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Depression symptoms and BPD

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easternhealth

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Personality Disorders

- Cluster A: Schizoid, Schizotypal, Paranoid
- Cluster B: Borderline, Antisocial, Histrionic, Narcissistic
- Cluster C: Obsessive-Compulsive, Avoidant, Dependent

There tends to be overlap in each cluster.

ICD 11 moves away from this model to focus on psychosocial impairment and traits

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Borderline Personality Disorder

- DSM 5
- Pattern of unstable affect, relationships and self-image with impulsivity.
- Often linked to childhood trauma, but trauma is not a requirement of the diagnosis
- 75% female – but thought to truly be 50:50
- 42-68% heritable
- Also characterized by anatomical and hormonal changes

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BPD

Associated with

- High service utilization even without full diagnosis
- Challenging diagnosis and almost universal presentation with co-morbidity
- Stigma
- High rates of self-injury (75%) and suicide (10%)
- Persistent psychosocial impairment

BPD

Prevalence of 1 to 2% in general population

- At least 60,000 people in Victoria

4.3% of GP patients

9.3% of psychiatric outpatients

High prevalence but is often unrecognized, poorly understood and inadequately treated

Often prescribed multiple psychoactive medications

MDD

Estimated to be co-morbid with BPD up to 50%

In a group of people with MDD, 25% will meet criteria for BPD

- “Intense episodic dysphoria, irritability or anxiety” = “Depressed mood”
- “Chronic feelings of emptiness” = “Feelings of worthlessness”
- “Recurrent suicidal behaviour” = “Recurrent thoughts of death”

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Medications

There is evidence that people living with BPD are prescribed anti-depressants more often than people with just MDD

There is little evidence to support the use of anti-depressants in co-morbid BPD/MDD

Greater self-rated severity of MDD symptoms in a person living with BPD has poorer response to medication

Improvement in BPD symptoms “steers” MDD depression

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Purpose of this study

There remains stigma in diagnosing BPD and some are reluctant to make the diagnosis when it emerges in adolescence. These factors may lead a clinician to prioritize an alternative diagnosis.

There is concern that diagnostic uncertainty and stigma can contribute to delayed diagnosis and ineffective treatment

Do rating scales contribute to the issue?

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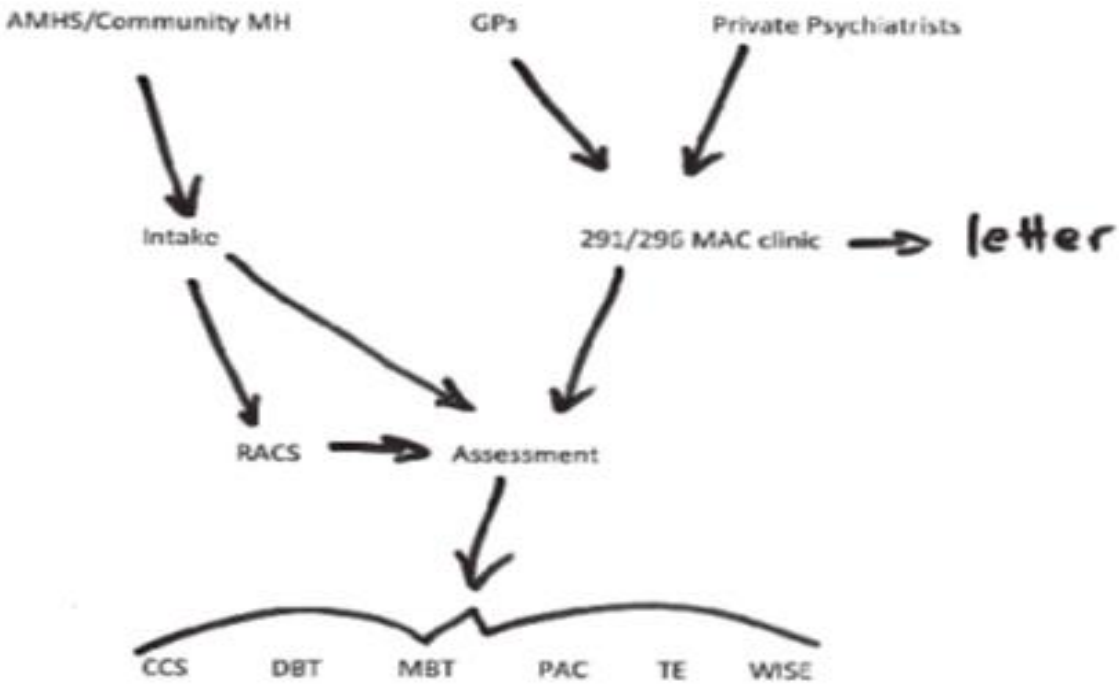
The study sample



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Methods

BDI – routinely administered client-rated scale

HAM-D – gold-standard clinician-rated scale

QID self/QID clinic – identical questions allowing direct comparison

K10 – 10 items, client-rated scale common in primary care

Methods

Inclusion criteria

i. Confirmation of a diagnosis of borderline personality disorder following referral to the service for psychiatric assessment by a general practitioner, and

ii. Provision of written informed consent to participate in this study

Exclusion criteria

i. Clients who do not have a diagnosis of borderline personality disorder

ii. Clients unable or unwilling to provide informed consent

iii. Clients deemed unable to participate in the study. This criterion was subject to clinical judgement, but included exclusions including unstable mental state or cognitive disorder

Results

N= 22 collected over 3 months

100% participation when offered

5 men and 17 women - men comprised 23%

Age range 18 to 73 - median 33.

17 (77%) were prescribed an anti-depressant at the time of assessment

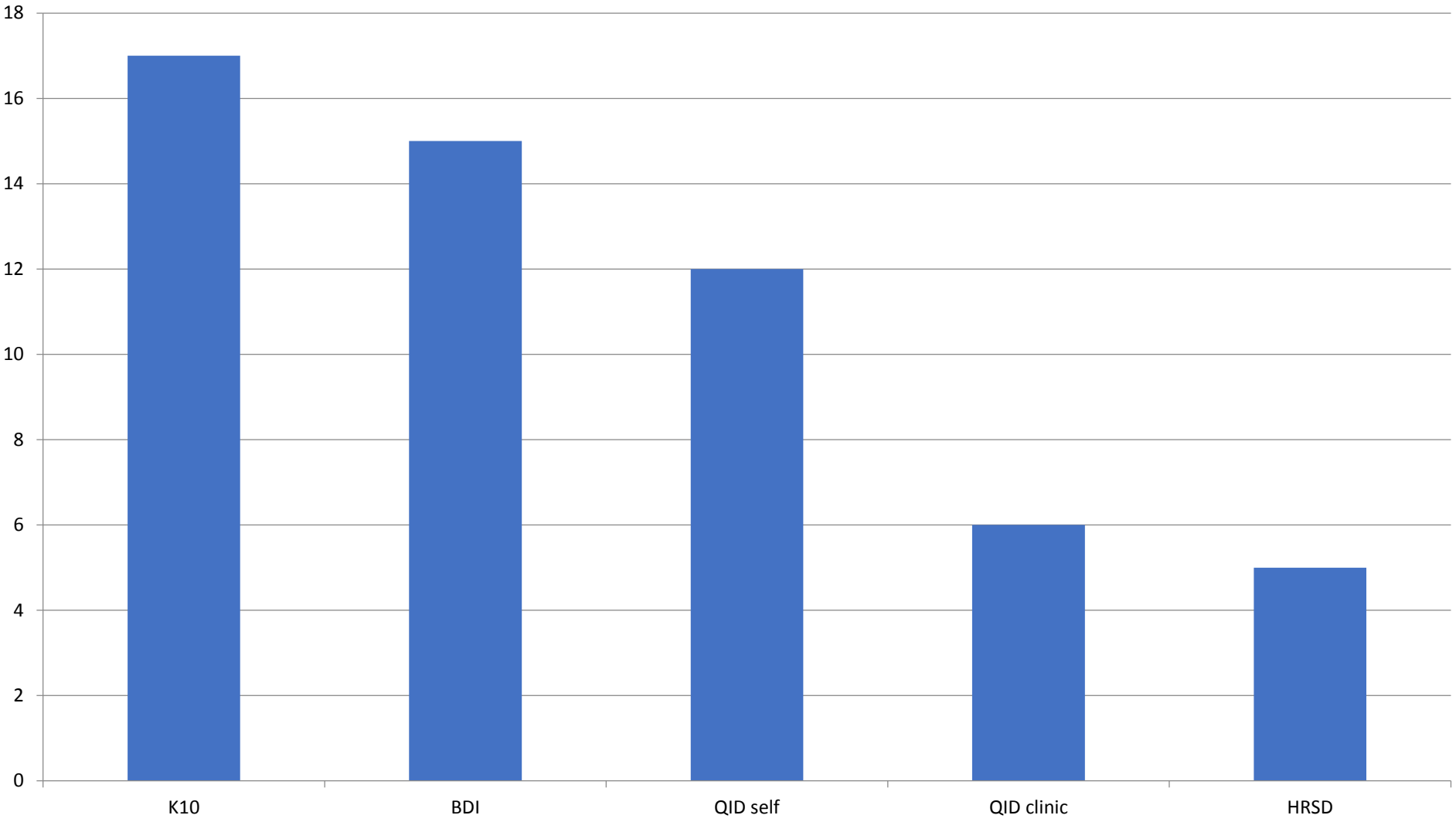

Figure 1: Number of participants described as 'severe' or 'extreme' according to each rating instrument.

Client-rated scales return a higher proportion with either 'severe' or 'extreme' symptoms according to the language used by the rating scale compared to clinician-rated scales.

Rating Instruments	Kappa Measure of Agreement
BDI vs HRSD	κ = 0.09 (95% CI: -0.16 - 0.34); p=0.52
BDI vs QID clinic	κ = 0.30 (95% CI: 0.05 - 0.55) p=0.05
BDI vs QID self	κ = 0.53 (95% CI: 0.18 - 0.88); p=0.01*
BDI vs K10	κ = 0.55 (95% CI: 0.16 - 0.93); p=0.01*
QID self vs QID clinic	κ = 0.48 (95% CI: 0.17 - 0.78); p=0.01*

Table 1: Summary Table of the Cohen's Kappa Coefficient. There was not statistically significant congruency between the BDI and HRSD or between the BDI and the QID clinic, indicating that there was a difference in the rating scores between these client-rated and clinician-rated scales. There was significant congruency between the client-rated scales (BDI, QID self, K10). There was also significant congruency between the QID self and QID clinic.

Results

Correlation	R value	Strength of Correlation
BEST vs K10	0.59	Strong
BEST vs QID self	0.48	Moderate
BEST vs BDI	0.32	Moderate
BEST vs QID clinic	0.29	Weak
BEST vs HAM-D	0.27	Weak

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What does it all mean?

People living with BPD are often desperate for support and treatment.

If a rating scale or a clinician uses a particular language, such as enquiring about symptoms of depression, then it may be that a person with BPD will use that language to express their distress.

This potential confusion has important implications for prioritizing treatment approaches

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Implications for prescribing

A rating of “severe or extreme” may compel a clinician to take action, such as medication.

17 of the sample was prescribed anti-depressants when only 2 met severity criteria according to the HAM-D.

Those 2 with high HAM-D scores also had the highest scores on the BEST.

A reminder that there is little evidence for the use of medications in treating MDD co-occurring with BPD.

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Implications for psychotherapy

- A focus on a diagnosis of depression may delay provision of long-term psychotherapy in favour of biological interventions – medications, ECT, etc.

- CBT does not have as strong an evidence based in BPD

- Why might CBT not be as effective?

- Do you think that psychotherapy is seen as passive?

What to do in practice?

The NHMRC guidelines from 2012 indicate that a health professional should consider the diagnosis of BPD for any person (including those aged 12 to 18) who presents with the following:

- Frequent suicidal behaviour or non-suicidal self-injury
- Marked emotional instability
- Multiple co-occurring psychiatric conditions
- Non-response to established treatment for current psychiatric treatments
- A high level of functional impairment

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Common comorbid diagnoses

- Bipolar
- Schizophrenia
- ADHD
- Autism
- Depression
- PTSD
- Eating disorders

- How might we differentiate them?
- What is the priority?

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Assessment tools

- Clinical diagnosis remains the gold-standard

- BPQ
  - 80 questions, consumer-rated
  - Assesses impulsivity, affective instability, abandonment, relationships, self-image, self-mutilation, intense anger, suicide/NSSI, emptiness, psychotic symptoms

- Zanarini scale
  - Brief, consumer-rated
  - 8 out of 10 indicative of BPD

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What to do

- The most important step is to make the diagnosis of BPD one of your priorities if it is present

- Access to specialist treatments and training is limited

- What do you do?

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General treatment principles

- The diagnosis should be discussed with the consumer
- Mainstay is psychotherapy
- Little evidence for antidepressants. Avoid benzos and opiates. Avoid medications dangerous in overdose.
- Can use medications, such as Quetiapine, Lamotrigine or Olanzapine for impulsivity and anger
- Admissions to hospital should not be viewed as failure
- High remission rate (45% by 2 years, 85% by 10 years) if people can survive
- Substance use is major barrier to recovery
- Therapeutic interactions are possible in any environment with some knowledge of common factors

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What are the common factors?

- Structure
- Validation
- Encourage self-observation
- Clear treatment framework
- Attention to affect
- A focus on treatment relationship
- An active therapist
- Exploratory and change-oriented interventions
- A well thought-out and agreed crisis management plan
- Supervision for the therapist
- Support for families

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Improving your skills

- There are general treatment principles, but there is also great scope for improving specific skills

- Much can be learned from any of the evidence-based psychotherapies without formal practice
  - TFP, MBT, DBT, SFT, ACT

- The study and treatment of personality disorders is an expanding field
  - New attention from government and section of RANZCP

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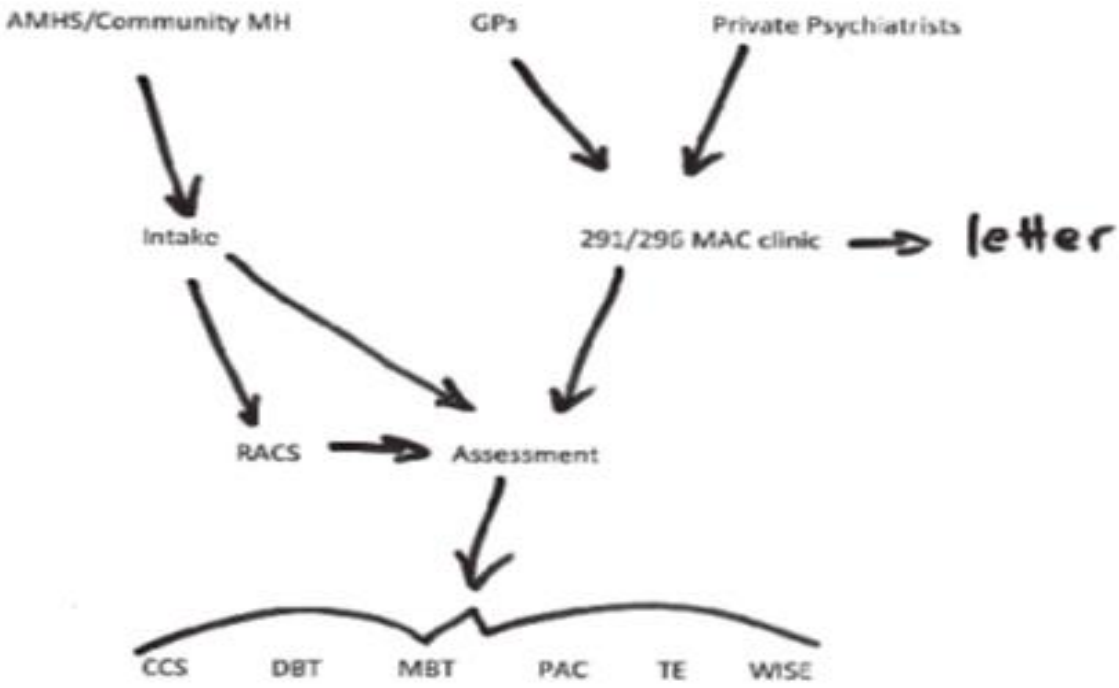

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Summary points

Symptom rating scales may not be reliable in the presence of BPD

BPD is often not diagnosed and may lead to ineffective treatment

The diagnosis of BPD should be a priority

Any clinical relationship can be therapeutic, but specific training can greatly increase comfort and skill