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Letter to the Editor

Pharmacological Treatment of Borderline Personality Disorder – The Conundrum between Research and Clinical Practice

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LETTER TO THE EDITOR

The pharmacological treatment of Borderline Personality Disorders (BPD) lacks evidence to support the long-term prescription of medications [1]. However, curiously, the use of psychotropic drugs has been the rule in these patients for two main reasons: the first would be the high incidence and prevalence of comorbidities such as depression, anxiety, phobic disorders, bipolar disorder, substance-related disorders, among other mental illness; the second reason would be related to the approach of these cases in outpatient or emergency clinical or psychiatric settings, where access to psychotherapies would be more restricted and the severity of the psychopathological conditions would require the professional to adopt a certain medication prescription for the comorbidity or, when BPD is the main and unique diagnosis, for the target symptoms.

The Damiano and Soares [2] editorial entitled "Should psychiatrists be more cautious about the use of antipsychotics for patients with borderline personality disorder" draws attention to a known dilemma of mental disorders that require long-term use of antipsychotics for maintenance treatment. Indeed, in BPD, the most studied of this nosological category, there is no evidence to support the prolonged use of this class of medication.

What is clear in the worldwide literature is a tendency towards the medicalization of patients diagnosed with BPD, even in the absence of psychiatric comorbidities, including the strategy of associating different classes of medication called “polypharmacy” and defined as the concomitant use of two or more psychotropic drugs. The reasons for prescribing antipsychotics for BPD may involve the severity of some patients (who would not benefit from psychotherapy alone), risk of impulsivity, selfharm, suicide, professional despair, pressure from family members and health service managers.

Based on the patients' references, there are cases of BPD that may respond to antipsychotics and this factor could sustain the prolonged use of the medication. It should be noted the possibility of non-adherence to psychotherapeutic proposals as potential reinforcers to these situations.

When studying the publications available for the pharmacological treatment of BPD, it can be observed that the methodologies for identifying potential benefits of treatments adopt specific scales that split subjective symptoms of patients into factors, often measuring independently variables to the response of the specific treatment. The number of patients enrolled in the studies is also limited, which compromises the statistical analyses. The objective nature of the categorical diagnosis of BPD also hinders the consistency of the diagnosis over time. We all know that psychiatric scales aproximate our field to the evidence-based medicine and that is the ultimate paradigm. Nevertheless, the subjective phenomenon behind personality disorders still works as a barrier for research to become more homogeneous and with more consistent results.

One important issue regarding (not only) BPD, is the wide distance between psychopharmacological studies and the clinical practice. Inside the intimacy of our private clinic, psychiatrists frequently claim for more guidelines that could support the manegement of severe cases that “ask” for a prescription. Until this publication, all medicines prescribed to a patient with a BPD diagnosis are considered off-label. And this status highlights our responsibility when adopting a treatment that maintain an antipsychotic as a long-term strategy to a BPD patient with clinical comorbidities, such as obesity, binge eating disorder, diabetis, hypertension, dislipidemia and metabolic syndrome.

Facing situations like mentioned above, the psychiatrist should be aware that sharing all the available information about the limitations and risks associated with long-term use of antipsychotis are crucial to the doctor-patient ethical relationship. The adoption of a multidisciplinary team would help to diminish the hazards. For example, the therapeutic pressure for psychotheray should be a rule, and it is indeed, but often forgotten. There are scarce publications about the benefits of physical exercise to BPD treatment. At least, the benefits of sports on metabolism and quality of life are well known and spare us to reference citation.

The difficulty of finding a drug that helps in the long-term treatment of BPD should not be overlooked. Many psychiatrists

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face, in their private or specialized outpatient clinics, the dilemma of having to keep a maintenance antipsychotic treatment despite the absence of scientific evidence to support the conduct. In view of what is exposed in this letter to the editor, it is worth questioning whether the methodologies really apply to this nosological class, that is, are we researching with the ideal tools? Do we need other methodologies of clinical trials for BPD? As we know, the observer's lens influences the phenomena of nature and can negatively interfere with the results. Signs like these can be an alert for new paradigms of scientific investigation in psychiatry.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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