Treatment-Resistant Borderline Personality Disorder

by GLEN O. GABBARD, MD

The optimal treatment of patients with borderline personality disorder (BPD) generally involves a combination of medication and psychotherapy. Currently, there are no rigorous empirical studies documenting the efficacy of combined treatment, but a growing number of studies suggest that both psychotherapy and pharmacotherapy independently produce significant changes in a variety of symptoms associated with BPD. In a randomized, controlled trial, dialectical behavior therapy (DBT) during a 12-month period reduced the need for hospitalization dramatically and decreased the frequency and severity of parasuicidal behavior. Studies of psychodynamic therapy, using a "follow along" or "pre-post" design, have suggested that patients with borderline and other severe personality disorders may benefit from treatments of that nature as well. A number of psychopharmacologic agents have been shown to improve specific target symptoms associated with BPD. Because of the protean nature of BPD, much of the research has been directed at specific clusters of target symptoms. These are often divided into symptoms of affective dysregulation, symptoms involving psychotic or cognitive perceptual distortions, and symptoms manifested by impulsivity or loss of control. Selective serotonin reuptake inhibitors (SSRIs), lithium, antiseizure medications, both typical and atypical antipsychotics, and monoamine oxidase inhibitors have all been shown in controlled studies to be useful in controlling one or more of these symptom areas. Although the effects are modest, symptomatic improvements resulting from pharmacotherapy may usefully facilitate the patient's capacity to engage in psychotherapy.

There is no consensus regarding which characteristics constitute treatment-resistant status in patients with BPD. Patients in this diagnostic category are generally regarded as rather difficult to treat. In a retrospective chart review of more than 2,000 patients, Howard et al. noted that whereas 50% of depressed and anxious patients are improved in 8 to 13 sessions, similar levels of improvement in BPD patients require 26 to 52 sessions. Some do not improve until the second year of treatment. Hence, a fairly significant trial of treatment is required before such patients can be designated as treatment resistant. In the absence of consensually held criteria, I would suggest the following characteristics as possibly emblematic of treatment resistance: (1) little or no improvement after 1 year of competent psychotherapy; (2) no improvement in target symptoms after sufficient trials of two different psychopharmacologic agents specifically suited for those symptoms; (3) a repeated pattern of dropouts from psychotherapy; and (4) pervasive noncompliance: many absences from psychotherapy and refusal to take medications as prescribed.

TEMPERAMENT AND CHARACTER

The approach to the treatment-resistant borderline patient depends on a thoughtful integration of psychotherapy and pharmacotherapy. This biopsychosocial strategy reflects our contemporary understanding of personality as involving both biologically based temperament and psychosocially based character. Cloninger et al. have constructed a psy-
chobiologic model of personality involving four dimensions of temperament and three dimensions of character. Within this model, approximately 50% of personality can be attributed to temperament, which is heavily influenced by genetic variables, and approximately 50% is accounted for by environmental variables (Table 1).

The four dimensions of temperament are: (1) novelty-seeking, characterized by frequent exploratory activity in response to novelty, impulsive decision making, extravagance in the approach to cues and reward, quick loss of temper, and active avoidance of frustration; (2) harm-avoidance, which involves pessimistic worry about the future, avoidant behavior such as fear of uncertainty and shyness regarding strangers, and rapid fatigability; (3) reward-dependence, characterized by sentimentality, social attachment, and dependence on approval of others; and (4) persistence, which refers to the capacity for perseverance despite frustration and fatigue. These dimensions are 50% to 60% heritable (independently of one another), manifest themselves early in life, and involve preconceptual biases in perceptual memory and habit formation.

Certain temperaments are characteristic of specific types of personality disorders. Cluster A personality disorders are strongly associated with low reward-dependence. Cluster B patients tend to be high in novelty-seeking. Cluster C patients are high in harm-avoidance. BPD patients are unique in being high in both novelty-seeking and harm-avoidance.

The three dimensions of character are shaped by family and social influences, trauma, and stressors in the environment. Self-directedness involves acceptance of responsibility for one’s choices rather than blaming others, acceptance of self, resourcefulness, and the identification of life goals and purposes. Cooperativeness is a measure of object relatedness and taps such dimensions as empathy, helpfulness, coopera-
sion, and social acceptance. Self-transcendence refers to the individual’s spiritual acceptance, identifications beyond the self, and altruistic pursuits.

Cloninger et al. found that the character dimensions of self-directedness and cooperativeness are critical factors in the diagnosis of personality disorder. In fact, low self-directedness and low cooperativeness are associated with all categories of personality disorder. Whereas temper-ament is highly stable over time, even with psychotherapy, character is malleable and develops throughout adulthood.

Failure to make the distinction between temperament and character may be a crucial factor in “treatment resistance.” Our advance in knowledge is allowing us to develop the capacity to target certain temperament symptoms, such as impulsivity and affective lability, with increasing specific psychopharmacologic agents. At the same time, the patient’s problems with self-directedness and cooperativeness, character dimensions that determine the presence of personality disorder, can be approached psychotherapeutically. In the ensuing discussion, I outline strategies for dealing with temperament and character separately, with the full knowledge that the two must be integrated in practice.

PSYCHOTHERAPEUTIC STRATEGIES

Psychotherapy is tailored to the problems occurring in the realm of self-directedness and cooperativeness. These terms readily lend themselves to more typical conceptual terms used by psychotherapists, such as internal object relations, self-esteem, ego functions, schema, and cognitive distortions. It is useful to think about the character dimension of the BPD patient as involving an ongoing attempt to actualize certain patterns of internal object relations in a current relationship. Through his or her behavior, the patient subtly tries to impose a certain way of responding and experiencing on others, including the clinician. For example, I once entered the waiting room to introduce myself to a patient referred to me for a consultation. As I extended my hand, the middle-aged female patient with BPD rolled her eyes and exclaimed, “Oh, my God! I can’t believe they referred me to a male consultant! I hate men!” Once I had invited her into my office, she continued to berate me for not knowing the details of her history as described in the medical record. I found myself becoming increasingly irritated with her and wanting to make provocative and sarcastic remarks, which would then, of course, confirm her negative view of male consultants.

Through this brief vignette one can see how fixed character traits in the patient may be viewed as playing a role in actualizing an internal object relationship that is repeatedly played out in the patient’s interactions with others. The transference-countertransference dimensions of the clinical interaction provide a privileged glimpse of the typical patterns of relatedness.
that cause difficulties in the patient’s outside relationships. Even negative relationships involving a “bad” or tormenting object may provide safety and affirmation for a variety of reasons. In other words, for a child who is abused or neglected, a neglectful or abusive relationship may be safe in the sense that it is preferable to having no object at all or being abandoned. It is also predictable and reliable and provides the child with a sense of meaning and continuity.\textsuperscript{12}

The repetitive interactions seen in BPD patients may involve actual objects from the past, but they may also involve wished-for relationships, such as those often seen in patients with childhood trauma who seek a rescuer. Clinicians who are influenced by the patient’s interpersonal pressure to respond in a particular way may unconsciously accept the role in which they have been cast. They may also ignore or reject it. They may even defend against it by assuming an opposite stance. Confronted with a patient’s contempt, the clinician may choose to be saintly and empathic in an effort to transcend the hatred generated by the patient. In this conceptual model of character, the clinician needs to maintain a free-floating responsiveness\textsuperscript{12} to the patient’s provocations as a way of diagnosing and understanding the patient’s usual mode of object relatedness in life outside of the treatment situation. The psychotherapist’s task is to clarify the nature of these unconscious relational patterns and make them understandable to the patient.

One of the major difficulties encountered in the psychotherapy of borderline patients is the therapist’s countertransference problems in dealing with the onslaught of anger and rage from the patient. The therapist may be helped by recognizing and empathizing with the patient’s need to have a “bad” object in the environment. This provides a predictable mode of object relatedness and may be the only means for the patient to attach to others. If the therapist resists the patient’s efforts to transform him or her into a hated object, the patient may simply escalate the uncooperative and contemptuous behavior until the therapist is eventually so exasperated that the countertransference irritation can no longer be concealed. The psychotherapist’s optimal strategy is to allow the transformation into an attenuated version of the “bad” object while maintaining a reflective stance about it so that the interaction can be processed with the patient constructively. For example, with the middle-aged patient on whom I consulted, I made the following observation: “I get the feeling that it’s very important for you to provoke me into being angry with you so that you can confirm that male clinicians are neither competent nor professional. I wonder if I’m observing a pattern that occurs in other male relationships.” In this manner the clinician attempts to help the patient open up a reflective space where the unconscious and habitual interactions with others can be contemplated and understood. Over and over again the therapist must bring these interactions into the patient’s awareness and not simply enact them without reflection.

PHARMACOTHERAPY

Medication and psychotherapy work synergistically with borderline patients. Temperamental variables such as temper outbursts may be successfully modified with medications such as lithium or SSRIIs, but these medications will not change self-concepts or internal object relations. Data are accumulating on the specific effects of SSRIIs in BPD patients. In a 14-week double-blind, placebo-controlled trial in 31 outpatients, Markovitz\textsuperscript{14} found a broad range of improvements in the group treated with fluoxetine versus the group treated with placebo. Those receiving fluoxetine showed significant positive changes in depression, anxiety, paranoia, psychoticism, interpersonal sensitivity, obsessiveness, and hostility. Improvement in these dimensions was not limited to patients with comorbid affective disorder, suggesting that the changes were not simply the result of an improvement of depression. Salzman et al.\textsuperscript{15} also found that anger improved significantly in BPD patients who used fluoxetine as compared with controls. Although anger improved in the study by Salzman et al. with an average dose of only 40 mg, Markovitz’s patients required doses of 80 mg/d. Lower doses were not effective. Markovitz’s patients appeared to have more serious psychopathology and higher degrees of obsessiveness, which may serve as a guide to adjusting the dose.

These recent studies of the use of SSRIIs in BPD suggest that the temperament may be responding to the medication rather than an Axis I depression. Gunderson and Phillips\textsuperscript{16} and Rogers et al.\textsuperscript{17} have distinguished between the characterologic depression of BPD patients and the more classic unipolar depression. The former is characterized by emptiness; feelings of neediness and anger; recurrent suicidal gestures; and demanding hostile, dependent relationships. By contrast, the unipolar depression is more likely to have features of guilt, remorse, suicidality without gestures, a history of stable relation-
ships, and a concern with defeat and failure.

Further support for the notion that SSRIs treat an underlying temperamental disposition involving impulsivity rather than true depression in patients with BPD comes from a recent study of the impact of fluoxetine on impulsive-aggressive behavior. In this investigation, 40 patients with personality disorders were identified who did not have comorbid depression or another affective disorder. In a double-blind, placebo-controlled study, daily doses of 20 to 40 mg of fluoxetine were administered. Those who received the active agent had statistically significant reductions in impulsive-aggressive behavior, mainly verbal aggression and aggression against objects, rather than assaultive behavior.

Not all patients with BPD respond well to fluoxetine. Soloff has developed algorithms to guide the practitioner in considering alternative treatments. In the area of affective dysregulation, if the first SSRI tried appears to be ineffective or only partially effective, there are some data supporting switching to another SSRI with the expectation that some patients who do not respond to the first will respond to the second. Moreover, those SSRIs that act on multiple transmitters, such as nefazodone or venlafaxine, may be effective when a pure SSRI is not. Markovitz suggests that pushing some of these agents into a high-dosage range may be necessary before optimal response is obtained.

If there is still only minimal improvement in the area of affective dysregulation, a low-dose neuroleptic may be added for anger or clonazepam may be added if anxiety is a major difficulty. Alprazolam should be avoided because of its tendency to produce disinhibition in BPD patients. Clonazepam does not seem to produce the same side effect. Of course, clonazepam also increases sedation, which may account for its usefulness as an augmenting agent.

If affective dysregulation continues to be a major problem, the clinician may wish to switch to a monoamine oxidase inhibitor (MAOI). These agents have long been found to be effective in some BPD patients, especially those with paradoxic symptoms, such as hypersex or hyperphagia. Clinicians must use MAOIs with considerable caution. BPD patients are notoriously noncompliant with treatment regimens, and a special diet is required to avoid life-threatening side effects when a patient is taking an MAOI. In general, the clinician's therapeutic alliance with the patient must be extremely sound and well established for the clinician to be willing to take the risk of prescribing MAOIs. The patient must be educated about the diet, and there must be an understanding that the patient will call the clinician before acting impulsively.

If the patient's principal symptomatology involves the impulsive behavioral domain, an SSRI would still be the agent of choice to initiate the pharmacotherapy. As noted previously, if there are obsessional symptoms or severe pathology, the dose of fluoxetine may need to be pushed up as high as 80 mg before concluding that it is not effective. Binges with food, sex, spending, or substance abuse may be among the behaviors that need to be monitored. Others include explosive temper tantrums, reckless behavior, self-mutilation, and self-mutilation. If these behaviors are not toned down by an SSRI, the clinician should consider a low-dose neuroleptic. If the results remain unimpressive, Soloff recommends adding lithium carbonate or switching to an MAOI. In the case of patients who are complying with the treatment but still have little improvement, lithium may be added to the MAOI, and either valproate or carbamazepine can be tried if lithium is not working. Both valproate and carbamazepine must be considered experimental at this stage. There is some evidence that carbamazepine is effective in reducing behavioral dyscontrol in BPD patients, but patients often do not notice much change. There are no controlled studies on valproate, although open trials suggest a reason for optimism regarding its usefulness. In the event that antiseizure medications are ineffective, atypical antipsychotics may be tried as a last resort for impulsive behavioral symptoms.

The other symptom domain that is likely to be influenced by judicious use of medication is the cognitive perceptual area. It is now well established that BPD patients can slip into brief psychotic episodes characterized by paranoid ideation and ideas of reference. They may also have depersonalization, derealization, and various kinds of quasi-psychotic thoughts. For these symptoms low doses of typical neuroleptics, such as haloperidol or trifluoperazine, are often useful. Doses in the range of 1 to 4 mg/d of haloperidol or 2 to 6 mg/d of trifluoperazine are generally sufficient. If the efficacy is inadequate at lower doses, these doses can be increased to 4 to 6 mg/d and 5 to 15 mg/d, respectively. If efficacy remains only partial, the addition of an SSRI is sometimes helpful.

Recently, there has been interest in the use of atypical antipsychotic drugs because they not only lack some of the neurologic side effects induced by traditional neuroleptics, but also appear to have superior efficacy in some patients. A group of patients with treatment-resistant psychotic symptoms, when involved in an open-label trial of clozapine administered at a mean dose of 253.3 mg/d, had impressive results.

Twelve inpatients with BPD who had persistent psychotic-like symptoms received clozapine doses ranging from 25 to 100 mg/d for 16 weeks. Psychotic-like symptoms improved within the first 3 weeks of treatment, as did impulsive behaviors and affective-related symptoms. Hence, one might consider a trial of clozapine in patients who are persistently struggling with psychotic symptoms. These strategies are summarized in Table 2.
SUMMARY

When an impulsive or explosive temperament is adequately treated by an SSRI or another agent, the patient often finds that the negative affects states are sufficiently reduced so that collaboration with the therapist is possible. Angry transference states are diminished so that the patient can think with the therapist about the origins of difficulties in the transference. Often a reflective space is facilitated by the use of SSRIs, which build in a delay mechanism so that the patient can think before acting impulsively.

There is considerable merit in having one psychiatrist conduct the psychotherapy and prescribe the medication rather than splitting those functions between two separate clinicians. The difficult characterologic dimensions that manifest themselves in the re-creation of an internal object relationship in the transference will occur around medication prescribing in the same way that they do in the psychotherapy. It is ideal if the same clinician is involved in the delivery of both treatments so that these recurrent themes in the relationship can be addressed constantly and understood as they emerge.

Although separating the two functions may also be effective, there is a much greater risk of splitting, in which one treatee is idealized and the other is devalued. Frequently the pharmacotherapist is regarded as a benign figure who is interested in symptom relief, in contrast to the therapist, who instead is spending time on painful and unpleasant issues. Many BPD patients will create considerable tension between the two treaters by the way they portray one to the other.

In working with both the medication and the psychotherapy, a continued focus of the clinician's effort should be to forge a solid therapeutic alliance. The development of this alliance can best be measured by monitoring how well the patient is able to collaborate with the therapist in the pursuit of commonly held goals. In this regard the alliance is both an enabling variable and a mini-outcome variable. The repeated emphasis on working together goes a long way in impressing upon the patient that, fundamentally, the doctor-patient relationship is not an adversarial one. If the patient is unable to collaborate in this manner, the clinician then has an opportunity to further interpret and clarify the patient's problematic internal object relations.

There is no "quick fix" for the BPD patient. Nevertheless, long-term follow-up studies suggest that there is reason for optimism when clinicians are persistent in their efforts to help. In a recent 3-year prospective outcome study, Najavits and Gunderson found that BPD patients follow a course of erratic improvement in the first few years of treatment, and that their overall outcomes are better than might be expected. Some will become chronic, and somewhere between 3% and 10% will ultimately commit suicide. Nonetheless, persistent efforts at adjusting the psychotherapy and the medication are likely to pay off in improved functioning and better quality of life.

REFERENCES


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<td>Medication Strategies for Borderline Personality Disorder Target Symptoms</td>
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SSRI = selective serotonin reuptake inhibitor; MAOI = monoamine oxidase inhibitor.

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**ERRATUM**

There is an error on page 529 of the article "ECT in the Media" by Charles H. Kellner, which appears in the September issue of the Journal.

The sentence which reads "Our own American Psychiatric Association newspaper, *Psychiatric Times,* recently printed an article that was previewed on the contents page as "ECT Used As Homosexuality Cure." should have read "Our own American Psychiatric Association newspaper, *Psychiatric News,* recently printed an article that was previewed on the contents page as "ECT Used As Homosexuality Cure."

The Journal regrets this error.