Abstract – First-line treatment for borderline personality disorder is psychotherapy. However, medication can play an important supportive function. Especially feelings of emotional instability, existential fears about loss of a relationship and co-morbid depression can be addressed with medication often quite successfully.

Keywords: borderline personality disorder, BPD, medication, psychiatry
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The Feeling of Instability

Borderline Personality Disorder is very much about the feeling of instability and dependency. The sense of self feels fragile and deficient, which can lead to the perception of an inner void. Characteristically, there is a need for a very close relationship, sometimes even a need for fusion with the other, yet an intense fear of closeness, instability in one’s professional life, and a tendency to see people and situations as either idealising good or very bad. This lack of stability is linked to a sense of self, which at times can be become fragmentary, and there can be an intense existential fear of ‘losing oneself.’

Psychotherapy

Psychotherapy is the first line approach in treatment. The objective is to rediscover the inner resources, the values and basic interests, which remain constant over time and can provide a greater sense of stability with respect to oneself. This rediscovery can also mean confronting situations in the patient’s life which are out of sync with the closely held values, interests and
his or her resources. The consequential adjustment process can cause fears and anxiety, and therapy should be supportive in this respect.

**Medication**

Medication can be an important support to reduce the fear and anxiety, add a greater sense of stability about oneself and increase the mood. Primarily, antidepressants are used that are selective for the serotonin (SSRIs). However, sometimes, the addition of an antipsychotic, preferably from the second-generation group, may become necessary if psychosis-like symptoms occur, and if the sense of self becomes too weak to keep the patient firmly grounded in a shared reality.

**Selective Serotonin Reuptake Inhibitors (SSRIs)**

Selective serotonin reuptake inhibitors are antidepressants which help reduce anxiety, increase the mood and give the patient a greater sense of stability and internal coherence. They take a couple of weeks, in BPD sometimes months or occasionally even half a year. Other people may notice small improvements even before the patient does.

**Initial ‘Worsening’**

In some cases, as access to the own emotions improves and the patient feels them more intensely, partly because inhibitions in the shape of fear and anxiety decrease, there may even be a greater experience of sadness and other potentially painful emotions. However, reconnecting with the own emotions and becoming able to describe and explain them is usually a good sign that a patient is making progress.

A common approach is to use SSRIs in higher doses, e.g. sertraline 150mg. For suitable SSRIs a good dose is three times the minimum maintenance dose, such as sertraline 150mg, fluoxetine 60mg and so on, as long as the medication is approved for use in that dose. Escitalopram 30mg, for example, would be an off-label use, although this SSRI has been used in doses of up to 50mg in research.

**Mechanism**

There is little clear data on how and to what extent SSRIs work in cases of borderline disorder. However, clinical observation shows in many cases that they can be helpful in giving patients
suffering from borderline personality disorder more stability in their emotions and consequently in their personal and professional life.

Second Generation Antipsychotics (SGAs)
There is some evidence for beneficial effects by second-generation antipsychotics, mood stabilisers and omega-3 fatty acids, while the overall evidence base is still unsatisfying. [1]

Any antipsychotic, including older ones like haloperidol, can be helpful when the symptoms become psychosis-like, and/or the patient is agitated or highly anxious. However, because first-generation antipsychotics, including haloperidol, are usually considered less safe with respect to potential (long-term) side effects, second generation antipsychotics should usually be preferred, if possible. There may not be a choice and one has to use antipsychotic. However, this should be in the minority of cases. Two considerations should be kept in mind.

Side Effects
Firstly, antipsychotics generally have more serious potential side effects than the SSRIs. While the risk for serious side effects like tardive dyskinesia is quite low in most SGAs, including risperidone in lower doses, they can persist, even after the medication is discontinued. Among the more common side effects are weight gain (particularly olanzapine), sedation (often quetiapine), or an emotional numbness, which can occur with every more potent antipsychotic.

Serotonin Syndrome
Secondly, adding an antipsychotic with an affinity for the serotonin system to an SSRI can, at least in theory, increase the risk of the serotonin syndrome, which can be fatal. Cases have been reported and patients should be made aware that they should contact the prescriber immediately if they develop symptoms of it, which can include fever and gastrointestinal pains.

QT Prolongation
A possible combined effect of an SSRI and a second generation antipsychotic on the QT interval (QT prolongation) requires in many cases that an ECG is made before administering these substances.
Other Substances

Research trends indicate increasing attention to alternative treatments such as dietary supplementation by omega-3 fatty acids or oxytocin. [1]

The Combination of Psychotherapy and Medication

Psychotherapy and medication should reinforce each other synergistically, rather than be in conflict. This requires a good working relationship between psychotherapist and prescriber, if it is not the same person, particularly in patients with BPD who have a tendency for splitting and seeing, alternatively, one person as all good and the other person as all bad, which can affect the working relationship among the treating professionals. Thus, communication among healthcare professionals is as important as a good communication and a stable and trusting relationship between them and the patient.
References

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