# Guidelines for the Pharmacological Treatment of Antisocial and Borderline Personality Disorder

## Version 1

**Summary:**
Advice and guidelines on the use of medication in the treatment of personality disorders

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Antisocial, borderline, personality disorder, pharmacological treatment, BPD, ASPD

**Target Audience:**
Mental health staff working with patients with a personality disorder

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If the MDT is of the opinion that a pharmacological intervention is necessary the following protocol should be followed:

1. People with ASPD often present with co-morbid diagnoses or substance misuse concerns. Treat the co-morbid diagnoses such as depressive disorder, bipolar disorder or schizophrenia according to the relevant NICE or trust guidelines.

2. Pharmacological interventions should not be routinely used for the treatment of antisocial personality disorder or associated behaviours of aggression, anger and impulsivity. However there will be situations where pharmacological intervention may be necessary.

3. In situations where arousal levels need to be controlled behavioural interventions should be considered first but in some inpatient situations pharmacological interventions may be required to enable the patient to engage with the treating team. Consider using second generation antipsychotic eg. olanzapine or a benzodiazepine (e.g. lorazepam) in the short term. The team should be aware of the risk of misuse or overdose.

4. The decision to use pharmacological treatment should be an MDT decision, discussed with the patient who should be made aware of prescribing off licence. The rationale should be clearly documented with clear objectives for treatment. The treatment should be regularly reviewed and if there is no improvement in symptoms after 3 months then the medication should be discontinued.

5. In all situations prescribers should be aware of the risks of poor concordance, misuse and overdose. Doses should remain within BNF limits.
GUIDELINES FOR PHARMACOLOGICAL TREATMENT OF BORDERLINE PERSONALITY DISORDER (BPD)

1. Current NICE guidelines recommend that drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder\(^1\). However there are situations where clinicians may need to use pharmacological interventions with BPD patients. This may be in outpatient settings including crisis teams or in inpatient (including forensic) settings. There is little evidence available for the psychopharmacological treatment of these patients as there are few RCTs so the following protocol is based on the limited evidence available\(^2\). Pharmacological treatments should not be a substitute for psychological interventions. **The reason for the use of pharmacological intervention must be properly recorded and reviewed at regular intervals.**

2. Treat co-morbid diagnoses such as depressive disorder, bipolar disorder or schizophrenia according to the relevant NICE or trust guidelines.

3. In crisis situations consider the cautious use of sedative medication, as part of an overall treatment plan but this should be reviewed after one week. Short term prescribing in crises should attempt to use drugs with low side effect profile, minimal potential for misuse and relatively safe in overdose. The Maudsley prescribing guidelines recommend promethazine for BPD\(^3\) but in practice benzodiazepines (lorazepam or diazepam) are often used although prescribers should be aware of the risks of disinhibition, excessive sedation, tolerance and addiction.

4. There is no evidence that SSRIs (II) alone are beneficial for symptoms of BPD unless being used for co-morbid depressive disorder\(^3\).

5. For insomnia follow NICE guidelines and consider antihistamine or a hypnotic for short-term use\(^1\).

6. For symptoms of affective dysregulation consider mood stabilizers as first line treatment eg sodium valproate (I) or a second generation antipsychotic such as Olanzapine (II) Quetiapine or Aripiprazole (II) but be cautious due to the risk of overdose. There is no evidence for the role of Carbamazepine\(^2,3\).

7. For poor impulse control consider mood stabilizers (Sodium Valproate (I), lamotrigine (I) or topirimate (III)). The evidence for the use of second generation antipsychotics is mixed. Aripiprazole (II) and low dose olanzapine (II) have been shown to reduce impulsivity\(^2,3\). Clozapine may have a role in the management of impulsive behaviour if other measures have failed\(^4\).

8. For the treatment of persistent psychotic symptoms, initially consider a review of diagnosis. Otherwise second generation antipsychotics (olanzapine (II), aripiprazole (III), quetiapine (III) clozapine (IV)) should be considered for the treatment of persistent psychotic symptoms\(^3\).

9. In small studies of patients with BPD, clozapine has been found to be beneficial in controlling aggression, severe self-mutilation, need for seclusion, and need for close observation on inpatient wards (III)\(^4\). Quetiapine has also been evidenced to be effective in these circumstances (I)

10. In all of these situations the decision to use pharmacological treatment should be discussed with the MDT and patient who should be made aware of prescribing off licence. The patient should consent to the treatment and the decision should be properly documented. The diagnosis and treatment should be regularly reviewed and
if there is no improvement in symptoms after 3 months then the treatment should be reconsidered.

11. All treatments should be prescribed within BNF limits.

12. Avoid poly-pharmacy where possible.

13. Caution with prescribing mood stabilisers (such as sodium valproate or lithium) in women of childbearing age.

Level of evidence: I: at least one RCT (but in all cases small samples), II: controlled trial(s), III: descriptive trial(s), IV; experts opinion (NICE criteria).

References:
Diagnose Borderline Personality Disorder
Consider common co-morbidities e.g. Post-Traumatic Stress Disorder, mood and psychotic disorders

Check for co-morbid diagnoses especially depressive disorder

If no response

No co-morbid disorder

Provide support, Psychological treatments including DBT, Schema focused therapy, CBT

Yes

Treat co-morbid diagnoses according to NICE and Trust Guidelines

Co-morbid disorders tend to be more resistant to treatment in this group

If in crisis (e.g. acute distress, agitation, self-harm) manage with increased support, and psychological intervention.

Crisis continues with increased risk behaviours consider pharmacological treatment

Treat insomnia or anxiety symptoms according to NICE or trust Guidelines

Review Symptoms
Consider second opinion

Review for Co-morbid diagnoses and treat accordingly

Consider pharmacological treatments
Any drug treatments must be used in conjunction with psychological treatments

No co-morbid diagnosis

General prescribing advice
1. Pharmacological Interventions should not be used routinely
2. Co-morbid disorders must be excluded or treated accordingly
3. Be aware of poor concordance in this patient group
4. Be cautious of the overdose risk and potential toxicity of medication
5. Patient must be informed when prescribing off licence and a clear record of the rationale should be documented
6. Prescribe within BNF limits
7. Record reasons for prescribing
8. Review prescribing every 3 months

Note: These guidelines reflect the latest evidence and have been developed by specialists from both primary and secondary care. Clinicians are expected to consider the recommendations made in these guidelines but they do not override individual clinical judgements in consultation with the patient, carer or guardian.