Personality Disorder

If you only read four things:

1. People with a personality disorder may find it difficult to have close relationships, get on with other people, control their feelings and behaviour, listen to others.
2. There are estimated to be around 84,000 people aged over 16 in Suffolk with enough traits of a personality disorder to justify further investigation.
3. Brief psychological interventions are unlikely to be effective.
4. People with personality disorders are likely to have other mental health conditions, which must also be treated.

Key points
Personality disorders are a complex group of conditions identified by how an individual thinks, feels and behaves.

According to the Royal College of Psychiatrists, these conditions make it difficult for:

'you to live with yourself and/or with other people. You don’t seem to be able to learn from the things that happen to you. You find that you can’t change the bits of your personality (traits) that cause the problems. These traits, although they are part of who you are, just go on making life difficult for you - and often for other people as well.'

People with a personality disorder may find it difficult to:

- make or keep close relationships
- get on with people at work, and friends and family
- keep out of trouble or control their feelings or behaviour
- listen to other people
- avoid becoming unhappy or distressed and upsetting or harming others

The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) describes ‘impairment of personality functioning and the presence of pathological personality traits’ and identifies ten distinct personality disorders. For diagnosis, each requires identification of certain criteria.

These can be grouped into three clusters:

- **Cluster A: “Odd or Eccentric”** includes paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder
- **Cluster B: “Dramatic, Emotional, or Erratic”** includes antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder
- **Cluster C: “Anxious and Fearful”** includes avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder
User views
The ‘Conversations’ (quoted in the 2015 version of this report) identified a lack of provision for personality disorder:

- “more treatment available especially for personality disorders to avoid crisis”
- “upon diagnosis of personality disorder the service user needs more than an information sheet to explain the disorder”
- “more understanding of certain disorders, i.e. personality disorders to raise awareness and to dispel myths and misguided ideas about certain disorders. Some professionals most definitely need to have a better understanding”
- “training session on personality disorder required”
- “services for people with PD need for more services”

The numbers
Prevalence
The tables provide estimates of personality disorders by local authority and by CCGs. There are estimated to be around 84,000 people aged over 16 in Suffolk with enough traits of a personality disorder to justify further investigation.

The estimates are calculated from a national survey that screened for personality disorders based on self-reported data. The rates are not comparable with the two-phase rates from previous reports (e.g. NHS Digital. Adult Psychiatric Morbidity in England - 2007, Results of a household survey). A positive screen for personality disorder only indicates that someone may have sufficient traits to warrant further investigation. Screen positive rates tend to be higher than actual rates of disorder. ‘Screen’ does not indicate that the tests used in the survey are part of any national screening programme in England.
Table 1: Male: Estimated number aged 16+ years* who would screen for any personality disorder (SAPAS)\(^4\)

National prevalence estimates from survey in which participants were categorised following clinical interview\(^4\). Using rates against figures for residents of local authority districts in Suffolk, and registered patients in Ipswich and East Suffolk CCG and West Suffolk CCG.

<table>
<thead>
<tr>
<th>Prevalence per 1,000</th>
<th>Registered patients (01/18)</th>
<th>ONS Population projections: 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ipswich &amp; East Suffolk</td>
<td>West Suffolk</td>
</tr>
<tr>
<td>16/18-24</td>
<td>183.9</td>
<td>3,574</td>
</tr>
<tr>
<td>25-34</td>
<td>174.2</td>
<td>4,287</td>
</tr>
<tr>
<td>35-54</td>
<td>127.7</td>
<td>6,984</td>
</tr>
<tr>
<td>55-74</td>
<td>94.7</td>
<td>4,668</td>
</tr>
<tr>
<td>75+</td>
<td>81.6</td>
<td>1,445</td>
</tr>
<tr>
<td>All</td>
<td>132.4</td>
<td>21,939</td>
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</table>

* Antisocial Personality Disorder cannot be diagnosed before 18 years old.

Table 2: Male: Population estimates

<table>
<thead>
<tr>
<th>Male</th>
<th>Registered patients (01/18)(^6)</th>
<th>ONS Population projections: 2018(^7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ipswich &amp; East Suffolk</td>
<td>West Suffolk</td>
</tr>
<tr>
<td>16 - 24</td>
<td>19,434</td>
<td>11,320</td>
</tr>
<tr>
<td>25-34</td>
<td>24,607</td>
<td>14,882</td>
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<td>35-54</td>
<td>54,678</td>
<td>34,358</td>
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<tr>
<td>55-74</td>
<td>49,285</td>
<td>30,730</td>
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<tr>
<td>75+</td>
<td>17,708</td>
<td>11,292</td>
</tr>
<tr>
<td>All</td>
<td>165,712</td>
<td>102,582</td>
</tr>
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</table>

Table 3: Female: Estimated number aged 16+ years* who would screen for any personality disorder (SAPAS)

National prevalence estimates from survey in which participants were categorised following clinical interview. Using rates against figures for residents of local authority districts in Suffolk and registered patients in Ipswich and East Suffolk CCG and West Suffolk CCG.

<table>
<thead>
<tr>
<th>Prevalence per 1,000</th>
<th>Registered patients (01/18)</th>
<th>ONS Population projections: 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ipswich &amp; East Suffolk</td>
<td>West Suffolk</td>
</tr>
<tr>
<td>16/18-24</td>
<td>265.7</td>
<td>4,901</td>
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<tr>
<td>25-34</td>
<td>166.6</td>
<td>4,065</td>
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<tr>
<td>35-54</td>
<td>128.2</td>
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<td>55-74</td>
<td>94.0</td>
<td>4,741</td>
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<tr>
<td>75+</td>
<td>79.1</td>
<td>1,791</td>
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<tr>
<td>All</td>
<td>140.5</td>
<td>23,748</td>
</tr>
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</table>

* Antisocial Personality Disorder cannot be diagnosed before 18 years old.

Table 4: Female: Population estimates

<table>
<thead>
<tr>
<th>Female</th>
<th>Registered patients (01/18)</th>
<th>ONS Population projections: 2018</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Ipswich &amp; East Suffolk</td>
<td>West Suffolk</td>
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<tr>
<td>16 - 24</td>
<td>18,446</td>
<td>10,894</td>
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<tr>
<td>25-34</td>
<td>24,397</td>
<td>14,967</td>
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<tr>
<td>35-54</td>
<td>53,099</td>
<td>33,429</td>
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<tr>
<td>55-74</td>
<td>50,460</td>
<td>32,150</td>
</tr>
<tr>
<td>75+</td>
<td>22,642</td>
<td>13,951</td>
</tr>
<tr>
<td>All</td>
<td>169,044</td>
<td>105,391</td>
</tr>
</tbody>
</table>


Table 5: People: Estimated number aged 16+ years* who would screen for any personality disorder (SAPAS)**

National prevalence estimates from survey in which participants were categorised following clinical interview⁴. Using rates against figures for residents of local authority districts in Suffolk and registered patients in Ipswich and East Suffolk CCG and West Suffolk CCG.

See also the Common Mental Disorders chapter of the Suffolk Mental Health Needs Assessment.

<table>
<thead>
<tr>
<th>Prevalence per 1,000 (16+)</th>
<th>Registered patients (01/18)</th>
<th>ONS Population projections: 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ipswich &amp; E. Suffolk</td>
<td>West Suffolk</td>
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<tr>
<td>16/18-24</td>
<td>224</td>
<td>8,488</td>
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<tr>
<td>25-34</td>
<td>170</td>
<td>8,351</td>
</tr>
<tr>
<td>35-54</td>
<td>128</td>
<td>13,794</td>
</tr>
<tr>
<td>55-74</td>
<td>94</td>
<td>9,408</td>
</tr>
<tr>
<td>75+</td>
<td>80</td>
<td>3,234</td>
</tr>
<tr>
<td>All 16+</td>
<td>137</td>
<td>45,698</td>
</tr>
</tbody>
</table>

* Antisocial Personality Disorder cannot be diagnosed before 18 years old.

Table 6: People: Population estimates

<table>
<thead>
<tr>
<th>Persons: age</th>
<th>CCG Registered patients (01/18)</th>
<th>ONS Population projections: 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ipswich &amp; East Suffolk</td>
<td>West Suffolk</td>
</tr>
<tr>
<td>16 - 24</td>
<td>37,880</td>
<td>22,214</td>
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<tr>
<td>25-34</td>
<td>49,004</td>
<td>29,849</td>
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<tr>
<td>35-44</td>
<td>49,717</td>
<td>30,750</td>
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<td>35-54</td>
<td>107,777</td>
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<tr>
<td>55-74</td>
<td>99,745</td>
<td>62,880</td>
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<tr>
<td>16-64</td>
<td>246,583</td>
<td>151,515</td>
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<tr>
<td>16-74</td>
<td>237,500</td>
<td>146,503</td>
</tr>
<tr>
<td>75+</td>
<td>294,406</td>
<td>182,730</td>
</tr>
<tr>
<td>All 16+</td>
<td>334,756</td>
<td>207,973</td>
</tr>
</tbody>
</table>

What are the key inequalities in Suffolk?

More women are affected than men although the type of personality disorder which is most prevalent varies between men and women⁴.

Evidence

Borderline Personality Disorder: Treatment and Management CG78⁸

This guideline makes recommendations for the treatment and management of borderline personality disorder (BPD) in adults, and young people (under the age of 18), who meet criteria for the diagnosis in primary, secondary and tertiary care.

Borderline personality disorder leads to unstable mood, behaviour and relationships. There may be changes of mood leading to self-harm and suicidal behaviour. There can also be transient psychotic symptoms, with hallucinations and delusional thinking. People are at risk of suicide and are likely to struggle with relationships, employment and to be socially excluded. The severity of problems varies from mild to severe, with repeated crises and episodes of self-harm. The latter are frequent users of emergency services.

Although there are no medications specifically for borderline personality disorder, people will often have additional problems such as depression, anxiety, eating disorder, post-traumatic stress disorder or drug and alcohol misuse. People with borderline personality disorder should have the same access to services as others and be actively involved in making choices about their care and finding solutions.

The guidance describes the importance of:

- remaining optimistic about recovery
- building an open and trusting therapeutic relationship
- be aware of stigma
- being aware that changes in care arrangements will provoke reactions
- make careful plans around change

The guidance states that community mental health teams should be responsible for routine assessment, treatment and management for people with borderline personality disorder.

Assessment should cover:

- functioning and coping strategies
- other mental health problems and social problems
- need for psychological therapy, social support, employment support
- needs of dependents, especially children

Care planning should cover the role of professionals and agree treatment aims both short and long term. The aims could include issues such as employment.

A ‘crisis’ plan should be agreed, shared with the GP, including triggers to watch out for, self-management strategies and contact numbers for secondary care.
Psychological therapies should include an explicit plan shared with the user and should be based on the patient’s needs. Psychological therapy, especially for severe problems or co-morbidities, must be provided in a service with:

- “an explicit and integrated theoretical approach used by both the treatment team and therapist, shared with the client”
- “structured care”
- “provision for therapist supervision”
- sessions can be up to twice weekly

Brief psychological interventions specifically for borderline personality disorder, of less than three months, are not appropriate unless the above conditions are met.

The guidance suggests using a ‘comprehensive dialectical behaviour therapy programme’ for women with recurrent self-harming behaviour.

The Care Programme Approach (CPA), package of care for people with mental health problems, should be used when providing psychological treatment and outcomes monitored including functioning, drug and alcohol use, self-harm and depression.

Drug treatment should not be used for borderline personality disorder or the linked behaviour, for example, self-harm, emotional instability, or transient psychosis like symptoms.

The guidance recommends that the treatment of people with borderline personality disorder who do not have a diagnosed comorbid mental or physical illness and who are currently being prescribed drugs, should be reviewed with the aim of reducing and stopping unnecessary drug treatment.

The guidance recommends that mental health trusts should have specialist multidisciplinary teams for personality disorder. These teams should provide:

- assessment and treatment for those ‘with complex needs and/or high levels of risk’
- advice to primary and secondary care
- diagnostic advice to other mental health teams
- communication and information sharing
- advice on interventions, whether social, psychological and on drug treatment of ‘crisis, comorbidities and insomnia’
- develop guidelines for transition
- provide training to others
- ensure equality of access, including for minority ethnic groups

The staffing of the team would depend on local need, including the population served, and local prevalence.

**Antisocial Personality Disorder: Treatment and Management (CG77)**

The guidance emphasises the need for people with antisocial personality disorder (ASPD) to be actively encouraged and supported to engage with treatment and punitive approaches are likely to be less successful. It is important not to exclude people from care due to their diagnosis or history of antisocial behaviour. Care should be consistently planned according to treatment plan in all settings, and transfer of care should be avoided where possible. Care must be culturally appropriate and language and poor literacy should not be a barrier.

The guidance emphasises that women with antisocial personality disorder have higher incidence of common mental health disorders, such as depression, and other personality disorders.
The guidance notes that people with antisocial personality disorder are likely to withdraw from treatment and support and should be motivated to stay engaged. Families and carers should be encouraged to be involved, subject to confidentiality and consent and their needs should also be considered, especially where there are children and young people.

The guidance warns that antisocial personality disorder is under-diagnosed, and treatable conditions such as depression not picked up. Staff in substance misuse and probation services should be aware of the risk of antisocial personality disorder in their clients and know of appropriate referral pathways.

Assessment in secondary care, using structured validated methods, should include:

- behaviour
- functioning, coping strategies and risks
- other mental health problems such as depression substance misuse etc
- need for psychological treatment, social care and occupational support
- risk of domestic violence and abuse

The Care Programme Approach (CPA) should include risk assessment. For primary care settings this means awareness of history of violence, presence of stressors and possibly information from others which is relevant and referral to secondary care if there is perceived risk of violence or offending behaviour.

For secondary care, a more detailed history of violence is important along with history of contact with criminal justice system. It is likely that an initial assessment will be at a time of crisis. Secondary care may refer on to forensic services. Those considered at high risk should have a risk management plan, involving health and social care, probation and criminal justice where applicable.

The evidence for effective treatment is limited. There are four areas to consider:

- antisocial personality disorder itself
- behaviours associated such as impulsivity and aggression
- co-morbid conditions e.g. depression
- management of offending behaviour

People with antisocial personality disorder are likely to have poor compliance with treatment and should be offered care for co-morbid problems based on best practice evidence.

Psychological approaches including cognitive and behavioural interventions can be used for problems such as impulsivity, relationships, and antisocial or offending behaviour although programmes may need to be longer and more intensive.

Pharmacological approaches should not be routinely used but may be used for co-morbid conditions such as depression and anxiety.

Services for people with antisocial personality disorder require clear pathways and effective multi-agency care.

What are we doing?

Therapeutic options include:

- psychological treatments
- medication, including antipsychotics, antidepressants and mood stabilisers
Services and support are available through GP services and local mental health services. Patients with personality disorder may be supported by community based Integrated Delivery Teams (IDT) or Enhanced Care Pathway (ECP) teams. Patients may also require admission to second or third tier services.

Suffolk Mind provide the Waves Service for people with Borderline Personality Disorder, which caters for around 20 clients at any time.

What else could we do?

NICE has published detailed guidance in Personality disorders, and specifically in antisocial personality disorder (CG 77) and borderline personality disorder (CG 78).

NICE CG78 guidance states that community mental health teams should be responsible for routine assessment, treatment and management for people with borderline personality disorder. The guidance also recommends the use of psychological therapies in appropriate circumstances and the development of specialist teams.

Recommendations

- it is not clear from user views or activity information that the existing service meets the needs of patients with personality disorders. The role of the IDT and ECP should be clarified regarding personality disorders
- a specification should be developed which follows the recommendations of NICE guidance
- clinicians should be aware of the prevalence of personality disorders, the clinical features and risks
- training in risk assessment and care in a crisis should be available

Useful links

Related Suffolk Mental Health Needs Assessment topics

- Common mental disorders (Suffolk MHNA 2018)

Other links

- Rethink mental illness. Personality Disorders. (2016). Available at: https://www.rethink.org/diagnosis-treatment/conditions/personality-disorders
- Mental Health Foundation. Personality disorders. Available at: https://www.mentalhealth.org.uk/a-to-z/p/personality-disorders
• Personality disorder: No longer a diagnosis of exclusion. Available at: http://personalitydisorder.org.uk/

References


