REVIEW

Collaborative Deprescribing in Borderline Personality Disorder: A Narrative Review

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Learning objectives: After participating in this activity, learners should be better able to:
- Assess medication management in patients with borderline personality disorder (BPD)
- Evaluate the role of deprescribing as an active intervention in patients with BPD treated with polypharmacy

Abstract: Psychopharmacology in borderline personality disorder (BPD) is complicated by comorbid disorders, substance use, sensitivity to side effects, risk of self-harm through medication misuse, and intense but transient symptoms. Patients' relationships with medications may range from tenuous to highly enmeshed, and may profoundly influence the response to treatment. For these reasons, awareness of current evidence and flexible approaches are particularly relevant to prescribing in BPD. In this narrative review, we illustrate the current status of medication management in BPD by focusing on polypharmacy. We use a single vignette to explore the limitations of prescribing multiple medications and the factors contributing to polypharmacy. With the same vignette, and using the framework of deprescribing, we describe how medication regimens can be reduced to a necessary minimum. Deprescribing, originally developed in geriatric medicine, is an active intervention that involves a risk-benefit analysis for each medication, keeping in mind the patient's medical and psychiatric status and his or her preferences and values. Deprescribing lends itself well to use in psychiatry and especially in BPD because of its emphasis on the patient's preferences and on repeated conversations to revisit and update decisions. In addition to elaborating on the deprescribing framework, we provide recommendations for conducting these critical discussions about medications in BPD, with particular attention to the patient's relationship to the medication. Finally, we summarize our recommendations and strategies for implementing flexible and responsive medication management for patients with BPD. We suggest areas of future research, including testing the efficacy of targeted intermittent medication treatments.

Keywords: borderline personality disorder, deprescribing, polypharmacy, psychodynamic psychopharmacology, risk assessment

Prescribing psychotropic medications for people with borderline personality disorder (BPD) can be complicated by both medical and psychological concerns. BPD is commonly comorbid with other psychiatric disorders such as depression and posttraumatic stress disorder, as well as with nonpsychiatric medical problems.[1–4] Anecdotal evidence and one small study suggest that people with BPD may be more likely than other patients to experience adverse responses to medication.[5,6] Also, people with BPD can be highly sensitive to interpersonal dynamics in the prescribing relationship.[7,8] We propose that alongside the current best evidence for prescribing in BPD, an awareness of these issues can inform a flexible approach to working with BPD patients, and is most likely to yield positive outcomes.

People suffering from BPD are often prescribed a large number of psychotropic medications in response to intense affective and psychotic symptoms, self-harm and impulsive behavior, and strong feelings evoked in the prescribing provider. Although some evidence suggests that psychotropics can reduce the intensity of symptoms, their benefits need to be reevaluated frequently, as the natural course of these symptoms is to intensify and then resolve quickly. Furthermore, medications may be less safe in the context of impulsive substance use or self-harm. Hence, for people with BPD, the risk-benefit ratio of medications may fluctuate significantly within a short time frame.

Prescribers may hesitate to reduce medications because of insufficient time for discussions with the patient, inadequate training, or a "fear of rocking the boat."[9] In this article we offer the framework of *deprescribing* as a means of parsing

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medication regimens and working toward the minimum helpful treatment. We anticipate that having guidelines for the process of reducing medications may support providers to engage in needed changes. Deprescribing, an intervention originally described in geriatric medicine, has been described as the "the systematic process of identifying and discontinuing drugs in instances in which existing or potential harms outweigh existing or potential benefits within the context of an individual patient's care goals, current level of functioning, life expectancy, values, and preferences."[10(p 827)] The process of deprescribing has recently been expanded for use in psychiatry.[11] Using the following hypothetical vignette developed on the basis of our work with a series of patients, we demonstrate how deprescribing may be further modified for use in the patient with BPD:

> Jackie, a 27-year-old single woman, presents to your clinic after discharge from the psychiatric hospital. She is a slightly overweight, casually dressed young woman. She is glad you were willing to see her so quickly and asserts that she needs her medications sorted out, as the inpatient doctors did not pay attention to what she was saying. She asks to be restarted on clonazepam, dextroamphetamine, and fluoxetine in addition to the quetiapine and valproate that she is already taking. She adds that you seem like the kind of doctor who will really listen.
>
> Records indicate that Jackie was admitted for a possible suicide attempt. She had taken 4 mg of clonazepam together with four shots of vodka after an upsetting phone call with her long-distance husband. She endorses feeling empty and worthless, which worsens with relationship problems. Also, she feels desperate to communicate her strong feelings to the people she loves. Though people initially seem to understand, they often leave her feeling alone and betrayed. In those situations, she finds herself feeling odd, as though she is not part of the world everyone else is living in. She daydreams about ways to kill herself, and has discovered that digging into her upper arms with her fingernails is somehow relieving. Physical examination revealed rows of half-moon shaped marks on both her forearms.
>
> *Note:* An indented observation relating to this vignette will be included at the various points in the sections below.

TREATMENT OF BORDERLINE PERSONALITY DISORDER

Brief Review of Symptoms in BPD

BPD is a common mental health problem. Prevalence is estimated at 1%–5% in the general population and ~20% in mental health clinics.[12–14] The natural history of the disorder is for symptoms to lessen over time, but functional recovery lags behind symptom relief for many.[15] Many people afflicted by BPD suffer chronic suicidality[16] and make repeated suicide attempts.[17] Five to 10 percent of people with BPD ultimately complete suicide[17,18]—which is nearly 50 times the suicide rate of people in the general U.S. population.[19]

Symptoms that may suggest BPD should prompt further investigation. One approach to screening is to inquire about four domains of BPD symptoms: affective (depression, mood lability), impulsive, cognitive-perceptual (transient symptoms of psychosis, dissociation), and interpersonal.[20] Affective instability (mood fluctuations across minutes to hours rather than over weeks or months, as in primary mood disorders) is a highly sensitive, single-item screener for BPD: negative predictive value is 99% in a large community sample from an outpatient mental health practice.[21] For further investigation of positive screens (patients with symptoms in all four domains), standardized scales can be helpful, such as the Diagnostic Interview for Borderline Personality Disorder (a semi-structured interview),[22] the SCID-II self-report questionnaire (15 yes/no BPD questions),[23,24] and the Borderline Symptom List (23 BPD questions scored on a 5-point Likert scale),[25] among others. To distinguish BPD from syndromes that share similar experiences, it may be especially helpful to identify symptom fluctuations that occur in response to interpersonal problems,[26] such as affective changes as discussed above and psychotic symptoms of brief duration (sometimes termed *micro-psychotic episodes*).[27–30]

> *Observation:* From the above, we can conclude that Jackie fulfills several criteria for a diagnosis of BPD. She experiences mood instability, anger, dissociative episodes, and interpersonal problems, and often demonstrates impulsivity and suicidal or self-injurious behavior.

Treatment Approaches for BPD

The standard of care for treating BPD is psychotherapy.[31–33] For many patients, BPD-informed generalist mental health treatment is likely sufficient; these principles are reviewed in the *Handbook of Good Psychiatric Management for Borderline Personality Disorder*.[8] For more complicated patients, several different, manualized therapies have been delivered in group and individual formats to good effect, including dialectical behavioral therapy, mentalization-based therapy, and transference-focused psychotherapy.[34,35] Inpatient psychiatric hospitals can be helpful for stabilization of acutely suicidal patients, but this approach is generally considered only as a last resort, especially in view of the concern that it can actually exacerbate symptoms (reviewed in Biskin & Paris [2012][36]). No treatment for BPD targets a specific biological mechanism. Though no pharmacologic approach is available for treating the disorder itself, medications can be helpful for symptom management.

Role of Medications in BPD

Current guidelines recommend minimal medication use in BPD.[31–33] Cochrane reviews have examined the evidence for the potential benefit of medication in BPD, and their evolving conclusions reflect the small but growing evidence for some use of medication in BPD (see Text Box 1).

In 2006, the Cochrane Report was unable to recommend any medication.[67] By 2010, they found some evidence of benefit for core symptoms—in particular, for mood stabilizers

Text Box 1
Evidence Regarding Medication Response in BPD

Medication class	Evidence used
Mood stabilizer	Meta-analyses found small effects on affective symptoms, impulsivity, and interpersonal problems (for valproic acid, lamotrigine, and topiramate; not for carbamazepine)[37,38] A well-powered subsequent study found no effect of lamotrigine on overall BPD severity, or on affective, impulsive, interpersonal, cognitive domains[39]
First-generation antipsychotic	Anger (2 studies), suicidality (1 study)[37]
Second-generation antipsychotic	Benefit for affective, impulsive, psychotic-like, interpersonal symptoms[37,38] Suicidality: data conflicting[37]
Antidepressant	Affective symptoms: TCAs: one trial showed effect of amitriptyline[40] SSRIs: for affective symptoms, weak[38,41] versus no effect[37] No significant effect on impulsive or psychotic-like symptoms[38]
Lithium	There are few available data
Benzodiazepines	Finnish guidelines suggest that benzodiazepines should be avoided[42] One study: increased "dyscontrol"[43] No improvement in a small, double-blind, cross-over trial[44]
Stimulants	There is little evidence about the effects of stimulants in BPD[45]
Other	Clozapine case report[46] and case series[47] Omega fatty acids[48] Opiate antagonists: naltrexone for dissociation,[49] nalmefene for BPD symptoms and alcohol use disorder[50] Oxytocin[51–54]
Ongoing trials (medication and proposed mechanism)	Acetaminophen: may decrease "social pain"[55] Botulinum toxin: may alter emotional feedback from facial muscles[56] Brexpiprazole: novel second-generation antipsychotic; may be better tolerated[57] Ketamine: rapid-acting antidepressant; may increase neuroplasticity[58] Mifepristone: may alter the stress-response hormonal response[59] NMDA antagonist: potential for use in a variety of psychiatric disorders[60] Oxytocin: may improve social functioning[52,61–65] Selegiline: better-tolerated transdermal MAOI[66]

MAOI, monoamine oxidase inhibitor; NMDA, N-methyl-D-aspartate.

(lamotrigine, topiramate, and valproic acid) and second-generation antipsychotics (aripiprazole and olanzapine)—based on a handful of new reports.[37] Meta-analyses by Vita and colleagues (2011)[38] and Stoffers (2015 review of data from 2009–14)[41] concurred (see Text Box 1 for specific data reviewed). These conclusions remained rightly tentative, however, as trials were small and mostly unreplicated. A new, well-powered trial testing lamotrigine versus inert placebo in adults with BPD has found no benefit of lamotrigine at short (12 week) or longer (1 year) timepoints in terms of overall BPD severity, BPD core symptoms (affective lability, impulsivity, self-harm, cognition, interpersonal/social functioning), or health care costs.[39] More robustly powered studies are needed to confirm or disconfirm the benefit of other mood stabilizers and second generation antipsychotics.

Prescribing Patterns in BPD

Review of prescribing patterns suggests that patients with BPD are often taking complex regimens that do not reflect the available evidence about efficacy. Multiple groups found that >80% of BPD patients were prescribed psychotropics.[68–70] In one sample, more than half of BPD patients were prescribed three or more psychiatric medications.[71]

As-needed (PRN) use is also more frequent in BPD than in other personality disorders, though rates do fall as patients recover.[72] No evidence currently supports the use of PRN

medication in BPD (reviewed in Martinho et al. [2014][72]). Prescriptions of benzodiazepines for PRN use may be tempting to patients and providers working to reduce distress from intense anxiety. The small body of available data, however, does not support this practice.[43,44,73] Benzodiazepine use can lead to disinhibition,[43] result in a shift from positive toward negative emotions,[74] and further cloud cognition in these patients, who are known to have neuropsychological deficits in several domains.[74,75] Moreover, substance use disorders, in general, and tranquilizer use disorder, in particular, are frequent in BPD,[76] and difficulty with benzodiazepine discontinuation is substantial.[77]

Based on these data, real-world practice and the recommendation for focused, minimal prescribing are discrepant. Several different factors (to be discussed in the next section) may contribute to the overuse of medication in the treatment of BPD, including the lack of evidence to guide decision making.

Observation: Jackie's medication regimen demonstrates some of the problems that plague the real-world pharmacological management of BPD. Polypharmacy can result from repeated attempts to quell highly distressing and persistent symptoms with increasing numbers and doses of medication.

FACTORS THAT PERPETUATE POLYPHARMACY IN BORDERLINE PERSONALITY DISORDER

Underdiagnosis and Reluctance to Disclose Diagnosis

Without a formal diagnosis of BPD, the highly distressing and often treatment-resistant symptoms can be mistaken for treatment-resistant variants of other mental health conditions. In this situation, clinicians may intensify their efforts to subdue symptoms with medication. Clinicians may be reluctant to diagnose BPD, or may actually miss the diagnosis, partly because they have more experience diagnosing primary mood and psychotic disorders (the "Axis I" disorders originally set out in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV])[8] and also because some diagnostic tools can give misleading results—for example, by channeling the clinician toward a diagnosis of bipolar disorder.[20,78] However, as we have described above, a quick clarification of the frequency and triggers of symptom fluctuations is an effective screening method, and standardized BPD scales can help to distinguish commonly confused disorders such as treatment-resistant depression and bipolar disorder. While some patients with BPD may have comorbid bipolar disorder, major depression, or psychotic illness, many others are misdiagnosed because the BPD diagnosis is not considered.[79–81]

Clinicians may also be reluctant to diagnose BPD because they suspect that treatment does not help or that patients may feel insulted.[82] Stigma persists in the medical community and even among mental health practitioners,[83] perpetuating ideas that BPD is less "real" and less treatable than other serious mental health problems, such as bipolar disorder (reviewed in Zimmerman [2016][84]). Many practitioners report not recording BPD in the chart and not disclosing the diagnosis to patients.[85] Data suggest, however, that many patients feel relieved upon receiving psychoeducation about BPD (though this response may later be complicated as patients become increasingly aware of the stigma surrounding the diagnosis).[86,87] Moreover, clinicians who are trained to diagnose and disclose BPD feel more comfortable working with BPD patients.[83,88] Open discussion of the BPD diagnosis holds promise for more effective use of medications and helps to clarify the situations where medications may be more (or less) helpful.

Observation: Although it is clear to us that Jackie suffers from BPD, it is possible that her providers have not communicated this diagnosis to her; hence her frantic efforts to medicate her distress. A conversation about diagnosis will lead to discussion about what treatments can actually help Jackie in the long term.

Attempts to Treat All the (Many) Symptoms and (Common) Comorbidities with Medication

People with BPD can vary widely in the specific symptoms that they experience: only five of the nine DSM criteria are needed to make the diagnosis, so many different combinations can occur. This variability can augment the perception that the patient is presenting with a unique or mysterious clinical situation rather than an understandable one in the form of BPD. Also, because people with BPD can be quite sensitive to the side effects of medication,[5,6] additional symptoms can arise that may tempt providers and patients to consider additional medications.

The patient and prescriber can practice tolerating symptoms when they have a shared language for doing so. BPD is primarily treated by psychotherapy; strong emotions are expected and can be talked about; medications are adjunctive. This approach stands in contrast to the idea of some patients, and even some prescribers, that psychiatric stability is achieved largely or solely through medications. Physicians, like many experts, are susceptible to the "therapeutic illusion" that their "actions or tools are more effective than they actually are."[89,90] Overestimating the value of one's prescriptions can easily perpetuate the belief that withdrawal or change in a medication *will* destabilize a patient. This belief can cause, in turn, both the prescriber and the patient to remain in favor of keeping the medication unchanged, often at the risk of exposure to side effects. Ongoing discussion of medication's possible contributions to both clinical improvement and worsening can help avoid this pitfall and engage patients in the therapeutic task of seeking increased agency.[8]

Observation: It appears that Jackie may be unnerved by her hospitalization and is attempting to gain control of her life by asking for and adding medications. Although her inpatient doctor may have resisted the pressure to prescribe more medication in addition to valproate and quetiapine this time, this attitude may change with repeated

hospitalizations. Further, the outpatient doctor may err on the side of "safety" and decide not to change the valproate and quetiapine, all in an effort to keep Jackie out of the hospital. A provider working in the deprescribing framework[†] might include additional supportive caregivers at this point, such as a therapist or friend, aiming to shore up Jackie's sense of support and stability. A provider might also emphasize her interest in hearing Jackie's perspective about the goals of treatment, what interventions are helpful, and how to plan for frequent check-ins to update and adjust their shared understanding of goals.

Symptom Fluctuations and Temporary Exacerbations

BPD symptoms are understandable as responses to interpersonal interactions and stressful events in the patient's environment. Explicit consideration of these stressors is valuable both for the prescriber's process and for the prescriber-patient discussion. Within a medical frame, stressors and environmental protective factors can be considered as exacerbating and alleviating factors, respectively. In some cases, exposure to stressors can be predicted, and in such cases, collaborative review of stressors during the prescribing process can help to better target prescribing and can itself serve as a therapeutic intervention.

Observation: Jackie's attempt at self-harm and subsequent hospitalization occurred in the context of her argument with her long-distance husband. The addition of a medication—an antidepressant, for instance—may not address the central reason that led to the hospitalization in the first place. Further, it is very possible that, by the time that the antidepressant begins to exert its effect, Jackie may have already made up with her husband.

Comorbid Substance Use

Comorbid alcohol and other drug use disorders are common in BPD[76] and can cause medication nonadherence.[91] Prescribers not aware of the nonadherence, however, may end up escalating doses and adding medications. Some data suggest, too, that psychiatric patients with substance use disorders may be less likely to experience symptom remission with psychotropics—for example, in depression comorbid with alcohol use disorder.[92]

Observation: Jackie's impulsive overdose prior to hospitalization included misuse of a controlled substance (clonazepam) and alcohol. At step 2 of deprescribing (compile a list of medications), we recommend that careful evaluation of misused medications and abused substances can help to initiate critical discussions with the patient about the safe use of medication. The deprescribing stance is a transparent one, which invites the patient to both see and participate in the provider's decision making. This stance models a thoughtful and flexible approach to problems.

[†] See "Risks of Medication Use in BPD," Table 1, and "Strategies to Reduce Polypharmacy and Promote Quality Prescribing," all below.

Patient Requests for Medication

People with BPD can seem demanding because of impulsive anger and because of alternating idealization and devaluation. Frantic fears of abandonment can be activated by usual clinical schedules (the lack of provider availability over a weekend) or by proposed changes in care plans (decreased session frequency, decreased medication dosing). These strong displays of emotion and attendant obvious distress can lead to prescriptions aimed at calming the patient and deescalating a difficult interpersonal encounter.

Observation: Jackie has just transitioned from an inpatient unit to the outpatient setting. In addition to having to deal with the original problem that led to the hospitalization, Jackie has to deal with the loss of the constant support that inpatient care provides. This change of setting may be a part of why she is requesting more medications. In step 3 of the deprescribing framework, discussion of the meaning of medications can help to expand the provider's understanding of the patient as well as the patient's understanding of her own experience. An open and curious stance may set the stage for a productive medication meeting and may actually save time by getting to core issues that a more structured approach could miss.

Countertransference Prescribing

People with BPD can evoke strong emotions in their providers—which can lead providers to reflexively respond with efforts to quiet these strong emotions. Mintz and Flynn[7] have termed this response *countertransference prescribing*. Mental health providers may be less attuned to their own subjective experiences with patients when their role is defined as more biological (prescribing provider) than psychological (therapist). This decreased attention to countertransference may increase the risk of prescriber actions that are more about addressing the provider's distress than that of the patient.[7,93] The provider's potential countertransference responses include the following: the wish to rescue the vulnerable patient (or to punish/silence the demanding patient), the wish to be in control in a chaotic situation, and the wish to place something (medication) between oneself and the patient.[94]

Observation: Depending on prescribers' vulnerability, they may respond to Jackie's plea for help by prescribing all the medications that she asks for (which may fulfill their rescuer fantasies or distance them from Jackie) or firmly refuse to prescribe any other medication (as they do not want to be told what to do). The deprescribing framework may help when emotions run high, as it defines clear steps with specific recommendations. When a prescriber notices emerging strong feelings or perhaps a sense of needing to solve an unfamiliar problem, she may be able to ground herself by considering one step at a time and by consulting with colleagues.

Prescription Frequency and Pill Count

Some prescribers have also encountered insurance companies and mail-in pharmacy services that incentivize prescriptions

with larger pill counts. Writing prescriptions for longer planned stretches of time can increase the risk of overuse and overdose (due to large numbers of available pills at home), whereas shorter, smaller prescriptions can increase the likelihood of frequent meetings and facilitate nimble, responsive prescribing. Prescribers meeting their patients for brief frequent visits are more likely get opportunities to hear about problems before they escalate and to impart a sense of availability and helpfulness that may decrease patients' inappropriate use of medications to manage distress.

Observation: In addition to the psychological and safety issues for Jackie, practical issues can impede the prescribing practices that may otherwise be ideal for a certain situation. When large pill counts or infrequent visits are needed (due, for example, to insurance, transportation, or scheduling), supportive others may be able to help with safety and emotional support. Visiting nurse services with medication lockboxes to decrease free access to large pill counts are sometimes available. Phone meetings can potentially offer a change for check-ins. Acknowledging practical issues, while holding in mind their psychological import, may model problem solving and increase trust.

RISKS OF MEDICATION USE IN BPD

Interactions with Substances of Abuse

Medications can interact with one another as well as with substances of abuse. For instance, the use of alcohol or opioids with prescribed benzodiazepines can put a patient at serious risk of respiratory depression.

Adverse Effects and Contraindications

Some of the medications that are commonly prescribed in BPD have potentially serious side effects. Although many of the people who receive the diagnosis of BPD are female and of childbearing age, most of these medications are not recommended in pregnancy, and some, such as valproic acid and lithium, are known to have serious adverse effects on pregnancy. Also, both mood stabilizers and second-generation antipsychotics commonly lead to significant weight gain and to attendant serious medical problems, which, if treated at all, are treated by adding more medications of uncertain benefit.[95,96]

Means for Intentional Self-Harm

Patients who are at a high risk for self-harm may find the means in large numbers of prescribed pills. This problem is especially concerning with medications that have a narrow therapeutic index, such as lithium and tricyclic antidepressants.

Psychological Risks

Given their high levels of sensitivity to both interpersonal and somatic experience, people with BPD may be more likely to experience both side effects and withdrawal symptoms of psychotropic medications. Medications can, because of time spent discussing them, divert attention and energy from psychotherapy (the primary treatment modality in BPD).

STRATEGIES TO REDUCE POLYPHARMACY AND PROMOTE QUALITY PRESCRIBING

Deprescribing as a Conceptual Framework for Streamlining Medication Regimes in BPD

An intervention originally described in geriatric and palliative care medicine, deprescribing is now being adapted to psychiatry. It has been emphasized that deprescribing is not the withdrawal of care but a positive intervention aimed at the effective and "parsimonious use" of medications.[11] To deprescribe, one should consider intervention timing, medical and psychiatric history, psychosocial supports, and developing a plan for tapering, with ongoing monitoring and support (proposed procedures have been laid out in detail by Gupta and Cahill[11]). In Table 1, we list the Gupta and Cahill steps for deprescribing and suggest modifications for deprescribing in BPD. In particular, prescribing providers should pay special attention to the rapid and often dramatic changes in clinical presentation, sensitivity to withdrawal effects, and the psychological meaning of the medication to the patient.

Use of As-Needed Medications

Although evidence suggests that PRN medications for psychiatric disorders may be associated with increased risks of morbidity, side effects, drug interactions, and addiction, they may have a place in a deprescribing framework. When used for clearly defined goals and timeframes, PRN medications hold promise to offset the need for continuous antipsychotic regimens. This approach should be taken with particular caution in BPD, however, given the above-discussed difficulties in stopping medications in BPD. A follow-up study of BPD patients' use of PRN medications found that they were three times more likely to use such medications than were patients in comparator groups, and that two-thirds continued to use the PRNs over time.[72] Though the frequency of long-term PRN prescriptions to people with BPD could suggest that they are useful, recovery from BPD was actually associated with very low PRN use.[72] This finding is more consistent with the alternate explanation that ongoing PRN use may not be compatible with recovery.[72] It is critical that we identify and respond to factors that may influence recovery, as a large gap remains between the frequency of people with BPD experiencing symptomatic remission and the (much lower) frequency of functional recovery.[15]

For those providers who do choose to employ PRN medications in BPD, the deprescribing framework may help to avoid long-term, recovery-impairing prescriptions. For an acute mental health setting, Baker and Lovell[97] recommend identifying a specific target symptom for each PRN medication, limiting the number and dose of PRN medications used, and limiting the duration of each prescription. They suggest that close

Table 1

How to Deprescribe in BPD Treatment[a]

Steps	Components of each step	Suggested modifications in BPD treatment[b]
1. Choose the right time	Avoid times of acuity Well-established treatment alliance Caution with active substance abuse	Attend closely to short- and long-term fluctuations in symptoms and in alliance Encourage patients' agency by introducing the idea of deprescribing and then returning to this step to ask them to suggest a good time
2. Compile a list of all medications	Document: dose, route, expected duration, and original indication; current therapeutic + adverse effects Estimate: potential drug-drug interactions; future risk-benefit ratio	Given potential for multiple comorbidities and therefore multiple providers, extra care may be needed to develop a comprehensive list Periodic review will be especially important, given potential for new/different providers Carefully clarify which are prescribed versus which are taken Consider risks from any overused medications or substances of abuse
3. Initiate the discussion with the patient	Discuss with the patient: knowledge and attitudes about their medications; perceptions of risks/benefits; meaning of medication(s)	Meaning of medication may be especially important in BPD
4. Introduce the idea of deprescribing (include friends and family if possible)	Inform about the process of deprescribing and its indications Solicit ideas/concerns/expectations Address emotions (anxieties, also hopes!) of the patient, family, and clinical care team Collaborate with family, caregivers	Work with patient to offer best understanding of what really helps (therapy, which medications, etc.) for specific symptoms Patients, families, caregivers (and prescribers ourselves) may feel intense wish to "fix the problem" with medications, and deprescribing may induce anxiety; collaboration and open discussion of these concerns can be very helpful Be on the lookout for unrealistic hopes about both medications and deprescribing Be aware of "countertransference" prescribing, which can lead to over- or underuse of medications; it can be helpful to keep in mind usual treatment practices in your own care of patients, to consult with colleagues, and to use note writing as an opportunity to engage patients' perspectives and to consider your own emotions
5. Identify which medication would be most appropriate for a taper	Collaboratively weigh pros and cons of deprescribing each medication Solicit preferences	For a variety of reasons, the medication that a patient identifies for tapering may not correspond with that identified by the prescriber, based on the risk-benefit ratio; this step may itself be an opportunity to return to step 3 and to further explore patient's experience of medication, including which symptoms are important Consider safety of the current medications, including risk in overdose; dispensing smaller pill counts or having someone hold high-risk medications may decrease risk Consider long-term effects of medications
6. Develop a plan	Start date and rate of taper Is another medication/formulation indicated during the taper? Reinforce biopsychosocial strategies Inform about expected and possible discontinuation effects	Emphasizing the collaboration between patient and provider may engage the patient in feeling cared for Emphasizing the importance of patient feedback about effects may engage the patient in taking charge and growing agency

Table 1
Continued

Steps	Components of each step	Suggested modifications in BPD treatment[b]
	Agree on monitoring/follow-up schedule and crisis plan	Being specific about how and when reevaluation of the deprescribing effort will occur may be especially important Consider using both subjective reports and quantitative scales
7. Monitor and, if necessary, adapt	Repeat each of the points in step 6, and also potentially the following: adjust rate of taper; treat discontinuation syndrome or relapse; abort/defer deprescribing	Keep in mind: It is helpful to discuss and try to understand symptoms/problems/benefits that arise during this process Collaborative and flexible responses are likely to be helpful Periods of acuity can be transient in BPD, and discussion of context may help prescriber and patient to understand the role of deprescribing in clinical change; not every clinical change requires immediate change in medication plan Ongoing discussion with other caregivers is likely to help Deprescribing is a process, not an endpoint; needs may change over time with age, clinical status, social environment, etc.

[a] Adapted from Gupta and Cahill (2016).[11]
[b] Note opportunities for therapeutic process in each step.

follow-up should include careful assessment of PRN medication benefits and adverse events. These recommendations are also highly relevant to the outpatient setting.

Higher Sensitivity to the Meaning of the Medication

In the psychopharmacological management of the person with BPD, medications may take on great psychological import, including to function as transitional objects. In attending to the meaning of the medication while prescribing, Mintz and Flynn[7(p 145)] recommend that the prescriber "avoid mind-body split, know who the patient is, attend to ambivalence about loss of symptoms, cultivate the therapeutic alliance, attend to countertherapeutic uses of medications, and identify, contain, and use countertransference." An exploration and awareness of these issues is likely to increase the success of a deprescribing intervention (Table 2).

Involvement of Other Supportive People

Involvement of other trusted people, both clinicians and friends/family, is a key aspect of the deprescribing approach. We think of this point as relevant to both the practical and psychological aspects of medication management. Supportive people in the patient's life may be able to help with medication access, adherence, and safety. They may be able to participate in medication planning discussions and to help by taking notes or pointing out relevant benefits or roadblocks. However, the psychological aspects of having a trusted other as part of the prescribing relationship are especially important in BPD. A supportive other may be able to increase support at times of medication transition and increased psychological fragility. Split treatments—with one provider as therapist and another as prescriber—can nevertheless be fertile ground for psychological processes that can be difficult.

> *Observation:* In the post-hospital meeting with Jackie, a deprescribing-informed provider would express interest in Jackie's experience before and during hospitalization. The prescriber would express interest in working with Jackie to figure out plans about medication management, and ask about when might be a good time to start talking about past and current medications (step 1). If met with impatience, the prescriber could discuss how frustrating it has been live with these symptoms, and could talk about how they can collaborate to optimize risk and benefit so that the result is most effective and livable (step 2). It may be that infusing appointments with discussion of the meaning of medications (step 3) from early in the prescribing process will help the patient to feel understood (and help the provider actually understand!). The empathic stance here is not to prescribe in order to soothe, however, but rather to collaborate and understand, and then to prescribe when the provider has enough information to do it safely and with clearly defined goals and planned timelines for reevaluation. The provider needs to

Table 2

Overcoming Hurdles: Common Patient Responses to Deprescribing

Common reactions	Possible factors	Possible responses
"I know you're doing this because you don't want to see me. I should've known, I'm a horrible person and nobody cares for me or understands my suffering."	Anxiety about abandonment; medication symbolizes care	Assurance that medication reduction ≠ reduction in individual care Schedule frequent check-in visits, at least at first
"Dr. Jones was the best doctor ever. He prescribed the lithium that saved my life and now you want to take it away."	Splitting—idealization of previous provider and devaluation of new one Medication as a transitional object	Explore feelings about Dr. Jones's departure Alternative strategies to make treatment be/feel more continuous and less abruptly changed
"You are not good enough. I don't want to see you anymore. I want to see someone who will give me what I really need."	Splitting, perhaps triggered by feeling unheard or devalued	Value the patient's experience: ask about this medication, past/current symptoms Collaborate with patient by offering a range of possible options for medication, dosing amount and timing; encourage patient to lead decision making
"I am feeling really anxious/I cannot sleep since we cut back on the Klonopin."	Benzodiazepine withdrawal Medication as a transitional object	Slow the rate of taper Reassurance Teach sleep hygiene Medications, such as antihistamines, to allay withdrawal symptoms
"What if I lose my benefits if I am not on medication?"	Systemic issue in disability assessment	Validate the concern Clarity and transparency in communication with social services and patient
"The meds are working fine. Why do you want to change them?"	To some extent, this concern is legitimate, and a maxim Abandonment fears may also be present	Validate the logic of the argument Discuss that what counts as effective and useful can change over time

- set expectations that this discussion will be ongoing,
- be willing to express uncertainty where it is warranted, especially about the potential efficacy of medications in BPD (= good psychoeducation [step 3]),
- set the stage for a series of repeated, flexible discussions (as in step 7),
- be willing to express concern where it is warranted (for example, about the use of benzodiazepines in BPD,
- discuss risk openly with the patient, and elicit her concerns and ideas for managing risk,
- be active about including supportive others for the patient (therapist, friend, family) and for yourself (consult with colleagues), and
- end each meeting with a clear plan, perhaps a written plan with a copy for each of you. A plan from a first meeting might simply be to meet back after collecting more information.

CONCLUSIONS

Evidence for psychopharmacological management of BPD is limited. Further research is needed to identify useful agents for treating BPD and to determine best practices for prescribing. Deprescribing offers a framework for engaging potentially useful biological interventions and, perhaps more importantly, for articulating a psychotherapeutic approach to the patient with BPD. Both qualitative and quantitative methods will be useful in defining the relevant outcomes of deprescribing-informed methods versus traditional prescribing methods in BPD. Studies of the impact of short-course and longer-term PRN medication use would be beneficial. Novel and better-targeted pharmacologic and circuit-based interventions may arise from ongoing investigations of the underlying biology of BPD. The core of deprescribing, however, is in the flexible collaboration between the prescriber, the patient, and supportive others. Our proposal includes core elements that will benefit from direct testing: among others, how to engage in active collaborative discussions with BPD patients about medication management, how to involve family, and how to manage an effective, proactive approach to split treatment.

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