Not Just a Simple Treatment: Understanding BPD

Aubrey Levin, MB, CHB, MD, DPM, MRC (Psych)
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Borderline personality disorder (BPD) is the most treatable personality disorder. At least 2% of the population suffers from BPD. Proportionately, women are affected more by BPD; although, the gender bias is equalizing. However, BPD may also be increasing.

Possible etiological factors are:

- childhood abuse,
- neglect,
- powerlessness and
- lack of validation.

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Meet Rob

Rob is a 22-year-old single man who presents with:

- a poor work history,
- emotional lability,
- irritability,
- anger,
- depression,
- lack of trust in new relationships and
- impulsivity with:
  - spending sprees,
  - sexual hyperactivity and
  - substance abuse
- Rob has a low stress and frustration tolerance and he experiences blackouts following episodes of rage
- He is frequently suicidal, but *slashes* to relieve stress
- Rob changes doctors frequently, he seeks second opinions or gets several medications from different doctors (double dipping)
- Rob has poor reactions to treatment with benzodiazepines and hypnotics
- The best medications for Rob have been mood stabilizers, such as valproates, anti-depressants, such as selective serotonin reuptake inhibitors (SSRIs) and third generation neuroleptics
- Rob discontinues or increases medication on his own

For the rest of Rob's case, turn to page 87.

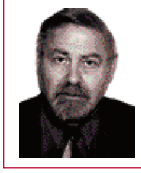
Table 1

Criteria for BPD

1. Frantic efforts to avoid real or imagined abandonment
2. Pattern of unstable and intense interpersonal relationships by alternating between idealization/devaluation
3. Identity disturbance with markedly and persistently unstable self-image or sense of self
4. Impulsivity that is potentially self-damaging in at least two areas, such as:
   - spending,
   - sex,
   - binge eating,
   - abuse of drugs and
   - driving recklessly
5. Recurrent suicidal behavior gestures, threats or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (*e.g.,* intense episodic dysphoria, irritability or anxiety [lasting a short time])
7. Chronic feelings of emptiness
8. Intense inappropriate anger
9. Transient stress-related paranoid ideation or dissociative symptoms

BPD: Borderline personality disorder

BPD is defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, as "A pervasive pattern of instability of interpersonal relationships, self image and affects and marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five or more of nine criteria" (Table 1). Additional criteria are outlined in Table 2.



Dr. Aubrey Levin is a Clinical Professor in the Department of Psychiatry at the University of Calgary, Alberta.

Table 2

Criteria for BPD not included in the DSM-IV

- Atypical auditory hallucinations
- Micropsychotic episodes
- Sensitivity to situational circumstances
- Feels and fears a lack of nurturing
- Have inanimate or transitional objects like teddy bears

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

Table 3

Management of BPD

1. Social learning

   Individuals will avoid situations that they cannot handle (*e.g.,* intense relationships)
2. Crisis intervention

   Patients will utilize psychiatric emergency services during crisis periods, which are often the only time that these patients present themselves
3. Short-term hospital stay
4. Psychotherapies: dialectical behavior therapy (DBT) or interpersonal psychotherapy (IPT)
   - DBT: techniques of acceptance and validation designed to enable the patient to learn more adaptive ways of dealing with their difficulties and acquiring the skills to do so. DBT focuses on present behavior and the current factors that are controlling behavior
   - IPT: encouraging, *inter alia*, interpersonal skills to improve coping

FAQ

Why not use psychotherapy as the first-line or only treatment?

Before trust is ever achieved, BPD patients require relief of symptoms, which first requires appropriate medication. Thereafter, psychotherapy can be more easily initiated.

Back to Rob

In Rob's case, IPT was initially very helpful, but as we started making headway, he felt that he had been too trusting and that he had revealed too much. As a result, he stopped attending regularly.

Eventually, only superficial supportive therapy could be provided together with medication taken inconsistently. However, his depression has lifted and his employment record and relationships have improved.

FAQ

Can BPD ever improve?

By increasing trust in the FP, applying pharmacotherapy, psychotherapy and crisis intervention, symptoms lift. However, with age, BPD tends to improve (Table 3).

FAQ

Should benzodiazepines and hypnotics (e.g., clonazepam and zopiclone) be used for stress relief?

Rather than using potentially dependency-producing and disinhibiting compounds to relieve stress, one should include:

- mood stabilizers,
- anti-depressants, or
- third generation neuroleptics and
- psychotherapy (Table 4).

Take-home message

1. BPD is the most amenable of the personality disorders using a combination of pharmacotherapy and psychotherapy
2. BPD is often:
   - misunderstood and
   - inadequately treated
3. With appropriate care, the suicide risk, the emotional suffering and anger, can be markedly reduced and BPD can be successfully managed

Table 4

Pharmacotherapy

Mood stabilizers

- Valproate
- Lithium (risks) or
- Gabapentin

Anti-depressants

- SSRIs, especially escitalopram
- Monoamine oxidase inhibitors, especially RIMA like moclobemide or mirtazapine

Neuroleptics (lower dosage)

- Second generation with anti-depressant qualities, such as quetiapine, olanzapine or zuclopenthixol

Anxiolytic

- Buspirone

Agents to avoid

- Benzodiazepines they cause disinhibition
- Older neuroleptics: can cause abnormal involuntary movements and could increase depression

The etiology of BPD has not been clearly established. Psychopharmacotherapy is still being assessed and uses off label treatments, although a great deal of research is being done on the biological factors and treatment.

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Resources

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