

Prescribing Medications for People with “Borderline Personality Disorder”

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No Medications are approved for BPD

- 81 % of cohort in collaborative borderline follow up project taking medication (CLPS study)
- Zanarina 78 % of BPD on meds > 75 % of time over 37 % of BPD on > 3 meds

What is biological?

Temperament Trait → social learning →

Medication can “turn down the noise” and allow one to use other therapies

Biologically Based Dimension Model —Larry Sever and Davis Am J Psych 1991

- impulsivity and serotonin
- depression and serotonin
- environmental hyperactivity and noradrenalin
- cognition and dopamine
- anxiety and noradrenalin or GABA

Advantage of “split treatment” separate prescriber and therapist

- Provides a “team”—2 people to buffer the lability of the relationship
 - Someone else to turn to when the person gets angry
 - Stabilizes relationship
 - Rules: never defend the other-
 - Never believe the complaints about the other
 - Refocus the patient to talk to the other—gently but firmly
- Gunderson

Potential disadvantage of separate prescriber and therapist

- Good communication takes both time and interest of both parties
- Splitting is a real risk
 - Different information given to each clinician
 - Easy for them to “fight” with each other
 - One becomes “good” and the other “bad”
- Can reinforce the belief that medication is separate from other parts of treatment

Interpersonal Issues in Prescribing

- ❑ The world is denying them something that they rightly deserve
- ❑ You are now treating them exactly how the world has always treated them

T. F. Main The Ailment Brit J Psychology 1957

It's easy to arrive at polypharmacy

- ❑ They want more meds
- ❑ They want new meds
- ❑ They have lots of symptoms
- ❑ They want to be fixed
- ❑ We feel that we need to do something
- ❑ Polypharmacy not always wrong, but it is not always wise

Medication as transitional object

- ❑ Very sensitive to weight gain and other side effects
- ❑ But patients also get very attached to their medication
- ❑ The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behavior disguised as treatment

Main--theAilment

Deficits in People with Borderline Disorder (Temperament)

- A. Affective Instability
- B. Impulsivity and low frustration tolerance
- C. Cognitive perceptual dysfunction
- D. Anxiety inhibition problems

Dimensions of Personality
(Siever and Davis (1991))

The goal is to stay in a long term, stable relationship:

- ❑ Know the limits of your responsibility
- ❑ Be aware of your own feelings
- ❑ Monitor and regulate interpersonal distance
- ❑ Be aware of "splitting"--being "right" may be less important than being a team

Be clear about the therapy contract

- A. What does the client want
 - What are the client's treatment goals
 - What would "doing better" or "doing worse" mean
 - What commitment is the client willing/able to make
- B. What do you want?
 - What are you able to deliver
 - What can you not tolerate
 - ❑ Behavior
 - ❑ Risk

Core Strategies for Therapy

- ▣ Validation
- ▣ Problem solving
- ▣ Skills training

Assumptions about borderline patients and therapy (from Lenihan)

- ▣ Patients are doing the best they can
- ▣ Patient want to improve
- ▣ Patients need to do better, try harder and be more motivated to change
- ▣ Patients may not have caused all of their own problems but they have to solve them anyway

Assumptions about borderline patients and therapy (cont)

- ▣ The lives of suicidal, borderline individuals are unbearable as they are currently being lived
- ▣ Patients must learn new behaviors in all relevant contexts
- ▣ Patients cannot fail in therapy
- ▣ Therapists treating borderline patients need support

Consider that problem behavior is exacerbated by:

- ▣ Treatable medical illness
- ▣ Co-existing mental illness
- ▣ Sequela of trauma
- ▣ Always consider substance abuse

Obtain a careful history

- ▣ What has been tried
- ▣ What has worked
- ▣ What has not worked.

Pharmacological Treatment:

- ▣ Difficult to prescribe for a patient who is impulsive, angry, and tends to have major issues with control.
- ▣ Patient may be abusing alcohol or drugs.

Elements of a medication trial:

- Collaborative relationship with shared treatment goals
- Identify specific target symptoms
- Discontinue medication if target symptoms do not improve

Monitor whether medication is working

- What does "getting better" mean?
- What does "getting worse" mean?
- Encourage use of daily chart or calendar
 - Identify 2 or 3 feelings/behaviors/activities that are treatment targets
 - Use a 1-10 scale
 - Rate every day

Medication decisions are never an emergency

- Patient education is critical
- Get clear agreement on what, for how long
- Never want a client to take medication more than the client wants to take the medication

Crisis Intervention is Critical

Crisis Vs ongoing life chaos

- Is this a crisis?
- Whom is this a crisis for?

Do not get overwhelmed by the client's sense of crisis.

Different models underlying medication use

- Biological trait model
- Subsyndromal model
- Co-morbidity or diagnosis model
- Symptom focused model
- Outcome focused model

Koenigsberg (1992)

Target of Medication

- Symptom
- Behavior
- Interpersonal strategy

Silk

Medication in Borderline Personality Disorder:
Mood stabilizers

- A. Divalproex Sodium (Depakote)
- B. Carbamazepine (Tegretal)
- C. Oxcarbazepine (Trileptal)
- D. Gabapentin (Neurontin)
- E. Lamotrigine (Lamactil)
- F. Topiramate (Topamax)

Divalproex may decrease impulsivity in
BPD

Hollander et al Am J Psychiat March 2005

- 12 week double blind controlled trial
- Improvement on Barratt impulsiveness scale and Overt Aggression scale
- Subjects with higher baseline impulsivity scores improved the most

Carbamazepine in BPD

- Gardner & Cowdrey (1986)--6 wk double blind crossover of carbamazepine 200 tid in 14 women with "pure" bpd.
- "Appeared to induce a state of "reflective delay".
- 11/14 of placebo discontinued treatment Vs 1/14 for carbamazepine
- Decrease in behavioral dyscontrol

Topiramate may decrease aggression in
BPD

Nickel et al, J of Clin Psych Nov 2004

- Double blind placebo controlled 8 week study
- N = 19 topiramate, 10 placebo
- Observed improvement in self-report scales
- Weight loss on the topiramate group

Lamotrigine for people with borderline disorder with
symptoms of affective instability and depression

- Retrospective chart review of 13 patients treated in a private practice
- GAS scores improved
- No controls, no randomness, no blindness

Weinstein and Jamison 2007

Medication in Borderline Personality Disorder:

Antidepressants

SSRIs

Salzman et al 1992 fluoxetine Vs placebo n = 24
improvement in depression, mood lability, anger, irritability

Other studies showed decrease impulsivity and self-mutilation

MAOIs

Suggested for "atypical depression" or "hysteroid dysphoria"

Parsons et al 1989: phenelzine, imipramine, Vs placebo
better response, and better response with more BPD sx
MAOI use not very problematic despite pt population

Risk of "rapid cycling"

Medication in Borderline Personality Disorder:

Traditional Antipsychotics

Goldberg et al 1986: random control of 50 patients with thiothixene 5 -40 mg

- **No overall difference, but decrease in psychotic like symptoms + phobic anxiety and OCD sx**

Soleff et al 1986: NTZ Vs haloperidol Vs placebo: haloperidol mean = 7.2 mg

- **Improvement in both psychotic like and depression**
- **Some patients seemed to get worse**
- **All studies had large drop out rates**

Typically use very low dose-may be less effective at full dose

Medication in Borderline Personality Disorder:

Atypical Antipsychotics

- Second generation agents better tolerated, better mood stability and help cognition relative to older medications
- Not FDA indicated. Research supporting the use of antipsychotics very limited
- Open studies and chart reviews generally much more positive than double blind random controlled studies

Risperidone in BPD

Khousam and Donnelly case report (1997): Women with 13 year hx of cutting herself whenever she felt "empty"

- **Previous trials of imipramine, nortriptyline, trazodone, fluoxetine, sertraline, paroxetine, lorazepam, cloanazepam, clorazepate, lithium, carbamazepine, valproate and methyphenidate**
- **Treated successfully with risperidone 4 mg/day, stopped cutting, obtained full time job.**

Clozapine with Borderline Patients

- Benedetti et al 1998: 16 week open study of 12 hospitalized patients
- Psychotic-like symptoms: paranoia, referential thinking, illusions, hypnagogic hallucinations, odd beliefs, magical thinking
- Dose 25-100 mg/day mean 43.8 mg/day
- BPRS change > 50 % in 4/12, > 25 % in 8/12

Alpha 2 Adrenergic Agonists

- Clonidine
- Guanfacine

Can decrease startle and overreaction symptoms of PTSD

Alpha 1 Adrenergic Antagonist

- Prasosin (Minipress)
- Terazosin (Hytrin)

Can decrease startle and overreaction symptoms of PTSD

Omega-3 fatty acid

- ❑ Double blind controlled study (20 women on omega-3, 10 on placebo)
- ❑ Reduced both depression and aggression in women with borderline personality disorder

Zanarini and Frankenburg, Am J Psych 160: 167-169, 2003

Medication in Borderline Personality Disorder:

Benzodiazepines

Use very rarely and very carefully

- ❑ Addiction
- ❑ Aggressive dyscontrol and rage reactions

Medication in Borderline Personality Disorder:

Medications for alcohol abuse

- ❑ Antabuse
- ❑ Naltrexone (ReVia)
Roth et. Al 1996: open trial with 7 patients without ETOH problems with analgesia and dysphoria:
 - ❑ 11 week follow-up:
 - ❑ 6/7 stopped self-injurious behavior
- ❑ Acamprosate (Campral)

Medication in Borderline Personality Disorder:

Stimulants

Comorbidity of Borderline and ADD

BPD describes a very heterogeneous group of people

Treatment planning is critical.

- A. Can allow the clinician to be proactive
- B. Involve the client

Risk

- ❑ There is no way to treat clients with borderline personality disorder without taking risks
- ❑ Need to balance short term Vs long term risks
 - **High lifetime risk of suicide.**
 - **Responding to each suicidal event may make it more difficult for people to stabilize their lives.**

Balancing risks

- ❑ Discussed carefully with the client
- ❑ The client's family
- ❑ Other members of the treatment team and support system

Clinical Suggestions:

- ❑ When you are stuck, enlarge the field
- ❑ Support the client's own competence whenever possible

Maintain Hope
