Medications and Borderline Personality Disorder

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## Conflict of Interest Disclosure

<table>
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<td>Honorarium</td>
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- Off-label use of medication will be described for classes of medications
Outline

- Overview of BPD
  - Emphasis on interpersonal nature of symptoms
- How this impacts medication use
- What is known about medication effectiveness
- Principle-based approaches
- What families should know and can do to be helpful
BPD Criteria

• Interpersonal Hypersensitivity
  • Abandonment fears
  • Unstable relationships (ideal/devalued)
  • Emptiness

• Affective/Emotion Dysregulation
  • Affective instability (no elations)
  • Inappropriate, intense anger

• Behavioral Dyscontrol
  • Recurrent suicidality, threats, self-harm
  • Impulsivity (sex, driving, bingeing)

• Disturbed Self
  • Unstable/distorted self-image
  • Depersonalization / paranoid ideation under stress
BPD’s Interpersonal Coherence

**Connected**
idealizing, dependent, rejection-sensitive

**Threatened**
devaluing, self-injurious
angry, anxious, help-seeking

Support by the other

Withdrawal by the other

**Alone**
dissociated, paranoid
impulsive, help-rejecting

**Desperate**
suicidal, anhedonic

Interpersonal Stress

Holding (hospital, jail, rescuer)

Gunderson 2014
Reactive Treatment: Perilous

• Persons with BPD often seek treatment reactively

• Example: Migraine Headaches
  • more medication overuse headaches
  • more unscheduled (acute) office visits
  • lower overall treatment response

Rothrock, Headache, 2007
Major Depression and BPD

- ~85% prevalence of MDD in BPD
  Gunderson 2008

- BPD has a markedly negative effect on MDD ("treatment resistance") until BPD remits, but MDD has only modest effects on BPD’s course.
  Yoshimatsu and Palmer 2014

- BPD is most common reason for persistence of depression.
  Skodol 2011
Bipolar Disorder and BPD

• ~15% prevalence
  • CLPS had 11% with BP I and 8% with BP II
  • MSAD had 1% with BP I and 14% with BP II

• No impact of BP I or II on BPD course
  • Modest evidence that BPD improvement impacts BP I > BP II

• Thus: *Comorbid but independent disorders*
MDQ and MSI BPD screen of 172 pts with BP, BPD, or Both

BP
Dec sleep, Inc Energy, Activity, Speech Confident, Hyper ?Unreal

Moodiness, Arguments, Distractibility, Spending

BPD
Self Harm, Anger Problems, Mistrustful in Relationships ?Irritability
What’s known about the meds

• Limited studies. About 30 RCT’s, mostly small
• Number of medications is inversely proportional to improvement
## At a glance

<table>
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<th>Antipsychotics</th>
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<th>Mood Stabilizers</th>
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<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Depression</td>
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<td>0</td>
<td>+</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Impulsivity</td>
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<tr>
<td>Functioning</td>
<td>+</td>
<td>0</td>
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*Adapted from Ingenhoven 2010*
### Symptom targets and medication types

<table>
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<tr>
<th>Mood</th>
<th>Instab</th>
<th>MDD</th>
<th>Ax</th>
<th>Anger/Impul</th>
<th>Cogn/Percep</th>
<th>SIB/Safety</th>
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<td>SSRI</td>
<td>?</td>
<td>?/+</td>
<td>?</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MS</td>
<td>+</td>
<td>?/+</td>
<td>?</td>
<td>++</td>
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**Note.** ++ = helpful; + = modestly helpful; ? = uncertain, - = negative

**Source.** Adapted from Mercer et al. 2009; Silk and Faurino 2012
Class findings

- SSRI antidepressants: Safest, modest benefit
- Atypical antipsychotics: Perceptual sx, maybe anger, beware weight gain
- Mood stabilizers: May help with reactivity, beware pregnancy, inconsistent dosing, interactions

- Benzodiazepines (esp alprazolam) have no role in BPD
Specific agents best studied

• Mood stabilizers
  • Best studied with favorable safety profile: lamotrigine (200 mg) and topiramate (200-250 mg)

• Antipsychotics
  • Aripiprazole (15 mg) and olanzapine (2.5-10 mg), quetiapine (150 mg)

• Antidepressants
  • MAOI’s, fluoxetine (more with impulsivity/aggression, esp in males)
Reality

• No medications carry a specific FDA indication for use in treatment of personality disorders
• BPD patients seem exquisitely sensitive to side effects
• Urges to help (or rarely to withhold help) are relevant
• Medications do not treat emptiness, loneliness, abandonment fears
Do no harm

- Can do harm by moving focus onto finding “the right” medications
  - Lower expectations
  - Remember medications are adjunctive
- Can do harm by moving focus to medications during crises
- Can do harm with weight gain, other side effects
- Can do harm by adding medications in a hospital
Polypharmacy is easy

• 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…
Meds: Key Principles

1) Collaborate to determine goals and set expectations

2) Measure the effectiveness of the intervention

3) Use a methodical approach to medication trials. Careful on adding without subtracting

4) Hold reasonable limits
Substance Use Disorders

• Highly comorbid (15-20%)
• Negatively impacts course of BPD, and BPD negatively impacts course of SUD
• Medication-assisted treatment can be helpful
• Fits the principles we have established
What families can do

• Catch yourself looking for external fixes
  • Recent example

• Beware being too enthusiastic about the process marked by medication reductions

• Validate feelings / experiences (rather than looking for solutions)