DISCLOSURES

- I receive royalties from the American Psychiatric Press, Cambridge University Press, Up-to-Date
- I am one of 3 Co-editors-in-chief of *Personality and Mental Health*, a journal owned by Wiley-Blackwell
- I will talk about the off-label use of psychiatric medication
No medications carry a specific indication for use in treatment of personality disorders

Thus all medications must be used “off label” though not uncommon (in U.S.) to use medications off-label

Medications for BPD are less effective for symptom or symptom complex than when used in other disorders (primarily Axis I)

BPD patients seem exquisitely sensitive to side effects
NEVERTHELESS WE TREAT PERSONALITY DISORDERS PHARMACOLOGICALLY

- CLPS* – 81% (of patients w/ personality disorders)
- Zanarini et al**: 
  - 78% BPD on meds >75% over 6 years
  - 68% OPD on meds > 75% over 6 years
- 71% BPD still on meds at 6 years
- 54% OPD still on meds at 6 years
- BPD 51%, OPD 22% on 2 or more meds at 6 years
- BPD 37%, OPD 8% on 3 or more meds at 6 years

Patient exhibits suspiciousness, referential thinking, paranoid ideation, illusions, derealization, depersonalization, or hallucination-like symptoms

Initial Treatment: Low-Dose Neuroleptic
(e.g., perphenazine, 4–12 mg/day
trifluoperazine, 2–6 mg/day
haloperidol, 1–4 mg/day
olanzapine, 2.5–10 mg/day \(^b\)
risperidone, 1–4 mg/day \(^b\))

Efficacy
  ↓
Continue

Partial Efficacy

No Efficacy

Increase Dose
(e.g., perphenazine, 12–16 mg/day
trifluoperazine, 5–15 mg/day
haloperidol, 4–6 mg/day)

Partial Efficacy

No Efficacy

Prominent Affective Symptoms
Add

SSRI (or MAOI)
Continue

Few Affective Symptoms
Switch

Atypical Neuroleptic or Clozapine

“Pharmacotherapy often has an important adjunctive role, especially for diminution of targeted symptoms such as affective instability, impulsivity, psychotic-like symptoms, and self-destructive behavior. However, pharmacotherapy is unlikely to have substantial effects on some interpersonal problems and some other features of the disorder.....Clinical experience indicates that many patients will benefit most from a combination of psychotherapy and psychopharmacology.”

-APA Guidelines, 2001, p. 10
COMMON STUDIES - BPD
AD, MS, AP, vs PLACEBO, (NO OMEGA-3)

- Bogenschutz, Nurnbg, 2004
- Coccaro, Kavoussi, 1997
- Cowdry, Gardner, 1998
- De la Fuente, 1994
- Frankenburg, Zanarini, 2002
- Goldberg, 1986
- Hollander, 2001
- Hollander, 2003/2005
- Leone, 1982
- Loew, 2006
- Montgomery, 1983
- Nickel, 2004
- Nickel, 2005
- Nickel, 2006
- Pascual, 2008
- Rinne, 2002

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● Salzman 1995  
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● Simpson 2004  
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● Soler 2005  
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● Soloff 1993  
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● Soloff 1989  
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● Tritt 2005  
Dug WF ING NOSE COCHL TOR NICE VITA

● Zanarini, Frankenburg 2001  
Dug WF ING NOSE COCH COCHL TOR NICE

● 23 COMMON STUDIES

● Ingenhoven – 21  
<1998 9

● Cochrane-Lieb -25 = 2 Omega-3s  
1998-2005 11

● Cochrane – Binks – 10  
>2005 3

● Mercer – 18

● Nose – 22

● WFSBP - 21

● Duggan – 22

● Saunders – 20

● Vita 17
DIMENSIONS OF PSYCHOPATHOLOGY

- **Affective Instability**: abandonment, affective instability, capacity for pleasure, depression, emptiness, euphoria/mania, identify disturbance, interpersonal sensitivity, irritability, rejection sensitivity, suicidality

- **Anxiety inhibition**: general anxiety, anxiety – intropunitiveness, obsessive-compulsive score, phobic anxiety, somatization

- **Cognitive perceptual**: paranoid ideation, perceptual distortion, psychoticism-schizotypy

- **Impulsivity/Aggression**: aggression, anger, hostility, impulsiveness

## CONVERGENT (OR CONTRADICTORY) EVIDENCE

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WHERE DOES THIS LEAVE US?

- Probably consider a revision
- Greater role for MS and AP with diminished role for AD (Abraham & Calabrese, 2008)
- The role of psychopharmacology is still adjunctive to psychotherapy
- Need to consider the algorithm, whatever its current decision tree, as iterative
- Many contradictions remain

Patient exhibits mood lability, rejection sensitivity, inappropriate intense anger, depressive “mood crashes,” or outbursts of temper

Initial Treatment: SSRI or Related Antidepressant

- Efficacy
  - Maintenance
- Partial Efficacy
  - Switch
- No Efficacy

Second SSRI or Related Antidepressant

- Efficacy
  - Maintenance
- Partial Efficacy
  - Add
- No Efficacy

Add:
Low-Dose Neuroleptic (for symptoms of anger), Clonazepam (for symptoms of anxiety)

(if ineffective) Switch to MAOI

- Efficacy
  - Maintenance
- Partial Efficacy
  - Add
- No Efficacy

Switch to MAOI

Lithium, Carbamazepine, or Valproate

* Caution should be used when augmenting to minimize polypharmacy

Angry/Labile – MS/ AP
Depressed – SSRI, AP

Augment* – AP w/ MS
Augment* – AC w/ AP
Depression--?????
**IMPULSE AGGRESSION**

Patient exhibits impulsive aggression, self-mutilation, or self-damaging binge behavior (e.g., promiscuous sex, substance abuse, reckless spending)

Initial Treatment: SSRI
(e.g., fluoxetine, 20–80 mg/day
sertraline, 100–200 mg/day)

- Efficacy → Maintenance
- Partial Efficacy → Add
- No Efficacy → Switch

Low-Dose Neuroleptic

- Efficacy → Maintenance
- Partial Efficacy → Add
- No Efficacy → Switch

Lithium Carbonate
(If ineffective) → Switch to Carbamazepine or Valproate

OR

MAOI
(If ineffective) Add Lithium; Switch to Carbamazepine or Valproate if Lithium is Ineffective

- Efficacy → Maintenance
- No Efficacy → Add
- Efficacy → Maintenance

Atypical Neuroleptic

MS or AP (low dose)
AP-w/ AD qualities
MS-Topiramate?

* Caution should be used when augmenting to minimize polypharmacy

Augment * w/ other (AD or MS)
"COGNITIVE PERCEPTUAL"
Our review (Saunders & Silk, 2009)

- Out of 20 studies, only 3 had more than 100 subjects and most (13) had less than 50.
- 73% of the subjects are women.
- 16 different instruments for affective instability.
  - 6 for Anxiety-Inhibition
  - 7 for Cognitive-Perceptual disturbances
  - 16 for Impulse, Impulsive-Aggression

DO MEDICATIONS WORK HERE?

- The best we can say is that they remain non-specific in their response.
- There is a high placebo response rate in clinical trials.
- Sometimes we can’t appreciate that the medications are working until we experience the patient in the absence of the medication.
- No long-term studies.
- No continuation studies.
POLYPHARMACY DANGER

- Potential for polypharmacy exists
  - Especially when the psychopharmacologist is over-enthusiastic
  - Believes that medications can and will cure if only the right combination can be found
    - “The less than completely responsive patient meets increasing forms of sadism disguised as treatment” – T.F. Main, 1957
- What polypharmacy can guarantee are drug-drug interactions and weight gain
These people are in real pain
Their ability to express that pain verbally and behaviorally can at times be profound
These people can have serious problems with impulsivity, self-destructive behavior, and suicidality
This is America and more is always better
We live in an age where augmentation of one medication with another is \textit{de rigueur}
Often we are trying to rid the patient of “depression” or at least to reduce it “even more”
DECIDING ON A MEDICATION

- What’s happening in patient’s life at that moment?
- Is there a symptom or symptom complex reminiscent of an Axis I disorder?
- Is there evidence for positive medication effect for that symptom/symptom complex in Axis II?
  - e.g. depression, panic
- Try to distinguish true Axis I episode from emotion dysregulation
- Try to distinguish a true major depressive episode from chronic dysphoria, loneliness, emptiness
- Always consider co-morbid substance misuse
DECIDING ON A MEDICATION

“If there were two medications, one for depression and one for moods bouncing around, and if you could only take one, which one would you choose?”

- No evidence that two medications work better than one for any symptom
- No evidence that two medications within the same class of medications work better than one
THANK YOU FOR YOUR ATTENTION!!