

Management and Effectiveness of Psychopharmacology in Emotionally Unstable and Borderline Personality Disorder

Kenneth R. Silk, MD

The article by Paton and colleagues¹ on the use of psychotropic medication in patients with emotionally unstable personality disorder (EUPD) in the current issue of JCP is an important article. Making the assumption that EUPD as defined by *ICD-10* (F60.3) is reasonably equivalent to borderline personality disorder (BPD) as defined in the United States by *DSM*, we are provided some insight into how practitioners think about prescribing medications to people with EUPD/BPD. The article not only offers information as to the class of medication these practitioners are using but also provides reasons why, ie, for what clinical signs and symptoms, the medications are being prescribed. Of course, this is not a one-to-one comparison, and we must try to infer things about psychiatric practice in the United States from this study of patients in self-selected psychiatric practices in the UK among patients not officially diagnosed with BPD according to the *DSM-IV-TR*,² the edition in effect when this study was performed.

Current Knowledge on Effectiveness of Medication in BPD

We possess little data as to how clinicians actually prescribe medications for patients with BPD or why they prescribe them. We do, however, have some information as to what classes of medications for what symptom or symptom complexes psychiatrists in the United States prescribed medications for people with BPD during 1996–1999, before the introduction of the American Psychiatric Association's BPD Guidelines^{3,4} in 2001. A study by Abraham and Calabrese⁵ in 2008 that reviewed MEDLINE publications of double-blind, randomized, controlled trials of medications in the treatment of BPD found, at least in research studies, that there has been a shift from studying selective serotonin reuptake inhibitors (SSRIs) to anticonvulsants (mood stabilizers) and atypical antipsychotics. While this shift reflected the classes of medications involved in systematic pharmacologic studies of BPD, their work did not reveal how practitioners were actually prescribing medications to BPD patients and may have reflected situations occurring in the research community rather than what was happening clinical practice. For example, of the systematic studies of BPD that occurred from 1998 forward, only 1 of 14 studied an antidepressant, while of the 9 studies conducted

before 1998, 6 examined antidepressant effectiveness. (One would not be surprised, however, to find a similar shift to atypical antipsychotic medication and/or mood stabilizers for a number of other psychiatric diagnoses, a shift that might be more reflective of which classes of medications still had compounds that were proprietary and thus had manufacturers willing to invest in systematic studies rather than the result of unique findings in the pharmacologic treatment of psychiatric disorders.) This finding of a shift in prescribed medication classes in BPD has been supported as well by a review by Belli and colleagues⁶ in 2012.

Saunders and Silk⁷ and Silk and Feurino⁸ examined systematic reviews and meta-analyses of double-blind, randomized, placebo-controlled trials of pharmacologic treatment in BPD and found that the evidence suggests, except when there is a bona fide concurrent major depressive episode (MDE), that SSRIs have little evidence for effectiveness in BPD. Most of the evidence supports use of mood stabilizers, especially in the face of emotion dysregulation and perhaps in impulsivity and aggression, and the use of atypical antipsychotics medication where there is evidence of cognitive-perceptual disturbances and distortions. They may have some effectiveness in impulsivity and aggression as well.^{7,8} The 8 different systematic reviews and meta-analyses that carefully review these various studies examined a subset of the same 23 or so randomized controlled trials with only 1 drawing from less than 18 of the 23 studies.⁸ Yet despite these reviews and meta-analyses examining the same set or subset of studies, these reviews do not come to similar conclusions about which medication or medication classes to employ for what symptom or symptom complex. They do trend in the direction of increasing support for the use of mood stabilizers and atypical antipsychotics in lieu of SSRIs, except in the presence of a full comorbid MDE. But each of the specific medications within a medication class is not thought to be equally effective.

Nonetheless, medications are used in these patients. The article here reports that 82% of those who had only a personality disorder diagnosis but 94% of those having both a personality disorder and at least 1 other psychiatric diagnosis were given psychotropic medication. What is important in the current study is that among those who had only the diagnosis of EUPD ($n = 786$), 28% were taking medications from 2 different medication classes, 23% from 3 classes, and 16% from 4 or more classes.¹ Unfortunately, this is not dissimilar to the 16-year data recently reported from the McLean Study of Adult Development.⁹ After 16 years of prospective follow-up, 71% were still taking psychotropic medication, with 35.5% taking 3 or more concurrent

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Corresponding author: Kenneth R. Silk, MD, Department of Psychiatry, University of Michigan Health System, Rachel Upjohn Bldg–Box 5769, 4250 Plymouth Rd, Ann Arbor, MI 48109-2700 (ksilk@umich.edu).

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medications, 18.6% taking 4 or more, and 6.9% taking 5 or more psychotropic medications.⁹ Rates of some categories of medications such as antidepressants fell over those 16 years (for SSRIs, tricyclic antidepressants, and monoamine oxidase inhibitors). Use of conventional antipsychotic medications fell, while atypical antipsychotic medication grew but then leveled off. Rates of mood stabilizers fell in the first 6 years of follow-up but increased in the eighth year and remained essentially stable for the next 8 years.¹⁰ These figures then also reflect the shift away from antidepressants and toward mood stabilizers and antipsychotics.

Managing Treatment of BPD

Despite the lack of good consistent evidence for the effectiveness of medications in the treatment of BPD, they continue to be used.^{9,11} But are they being used correctly? There is little evidence for the effectiveness of any single medication in this population and no evidence for the use of multiple medications. One can appreciate that people with BPD are in significant psychological pain and complain about a wide array of symptoms. Although patients are often in a desperate condition when they present to us, and they plead with us to help them and to make things better because of unbearable emotional pain,^{12,13} one must question whether simply adding (more) medications to the combination already not controlling the pain is a wise move.

Most guidelines for the pharmacologic treatment of BPD assign medications an adjunctive role to psychotherapy.² The UK NICE Guidelines¹⁴ are skeptical of the value of medications in BPD and suggest that if they are used at all, that they be used only for a short time. Chronic use of polypharmacy has no evidence of effectiveness, but it probably does lead to side effects and a propensity for significant weight gain. Weight gain cannot be helpful in a population of patients who are 75% female and who struggled with issues of self-esteem long before medication treatment.

Management Options to Avoid

There is a need for us to educate people on what they should *not* do when trying to manage (this is more a management than treatment issue) medications with BPD patients.¹⁵ Medications should be given cautiously. We should resist in most instances augmentation of one medication with another. Rather, we should take away a medication before changing to another. We should allow enough time with the patient on the medication to determine if it is useful; often we can only determine whether a medication has been helpful after taking it away or after people who regularly deal with the patient have input. We should not confuse the chronic unhappiness and loneliness and emptiness of BPD with major depression, and thus we need to restrain ourselves from trying to “break” pharmacologically a depression for which there is little evidence of response to psychopharmacology.¹⁵ We should refrain from medication changes or additions in times of crises, because most often the crises pass quite quickly and the medication may falsely be given credit for

the crisis passing. In general, there should be, from early in treatment, a discussion of how psychopharmacologic agents will be used. The establishment of an open collaborative framework around which medications are discussed may be more important than the actual medication chosen.

Future Direction

It is interesting that we use so many medications in so many combinations in a disorder where the role of medication is uncertain and our knowledge about the impact of any medication on the overall course of the disorder is nonexistent. While we may grow up in a society of excess, where more is often confused with better, we need much more information about if and how medications are useful in the treatment and management of BPD before we begin to use them in the numbers and the manner that we have been using them for years.

Author affiliation: Department of Psychiatry, University of Michigan Health System, Ann Arbor.

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