

# Medications and BPD

Dr Maria Naso reflects on medication management in the treatment of people living with BPD.

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I have worked in mental health since 1993. I was a rather excitable and hopeful first year psychiatry registrar. It was a time of change in mental health in South Australia - deinstitutionalisation was becoming a reality and community mental health services expanded.

It was an incredible time with biological treatments taking centre stage. I was surrounded by new antidepressants and 'better' antipsychotics, so no wonder the big pharma brainwashed me into believing this was psychiatry's time to shine.

Forward to 2019 - the NHMRC guidelines for the treatment of consumers with Borderline Personality Disorder were finally starting to be taken seriously with the BPD Collaborative driving some systemic changes in SA.

I have learnt an enormous amount about people living with Borderline Personality Disorder and most significantly I am no longer brainwashed by big pharma (there has to be some good about the process of aging).

I learnt that medication is not the panacea of life. In fact the longer I practice the less confident I feel about medication, especially in the management of BPD.

What I have seen first hand is also corroborated in scientific studies:

\* **People living with BPD are on numerous medications. Much more than those who have been**

**diagnosed with depression and anxiety.**

- \* **Despite huge amounts of medications, they are still presenting with symptoms of BPD**
- \* **These same people were overdosing during times of crisis with readily available medications.**
- \* **Despite numerous overdoses and at times ICU admissions people would continue to be supplied with the same medications.**
- \* **People living with BPD were suffering with potentially toxic side effects and minimal benefits to their mental health.**
- \* **The side effects I have seen include significant weight gain, metabolic syndromes (diabetes), drowsiness, blurred vision, nightmares, sexual dysfunction and even lactation in non pregnant, non breast feeding individuals.**

The side effects on their own are highly distressing and can interfere with the important work of psychotherapy. It is time for people with lived experience of BPD and carers to stand up and be fully informed about these medications.

I would like to make it very clear that medications can and do play a role in symptom reduction in people living with mental illness, HOWEVER this is only within a therapeutic relationship where the risk vs benefits can be monitored and

negotiated. If a medication is not of benefit then it should be weaned off slowly.

So why is it when the evidence states that medication is not first line treatment that so many people are on multiple toxic medications?

The answer lies with the psychiatrists, registrars and GP's. It is about us - the care providers - feeling a need to alleviate distress. As doctors we are trained to treat and manage distressing symptoms. I'm afraid that each time we get a prescription pad out we need to ask "Am I writing this script for my patient, or to make myself feel better?"

In the case of people presenting with BPD in crisis I am of the belief that short term distress minimisation can be of benefit. Once the crisis has settled the medication should be eased off gradually. What frequently occurs in practice is that the person is discharged on the medication and when the next crisis occurs the medication is increased and or another medication added.

Questions that should be discussed with the treating team are:

- \* **Why are you putting me on this medication?**
- \* **What is the evidence for its effectiveness?**
- \* **What side effects can I expect?**
- \* **How long will I be on this medication?**

Medication can be of value but it is not the mainstay of treatment.

**Dr Maria Naso (SA)** 

*Ed: Please discuss any medication concerns or changes with the prescribing doctor or your GP.*