Personality Disorder
Integrated Care Pathway

(PD–ICP)

3: Assessment, diagnosis and formulation

July 2015
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3. Assessment, diagnosis and formulation

3.1 Assessment

3.1.1 Introduction

Personality disorder and personality-related conditions are by their very nature complex. Their inherent complexity means that these conditions often require relatively more time to assess than many other disorders. Three to four sessions to assess and formulate is not untypical. Accurate diagnosis, formulation and treatment planning maximises the chance of recovery from these chronic conditions, which are associated with so much distress, poor functioning and resource uptake.

Personality disorder should no longer be viewed as a diagnosis of exclusion. In other words, it should be considered as a diagnostic possibility from an early point in the assessment process, rather than only receiving consideration later in the process when other diagnoses have been excluded. Early consideration of the diagnosis helps to avoid situations where patients receive inappropriate, unnecessary and sometimes harmful treatments.

While undoubtedly essential, diagnosis should constitute only one part of a broader formulation of an individual’s situation, their condition and their needs. In general terms, it is more important to identify the presence of personality disorder and to assess its severity than to subtype into specific personality categories. Personality disorder presents with certain symptoms which are predicated upon the interaction of an individuals personality traits and their environment. It is important to assess both symptoms and traits.

3.1.2 Symptoms

Symptoms occur as a result of maladaptation of the personality to the environment. It is helpful to think in terms of four broad headings:

- cognitive-perceptual (for example, excessive suspiciousness)
- affective (for example, emotional instability and anger difficulties)
- interpersonal
  - relationship with self/sense of self
  - interpersonal relationships
  - relationship with society
- behavioural/impulse control (including self-harm and suicidal behaviour)

3.1.3 Personality Traits

A personality trait (or variable) is a complex structure which represents the basic building block of personality. In a given individual, genetic and environmental factors transact to form a complex biopsychological system which produces observable trait-based behaviour.

Essentially, a personality trait represents a disposition to behave in a particular way. The term is also sometimes used to refer to individual features of specific personality disorder, especially when the full diagnostic criteria are not met. For example, someone meeting four of the five criteria needed for a diagnosis of borderline personality disorder may be referred to as having “borderline traits”.
Some traits which are of particular importance in personality disorder are listed below with brief descriptions of associated behaviours. Traits can be usefully organised into four main higher order trait domains: (emotionally) dysregulated, detached, dissocial, and compulsive. There may be overlap between some traits and it is worth noting that some of the names used for particular traits may have different meanings when used in other contexts. The traits below are drawn from the Personality Assessment Schedule (Tyrer, 2000). Other sources may label particular traits differently.

It is important to remember that no personality trait is inherently negative. Many traits can be described by more than one term, some with negative connotations and some with positive connotations. For example: impulsive versus spontaneous; stubborn versus determined; aloof versus self-contained and so on. Problems arise when a person’s personality traits are maladapted to their environment. With more extreme expressions of particular traits, maladaptation is likely in a greater number of environments leading to greater severity of personality disturbance.

**Dysregulated (Internalising) Domain**

- **Pessimism** — holds a pessimistic outlook on life.
- **Worthlessness** — feelings of inferiority
- **Lability** — mood instability
- **Anxiousness** — anxiety-proneness
- **Shyness** — shyness and lack of self-confidence
- **Sensitivity** — personal sensitivity and tendency to self-reference
- **Vulnerability** — experiences excessive emotional distress when faced with adversity
- **Childishness** — excessive self-centeredness
- **Resourcelessness** — tendency to give up when faced with adversity
- **Dependence** — excessive reliance on others for advice and reassurance
- **Submissiveness** — limited ability to express own views or stand up for oneself
- **Hypochondriasis** — over-concern about illness and health

**Detached (Schizoid/inhibited) Domain**

- **Suspiciousness** — excessive mistrust of others
- **Introspection** — prone to rumination and fantasy
- **Aloofness** — detachment and lack of interest in other people
- **Eccentricity** — oddness in behaviour and attitudes; unwilling or unable to conform

**Dissocial (Externalising) Domain**

- **Optimism** — unrealistically optimistic, over-confident, excessively self-important
- **Irritability** — excessively irritable
- **Impulsiveness** — excessive impulsiveness
- **Aggression** — excessive levels of (physical) aggression
- **Callousness** — indifferent to the feelings of others
- **Irresponsibility** — indifferent to the consequences of one’s behaviour
Compulsive (Anankastic) Domain

**Conscientiousness** — overly fussy, perfectionistic

**Rigidity** — inflexibility and difficulty adjusting to new situations

### 3.1.4 Areas of Assessment

Assessment for specific interventions may vary in emphasis but will generally cover the areas in the general assessment below. While it is recognised that a comprehensive assessment including all the components listed below may not be possible in every case, a detailed general assessment of personality disorder will typically include information gathered from four main sources: psychiatric history and mental state examination; collateral information; formal structured assessment tools; and clinician observations.

- **Detailed psychiatric history and mental state examination** including:
  - Important developmental and interpersonal factors such as:
    - Family and parental relationships including attachment patterns
    - Reactions to key developmental events and transitions
    - Losses, separations, relocations and responses to such events
    - Preliminary assessment of history trauma and neglect. Full exploration at assessment stage can be dysregulating and counterproductive if the patient does not have adequate self-regulatory skills. However, the patient should be made aware that traumatic events can be returned to in due course. An instrument such as the [Trauma History Screen](https://example.com) (Carlson et al., 2011) may be useful in gaining a trauma history.
    - Peer and romantic relationships
    - Important memories
  - Co-occurring disorders:
    - Axis 1
      - Post-traumatic conditions
        - Reliving experiences
        - Constriction/avoidance
        - Hyperarousal
      - Substance use
      - Other mental illness
        - Physical health conditions
  - Risk assessment: consider using a structured tool such as [STORM](https://example.com)
  - Personal strengths and attributes
  - Motivation to change
  - Symptoms: current difficulties or disturbance in the following domains:
    - Cognitive/perceptual
    - Affective
• Interpersonal
  • Relationship with self/sense of self
  • Interpersonal relationships
  • Relationship with society
• Behavioural/impulse control
  ▪ Traits: traits underlie the symptoms and can be grouped into 4 domains:
    • Dysregulated (internalizing)
    • Dissocial (externalizing)
    • Detached (schizoid)
    • Compulsive (anankastic)

• Collateral information:
  ▪ Healthcare records
  ▪ Informant information from (as appropriate):
    • Family
    • Friends and acquaintances
    • Professionals

• Clinician observations:
  ▪ Of interactions with others
  ▪ Within clinical encounters

• Formal structured assessment tools to be used where appropriate include:
  ▪ CORE-Outcome Measure (CORE-OM): self-reported general measure of well-being, problems, risk and functioning. This comes in CORE-34 (34 item) and CORE-10 (10 item) forms. (CORE, 1998)
  ▪ Global Assessment of Functioning (GAF): clinician-completed global assessment of functioning on 0-100 scale. This represents axis 5 of DSM-IV (DSM-IV, 1994).
  ▪ Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD): clinician completed semi-structured interview for borderline personality disorder based on the 9 DSM-IV criteria (Zanarini, 2003).
  ▪ Borderline Estimate of Severity over Time (BEST): self-reported measure of borderline personality disorder used in STEPPS. This measure is reasonably sensitive to change as it includes items relating to adoption of more adaptive behaviours. (Pfohl and Blum, 1997).
  ▪ Filter Questionnaire: self-report tool for presence of unhelpful core beliefs typically associated with borderline personality disorder (from STEPPS, Blum et al., 2008).
  ▪ Personality Belief Questionnaire (PBQ): self-report tool for presence of unhelpful core beliefs associated with a broad range of personality disturbance (Beck, 2001)
  ▪ Process of Recovery Questionnaire (PRQ): Self-report measure of recovery (Neil et al., 2007)
  ▪ Trauma History Screen (THS): self-report instrument assessing nature and severity of historical traumatic events. (Carlson, 2005).
  ▪ Personality Assessment Schedule (PAS): clinician-completed semi-structured interview of personality pathology from a trait perspective. (Tyrer, 1988).
  ▪ Clinical Global Impression (CGI): locally adapted clinician-completed tool with self-
3.2 Diagnosis

The current major diagnostic systems are the International Classification of Diseases, Tenth Edition or ICD-10 (World Health Organisation, 1993), and the Diagnostic and Statistical Manual-5 or DSM-5 (American Psychiatric Association, 2014). Both have a set of general criteria for diagnosis of personality disorder and sets of criteria for a number of specific personality disorders. There are slight differences in the categorisation of the two diagnostic systems but they are currently broadly similar. ICD-11 (due in 2017) is likely to fundamentally change the diagnostic process, switching to a simpler dimensional system, with greater scientific validity and clinical utility. However, until this happens, it is recommended that the current ICD-10 diagnoses are used. The exception is that DSM criteria should be used for the diagnosis of borderline personality disorder. This is because there the evidence base relating to treatments for Borderline Personality Disorder is based upon DSM-IV criteria rather than the ICD-10 equivalent diagnosis, Emotionally Unstable Personality Disorder.

In clinical practice, co-occurrence of several different specific personality disorders in the same individual is common. For example, only one in ten patients meeting criteria for borderline personality disorder only meet criteria for that specific personality disorder. In cases where the full criteria for more than one specific personality disorder are met, the diagnosis of F60.9 Personality disorder, unspecified should be made, with the prominent components specified. For example: F60.9 Personality disorder, unspecified (moderate, with borderline, dependent and anankastic components). It is useful, whatever the diagnosis, to indicate the severity as mild, moderate or severe. ICD-11 is likely to use “mild” to describe personality disorder with disturbance in only one higher trait domain, “moderate” for those with disturbance in two or more higher trait domains, and “severe” is likely to be defined as those with disturbance in two or more higher trait domains along with significant risk to themselves or others.

The diagnosis F61.0. Mixed Personality Disorder should be reserved for situations where the general criteria for personality disorder are met, but the full criteria are not met for any specific personality disorder category, although features from more than one specific category are present.

This phenomenon of co-occurrence underlines some of the shortcomings of the current classification systems. The DSM system has attempted to address the issue of co-occurrence of specific personality disorders by describing 3 clusters of personality disorders which are said to co-occur most frequently. While having some clinical usefulness, there is no robust empirical basis to these clusters:

- **Cluster A Odd/eccentric**: schizoid, paranoid and schizotypal personality disorders
- **Cluster B Dramatic**: borderline (emotionally unstable), narcissistic, histrionic and antisocial personality disorders
- **Cluster C Anxious/avoidant**: obsessive-compulsive (anakastic), avoidant (anxious) and dependent personality disorders

It is worth noting that for patients under the age of eighteen, clinicians are cautioned against making a diagnosis of personality disorder. However, undoubtedly patients under the age of eighteen do present with personality-related conditions. In such situations terms such as
“emergent personality disorder” or “evolving personality disorder” are sometimes used. If the clinician is unclear whether personality disorder is present or not, a presentation can still be referred to as a “personality-related condition”, or particular traits can be described. The primary aim in being clear about the role of personality versus major mental illness in such situations is to avoid inappropriate, unnecessary and sometimes harmful treatments and to enable appropriate early intervention.

3.2.1 ICD-10

3.2.2 F60 Personality Disorder ICD-10 (DCR-10) Criteria

3.2.2.1 General Criteria for Personality Disorder

G1. There is evidence that the individual’s characteristic and enduring patterns of inner experience and behaviour as a whole deviate markedly from the culturally expected and accepted range. Such deviations must be manifest in more than one of the following areas:
   1) cognition (i.e. ways of perceiving and interpreting things, people and events, forming attitudes and images of self and others)
   2) affectivity (range, intensity and appropriateness of emotional arousal and response)
   3) control over impulses and gratification of needs
   4) manner of relating to others and of handling interpersonal situations

G2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations

G3. There is personal distress, or adverse impact on the social environment, or both

G4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence

G5. The deviation cannot be explained as a manifestation or consequence of other adult mental disorders

G6. Organic brain disease, injury, or dysfunction must be excluded as the possible cause of the deviation.

3.2.3 F60.0 Paranoid Personality Disorder

A. The general criteria for personality disorder (F60) must be met.

B. At least four of the following must be present:
   1) Excessive sensitivity to setbacks and rebuffs;
   2) Tendency to bear grudges persistently, e.g. refusal to forgive insults, injuries, or slights;
   3) Suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous;
   4) A combative and tenacious sense of personal rights out of keeping with the actual situation;
   5) Recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner;
   6) Persistent self-referential attitude, associated particularly with excessive self impor-
7) Preoccupation with unsubstantiated ‘conspiratorial’ explanations of events either immediate to the patient or in the world at large.

3.2.4 F60.1 Schizoid Personality Disorder

A. The general criteria for personality disorder (F60) must be met.

B. At least four of the following must be present:
   1) Few, if any, activities provide pleasure;
   2) Display of emotional coldness, detachment or flattened affectivity;
   3) Limited capacity to express either warm, tender feelings, or anger towards others;
   4) An appearance of indifference to either praise or criticism;
   5) Little interest in having sexual experiences with another person;
   6) Consistent choice of solitary activities;
   7) Excessive preoccupation with fantasy and introspection;
   8) No desire for, or possession of, any close friends or confiding relationships (or only one);
   9) Marked insensitivity to prevailing social norms and conventions, disregard for such norms and conventions is unintentional

3.2.5 F60.2 Dissocial Personality Disorder

A. The general criteria for personality disorder (F60) must be met.

B. At least three of the following must be present:
   1) Callous unconcern for the feelings of others;
   2) Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations
   3) Incapacity to maintain enduring relationships, though with no difficulty in establishing them;
   4) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
   5) Incapacity to experience guilt, or to profit from adverse experience, particularly punishment;
   6) Marked proneness to blame others, or to offer plausible rationalizations for the behaviour that has brought the individual into conflict with society.

3.2.6 F60.30 Emotionally Unstable Personality Disorder, Impulsive Type

A. The general criteria for personality disorder (F60) must be met.

B. At least three of the following must be present, one if which must be (2):
   1) Marked tendency to act unexpectedly and without consideration of the consequences
   2) Marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized;
3) Liability to outbursts of anger or violence, with inability to control the resulting
behavioural explosions;
4) Difficulty in maintaining any course of action that offers no immediate reward;
5) Unstable and capricious mood.

3.2.7 F60.31 Emotionally Unstable Personality Disorder, Borderline Type

A. The general criteria for personality disorder (F60) must be met.
B. At least three of the symptoms mentioned in criteria B for F60.30 must be present, with at
least two of the following in addition:
   1) Disturbances in an uncertainty about self-image, aims and internal preferences
      (including sexual);
   2) Liability to become involved in intense and unstable relationships, often leading to
      emotional crisis;
   3) Excessive efforts to avoid abandonment;
   4) Recurrent threats or acts of self-harm;
   5) Chronic feelings of emptiness.

3.2.8 F60.4 Histrionic Personality Disorder

A. The general criteria for personality disorder (F60) must be met.
B. At least four of the following must be present:
   1) Self-dramatization, theatricality or exaggerated expression of emotions
   2) Suggestibility (the individual is easily influenced by others or by circumstances);
   3) Shallow and labile affectivity;
   4) Continual seeking for excitement and activities in which the individual is the centre of
      attention;
   5) Inappropriate seductiveness in appearance or behaviour;
   6) Over-concern with physical attractiveness.

3.2.9 F60.5 Anankastic Personality Disorder

A. The general criteria for personality disorder (F60) must be met.
B. At least four of the following must be met:
   1) Feelings of excessive doubt and caution
   2) Preoccupation with details, rules, lists, order, organisation, or schedule;
   3) Perfectionism that interferes with task completion
   4) Excessive conscientiousness and scrupulousness;
   5) Undue preoccupation with productivity to the exclusion of pleasure and interpersonal
      relationships;
   6) Excessive pedantry and adherence to social conventions;
   7) Rigidity and stubbornness;
8) Unreasonable insistence by the individual that others submit to exactly his or her way of doing things, or unreasonable reluctance to allow others to do things.

3.2.10 F60.6 Anxious (Avoidant) Personality Disorder
A. The general criteria for personality disorder (F60) must be met.
B. At least four of the following must be present:
   1) Persistent and pervasive feelings of tension and apprehension;
   2) Belief that one is socially inept, personally unappealing or inferior to others;
   3) Excessive pre-occupation with being criticised or rejected in social situations;
   4) Unwillingness to become involved with people unless certain of being liked;
   5) Restrictions in lifestyle because of need for physical security;
   6) Avoidance of social or occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval or rejection.

3.2.11 F60.7 Dependent Personality Disorder
A. The general criteria for personality disorder (F60) must be met.
B. At least four of the following must be present:
   1) Encouraging or allowing others to make the most of one’s important life decisions;
   2) Subordination of one’s own needs to those of others on whom one is dependent, and undue compliance with their wishes;
   3) Unwillingness to make even reasonable demands on the people one depends on;
   4) Feeling uncomfortable or helpless when alone, because of exaggerated fears of inability to care for oneself;
   5) Preoccupation with fears of being left to care for oneself;
   6) Limited capacity to take everyday decisions without an excessive amount of advice and reassurance from others.

3.2.12 F60.9 Personality Disorder, unspecified

3.2.13 F61.0 Mixed Personality Disorders
With features of several of the disorders in F60.x but without a predominant set of symptoms that would allow a more specific diagnosis.

3.2.14 DSM-IV

For borderline personality disorder, DSM-IV criteria should be used in preference to the ICD-10 criteria for emotionally unstable personality disorder for the reasons outlined above.

3.2.15 DSM-IV specific criteria for Borderline Personality Disorder
A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
   1) Frantic efforts to avoid real or imagined abandonment (do not include suicidal or self-
mutilating behaviour covered in Criterion 5);

2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation;

3) Identity disturbance: markedly and persistently unstable self-image or sense of self;

4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating), (do not include suicidal or self-mutilating behaviour covered in Criterion 5);

5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour;

6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);

7) Chronic feelings of emptiness;

8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights);

9) Transient, stress-related paranoid ideation or severe dissociative symptoms;

### 3.3 Formulation

The main purpose of assessment is to allow the collaborative development of a formulation of the different biological, psychological and social factors into a description of the patient’s life and personality which helps explain current problems and symptoms and identifies which problems, themes and goals will be the focus of treatment.

The style and emphasis of formulation will vary according to the specific purpose or intervention but relevant information for the formulation includes:

- Diagnostic formulation, with ICD-10 “F-codes” where applicable. This should include the primary diagnosis and any co-occurring diagnoses.

- Clinical formulation including:
  - Symptoms:
    - Cognitive/perceptual
    - Affective
    - Interpersonal
      - Relationship with self/sense of self
      - Interpersonal relationships
      - Relationship with society
  - Behavioural/impulse control
  - Important personality traits
  - Personal strengths
  - Over- and under-developed behaviours
  - Relevant core beliefs
  - Relevant developmental events such as childhood trauma

- Treatment plan:
  - Interventions and approaches by phase of recovery (including self-management approaches)
- Short term and long term goals
- Risk management plans; crisis plans

A useful method of formulation involves developing an understanding of the following five areas:

- **Problems**: shared view of the main difficulties with the patient wishes help
- **Predisposing factors**: factors from earlier life which increase vulnerability in adult life
- **Precipitating factors**: factors currently or recently present in the patient's life which can or have contributed to triggering the problems
- **Perpetuating factors**: factors which contribute to maintaining the problems
- **Protective factors**: factors which contribute to resilience and the ability to cope with adversity.

It can be useful to think of predisposing, precipitating, perpetuating and protective factors in terms of biological, psychological and social components.

While predisposing factors are usually historical and not amenable to change, change may be effected by reducing exposure to (or challenging) precipitating or perpetuating factors. There is also likely to be value in strengthening protective factors.

The draft formulation should be shared with the patient in verbal, written or diagrammatic form as appropriate. The patient should be asked for their views on the formulation and changes made appropriately. The aim is to develop a shared understanding of the difficulties and a commitment to the treatment plan — a formulation which the patient does not recognise or agree with, will not function as a basis for effective treatment. The formulation should be dynamic and should be updated in light of any new information or significant changes to the situation.

An example of a formulation and a blank formulation template can be found in the Appendix.
References


NICE. (2009). Borderline Personality Disorder Treatment and Management. NICE Clinical Guideline 78.


assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of Life Research, 13*(2), 299–310.

