypical antipsychotics, especially Abilify and Zyprexa
- Identity disturbance, chronic feelings of emptiness, fears of abandonment
  - no drug treatments
Little evidence for medications in BPD

- **NICE Guidelines (NHS-United Kingdom)**
  - January 2009, unchanged in January 2015 update
  - “There is little evidence of the effectiveness of pharmacological treatments for people with personality disorder”
  - “Drug treatment should not be used
    - specifically for borderline personality disorder or
    - for the individual symptoms or behaviors associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behavior, and transient psychotic symptoms)”
- No drug has UK marketing authorization for BPD (or FDA approval in the US)
- NICE panel critiqued 2010 Cochrane Review: “Despite considering similar evidence, [the Cochrane reviewers] draw largely different conclusions from those we drew in developing the NICE guideline… most [of the] recommendations were based on weak or low-quality evidence.”
NICE Guidelines

- BPD patients without comorbidities:
  - Review the treatment and consider reducing and stopping unnecessary drug treatment
- BPD patients with comorbidities:
  - Drug treatment may be considered in the overall treatment of comorbid conditions
- In treating insomnia, offer sleep hygiene first and only medicate short-term
- In a crisis, short-term use of sedatives may be considered (no longer than one week)
- Antipsychotics should not be used for medium- or long-term treatment of BPD
- NICE acknowledges the need for further research on mood stabilizers, especially lamotrigine and topiramate
NICE: Role of Medications in Crisis

- Ensure that drugs are not used in place of other more appropriate services
- Take into account the psychological role of prescribing/impact on the relationship
- Ensure there is consensus among providers and determine who the primary prescriber will be
- Prescribe a single drug and avoid polypharmacy wherever possible
  - Agree with the patient on target symptoms, monitoring and anticipated duration; arrange for follow-up within a week
  - Choose drugs with low side effects and addictive properties
  - Consider alcohol and illicit drug use
  - Choose drugs with relative safety in overdose and prescribe fewer tablets more frequently if necessary
  - Use the minimum effective dose
  - If medications must be continued for longer than a week, implement regular follow-up and review
Medicate comorbidities, if not BPD

- Recommended in NICE Guidelines
- Also recommended by Gunderson
  - Identify the primary treatment target
  - Treat comorbidities as primary if they prevent active learning (substance abuse, mania, complex PTSD) or reduce motivation (ASPD, anorexia)
- Treat BPD as primary if comorbidity likely to remit when BPD remits (MDD, panic DO, bipolar I/II in remission, bulimia)
CLINICAL TIPS

• Be sensitive to the psychological impact of your medications
• Medications can have a “holding function” for patients with BPD
• Medications act as an environmental intervention
Gunderson on Forming a Therapeutic Alliance around Medications

- The HOW’S:
- Authoritarian approaches may be counter-productive
- Create an atmosphere of hope, explain that recovery is possible
- Build a trusting relationship based on openness and reliability
- Aim to develop autonomy and promote choice
Gunderson on Forming a Therapeutic Alliance around Medications

- WHAT to Emphasize:
  - Don’t minimize subjective distress
  - Collaborate to identify treatment targets, assess benefits and side effects
  - Offer psychoeducation about BPD and medications
    - Be open about the limited evidence for use of medications for BPD
    - Emphasize that medications are adjunctive
  - Don’t ignore negative attitudes about you or your medications!
Working with a Team

- Most evidence-based treatments for BPD are team-based
  - Patients need interdisciplinary approach
  - Protects against therapist burnout
- Some tips for working with DBT teams:
  - Ask for the DBT formulation
  - Be aware that the individual therapist, NOT the prescriber is the leader
- Try to avoid multiple prescribers
- Make sure that you communicate what you are doing with other team members
Tip #1: First Do No Harm

Given limited evidence for benefit:
- consider side-effect profiles
- consider substance abuse history and lethality in overdose
Principle #1: First Do No Harm

Figure 4: Number of cases versus hazard index by antidepressant type.
Tip #1: First Do No Harm

- For sleep in suicidal patients
  - trazodone/mirtazapine safer than doxepin

- Changing antidepressant classes
  - Safest SSRI’s: sertraline, escitalopram, fluoxetine
  - Least safe TCA’s: amoxapine, amitryptiline, desipramine, imipramine
  - Safer alternatives to SSRI’s: mirtazapine, duloxetine, nefazodone
  - Safe(r) TCA’s: nortriptyline, clomipramine

- Bupropion may be tempting if you think your patient may have an underlying bipoplar diathesis
  - higher risk for overdose than commonly realized
  - risk with comorbid eating disorders
Tip #2: Evaluate for PTSD

- Evaluate for and treat PTSD early on
  - Alpha-blockers are relatively easy to use and have low side effects
  - Patients often see immediate benefits, which builds hope and strengthens the therapeutic alliance
  - Evaluating for symptoms does not require taking a full trauma history
Tip #3: Avoid benzos and limit prn’s

- Avoid benzodiazepines wherever possible
  - Low lethality in overdose, but…
  - Can be disinhibiting and increase behavioral outbursts
  - May inhibit processing of trauma?
Tip #3: Avoid benzos and limit prn’s

- Many BPD patients will come to you with heavy prn use
  - There is an art to tapering off
  - Assess what symptoms the prn’s are treating
  - Start a more appropriate long-term medication
  - Educate your patient on risks
  - Then put them in control of the process!
- Keep track of prn use and congratulate reductions
Tip #3: Avoid benzos and limit prn’s

- Alternatives for anxiety and mild agitation:
  - antihistamines
  - sedating mood stabilizers (gabapentin, valproic acid)
  - if your patient is in DBT, ask them what skills they’ve tried before using prn’s

- Alternatives for severe agitation
  - sedating antipsychotics (olanzapine, quetiapine, chlorpromazine)
Tip #4: Screen for Common Comorbidities

- Depression
- PTSD/Anxiety
- Substance abuse
- ADHD
- Chronic pain
- Eating disorders
- Bipolar disorder
- ASPD
Tip #4: Screen for Common Comorbidities

- Depression/dysthymia
  - Gunderson: Will resolve when BPD symptoms improve
  - Have realistic expectations for medications

- Substance abuse
  - Evidence for DBT in treating substance use disorders
  - If using naltrexone, know that evidence is weak for use in treating self-harm

- Eating Disorders
  - Bulimia more common than anorexia in BPD patients
    - Evidence for high-dose fluoxetine for binge eating
  - Medical issues can limit symptomatic approach
    - Cardiac risk: antidepressants, alpha-blockers
    - Hyponatremia: antipsychotics
Tip #4: Screen for Common Comorbidities

- ADHD
  - Stimulants work pharmacologically at cross-purposes with antipsychotics
    - can increase anxiety and irritability
  - Wellbutrin higher risk for suicide than is commonly realized
  - Alpha-blockers (clonidine, guanfacine) indicated for both ADHD and PTSD

- Chronic pain
  - High risk of dependence with opiates
  - High lethality in overdose of opiates and TCA’s
  - Gabapentin/pregabalin safer, but often rejected by patients as ineffective
Tip #5: Know When to Decrease Medications

• At the outset, consider decreasing medications if your patient has no comorbidities and/or mild symptoms
• BPD patients often take pride in being able to do well without medications
• Later on, consider whether you are using medications to treat BPD or a comorbidity
  • If symptoms have resolved, is it due to skills or medication?
  • Consider underlying genetic risk
Tip #5: Know When to Decrease Medications

- DBT Phase I:
  - Targets are life-threatening and treatment-interfering behaviors
  - At the end of this phase, may be ready to stop medications aimed at impulsivity +/- affective dysregulation

- DBT Phase II:
  - Targets are quality-of-life-interfering behaviors and PTSD
  - May see significant resolution of depression and dysthymia
  - Continue PTSD medications at least until patient has been able to complete an evidence-based trauma therapy
Summary

- Medications can have a role in treating BPD
  - No evidence for monotherapy for BPD
  - Symptomatic treatment has a limited evidence base
    - some evidence for medications for several core BPD symptoms
    - no evidence for medications for some important core symptoms
  - I prefer to treat comorbidities rather than engaging in symptomatic treatment
- Be sensitive to the impact of medications on the therapeutic alliance
  - There will be transference issues around you and your medications
  - Address negative attitudes when you see them
  - Positive transference to sedating medications can be a problem
- Work to establish a collaborative relationship with your patient and the team
- When prescribing:
  - Be clear what you are using each medication for
  - Consider risks (side effects) vs. benefits (evidence base)
  - Avoid disinhibiting and addictive medications wherever possible
  - Consider risk in overdose
  - Be planful about decreasing and/or discontinuing medications