The Royal College of Psychiatrists in Scotland

Briefing paper, August 2018

Personality disorder in Scotland:

raising awareness, raising expectations, raising hope

The Royal College of Psychiatrists in Scotland has identified personality disorder as a clinical and public mental health priority. We aim to promote education and awareness, and to campaign for service development in order to ensure the best possible outcomes for people with a personality disorder. We will achieve this through a 2-year campaign to raise awareness, identify areas of best clinical practice, make recommendations for change and break down barriers to effective care within and outside of our profession.

Our full report on personality disorder in Scotland, including a good practice guide, is now available on our website.

The publication of this report is intended to positively change attitudes of clinicians, the media and the wider public about the causes, prevalence and treatment of personality disorder. The report was put together by the Short Life Working Group on Personality Disorder whose membership includes representatives from faculties of RCPsych in Scotland, as well as others from various professional backgrounds and those with lived experience of the diagnosis.

This document will talk about **personality disorder (PD)** in general, as it is likely that many or all of the categories of personality disorder will disappear from the new International Classification of Diseases, in favour of an overall general category of "personality disorder".

This document will utilise the term **borderline personality disorder (BPD)**, rather than "emotionally unstable PD", as this is the term most commonly used in the public domain.

Why is personality disorder important?

Personality disorder (PD) is a common condition which is costly in terms of its impact on people's lives and in terms of the health and wider social costs of functional impairment. People with a diagnosis of PD are generally not well served by mental health and other services. However, as stated in the 2003 report[1] on personality disorder by the National Institute of Mental Health, PD should be part of the legitimate business of mental health services. Despite recent improvements, it is not clear that this aim has been achieved. There also remains significant stigma around PD which needs to be challenged.

People with a diagnosis of PD are no less deserving of care than people with other mental disorders. Working in mental health means working with people with PD as this is a common condition, often present alongside other mental disorders but often not recognised or formally diagnosed. People are entitled to expect a collaborative process of reaching and discussing a diagnosis and formulation as a basis for planning appropriate care.

There is a lack of understanding among professionals and the public regarding PD. There are effective therapies for the treatment of PD and guidelines for good general psychiatric care. We want to ensure that people with a PD are treated with compassion, curiosity and empathy by healthcare staff. In all settings, staff knowledge, empathy and skills can be improved with training, support and appropriate supervision. We want to challenge the stigma around PD, both within staff groups and in the public perception of what personality disorder means.

In this briefing we have provided facts about PD in the hope this will improve knowledge and awareness of this common condition.

What is personality disorder?

Personality disorder is usually defined as a deeply ingrained and enduring pattern of behaviour and inner experience. This affects thinking, feeling, interpersonal relationships and impulse control, and leads to significant functional impairment and distress. These patterns tend to affect all areas of life and functioning and tend to be inflexible and long lasting.[2][3]

A simple definition of personality disorder can be summarised as the **three Ps**:

- **Problematic** (outside the norm for the society in which they live, a source of unhappiness for the person and to others, and to severely limit them in their lives)
- **Persistent** (a chronic condition over a long period of time, usually emerging in adolescence and continuing into adult life)
- **Pervasive** (there are difficulties in all areas of the person's life, and how they react to the world around them. For example, work, family and relationship to sources of help may all be difficult).

The prevalence in the general population of all personality disorders is 6–10%.[4][5]

Consensus on how personality disorder develops

Most experts in the field subscribe to the biopsychosocial model for understanding the development of PD.

This means that PD develops because of interactions between:

- biologically/genetically determined vulnerabilities
- early experiences with significant others (attachment experiences)
- the role of social factors in buffering or intensifying problematic personality traits.

People with a diagnosis of personality disorder are more likely to have experienced a higher number of Adverse Childhood Experiences (ACEs), including childhood sexual abuse, inconsistent care and neglect.[7][8] It is important therefore that services for people with PD are trauma-informed, whilst also recognising that not all those with a PD diagnosis have had these experiences.

The prevalence of PD is estimated at up to 25%[6] of those in contact with primary care, and up to 50% of those in out-patient psychiatric contact.[9]

How common is personality disorder?

The prevalence in the general population of all personality disorders is 6–10%.[4][5] In specialised psychiatric care, this figure is estimated to rise to more than 50%.[9] Community prevalence is equal between males and females, but there is a higher prevalence in females in the clinical population, perhaps due to increased help-seeking.

Personality disorder is present in up to 50% of those in contact with specialist psychiatric services. However, it has been well described that there is **significant under diagnosis of PD** in these settings, with less than 8% of all psychiatric hospital admissions recorded as having a personality disorder.[5][10]

Co-morbidity with other mental disorders

In addition to the risk of self-harm and suicide, there is evidence a diagnosis of personality disorder is strongly associated with the diagnosis of other mental disorders, in particular anxiety disorders, affective disorders and substance misuse disorders.[4] Having a PD diagnosis also predicts a worse outcome and response to treatment, increases the risk of suicide in people with co-morbid mental disorders[11] and increases the risk of persistent and addictive drug use.[12]

Physical health and personality disorders

People with a diagnosis of personality disorder have higher morbidity and mortality rates than those without this diagnosis. This is due to higher self-harm and suicide risk, in addition to a higher incidence and mortality rate from cardiovascular and respiratory disease.[13][4]

Difficulties managing relationships with services and professionals may contribute to problems accessing appropriate help with physical health conditions, and the high prevalence of smoking and substance misuse are likely to be contributing factors.

Service users often describe difficulties interfacing with health professionals about physical health care needs, finding that they are often discriminated against because of their PD diagnosis. For example, being told that physical symptoms are "all in your head".

Risk of self-harm and suicide

Personality disorders are associated with considerable morbidity, including a high rate of deliberate self-harm, and a considerable lifetime risk of completed suicide. It is estimated that 75% of people with borderline personality disorder engage in deliberate self-harm and lifetime suicide risk in borderline PD is estimated between 8% and 10%, and in dissocial/antisocial personality disorder is estimated as 5%. Particular risk has been described around the time of first diagnosis.[14]

People with a diagnosis of PD have higher morbidity and mortality than those without this diagnosis. Life expectancy is 18–19 years shorter.[15]

Socio-economic cost of personality disorder

A personality disorder diagnosis is also associated with significant functional impairment, including low educational achievement, low income, conflict at work and unemployment. Several studies have found significant loss of days of productive role functioning and social role functioning in people with a PD diagnosis. This functional impairment tends to persist over time and remains relatively resistant to treatment.[16]

Individuals with a diagnosis of PD utilise more general practice, medical and psychiatry services, than those without this diagnosis. Estimates of direct healthcare costs and indirect loss of functioning costs are greater than for depression and generalized anxiety disorder), and comparable to schizophrenia.[17]

The need for diagnosis

Making a diagnosis of personality disorder relies on an understanding of the person's presentation over a significant period, and ideally with involvement of family, friends or others who know the individual well. There is a need to develop better understanding of PD and to reduce stigma, whilst acknowledging there are different views about this diagnosis.

It could be considered discriminatory not to make a diagnosis, as this may prevent the individual from accessing appropriate information about the disorder, pathways to evidence-based care and treatment where available, and it leads to under-representation of this mental health diagnosis in healthcare planning and policy.

It is essential to best care that staff have access to training on appropriate care and treatment for people with a diagnosis of PD, and for staff to engage in reflective practice.

Diagnosis for young people

Making a diagnosis has the value of offering an explanatory framework for young people and those caring for them, and most importantly can support them in accessing effective therapeutic interventions. There are several studies showing that careful diagnosis and time-limited interventions can result in significant reduction in symptoms and suffering.[18]

Treatment and recovery

There are effective therapy models for the specialist treatment of people with personality disorders. There are common factors from these models which can be utilised by staff in all agencies in providing good general care. People are entitled

to expect a collaborative process of reaching and discussing a diagnosis which should include a formulation and plan for care.

Recovery is possible. A 10-year prospective follow-up study showed that there was sustained remission (no longer meeting criteria for BPD for at least 4 years) for 30% of the sample at 4 years, rising to 50 % at 10 years' follow-up. This demonstrates a more hopeful picture of the course of BPD over time.[19]

Available therapies and treatments

- Of all personality disorders, the evidence for efficacy of psychological therapy is strongest for BPD.[20][21]
- Although findings support a substantial role for psychotherapy in the treatment of people with BPD, this is not yet a very robust evidence base and more research is required. The current evidence supports:
  - Dialectical Behavioural Therapy (DBT)
  - Mentalization Based Therapy (MBT)
  - Systems Training for Emotional Predictability and Problem Solving (STEPPS)
  - Schema Focussed Therapy (SFT)
  - Transference Focussed Therapy (TFP).
- There are no medications licensed for the treatment of personality disorder.
- There is no evidence for the use of any specific medication for crisis management in personality disorder.
- There is no clear evidence for the benefit of long-term hospital admission, but services are required for those in crisis.

What will the Royal College of Psychiatrists in Scotland do over the next 2 years?

1. Challenge misconceptions and reduce stigma around personality disorders

- The College will campaign to improve knowledge and awareness of personality disorder through public and professional educational events, engagement with politicians and healthcare providers, and media liaison.
- By producing and disseminating materials about personality disorders the College will seek to draw additional awareness to the campaign.

2. Advocate for adequate funding and equal service provision for personality disorders across Scotland

- The College will engage with politicians and healthcare providers to lobby for inclusion of specific actions on personality disorder in the Mental Health Strategy.
- The College will encourage each health board to have a personality disorder lead and to include personality disorder in mental health plans, ensuring availability of both long-term treatment and crisis care.
- The College will promote the establishment of a Managed Clinical Network for personality disorder to co-ordinate development of equitable service provision across Scotland.

3. Promote best practice in service delivery across both primary and secondary care

- By producing and disseminating a report on personality disorder which includes a good practice guide, the College will promote best practice in service delivery.
- The College will work jointly with the third sector, those with lived experience and the people who support them, to learn about their current and future expectations of care.

References

1. NIMHE, Personality Disorder: No longer a diagnosis of exclusion, 2003.
2. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013.
3. World Health Organisation, ICD-10 Classification of Mental and Behavioural Disorders, 1992.
4. J. Samuels, "Personality disorders: epidemiology and public health issues," *International Review of Psychiatry*, vol. 23 (3) pp. 223-233, 2011.
5. P. Tyrer, G. M. Reed and M. J. Crawford, "Classification, assessment, prevalence and effect of personality disorder," *Lancet*, vol. 385 (9969), pp. 717-26, 2015.
6. P Morans, R Jenkins, A Tylee, R Blizard, A Mann, "The prevalence of personality disorder among UK primary care attender," *Acta Psychiatrica Scandinavica*, vol. 102 (s405), pp. 52-57, 2000.
7. V. J. Felitti, R. F. Anda, D. Nordenberg, D. F. Williamson, A. M. V. Spitz, M. P. Koss and J. S. Marks, "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study," *American Journal of Preventative Medicine*, vol. 14 (4), pp. 245-58, May 1998.
8. M. C. Zanarini, A. A. Williams, R. E. Lewis, R. B. Reich, S. C. Vera, M. F. Marino, A. Levin, L. Yong and F. R. Frankenburg, "Reported pathological childhood experiences associated with the development of borderline personality disorder," *American Journal of Psychiatry*, vol. 154 (8), pp. 1101-6, 1997.
9. H. Beckwith, P. F. Moran and J. Reilly, "Personality disorder prevalence in psychiatric outpatients: a systematic literature review," *Personal Mental Health*, vol. 8 (2), pp. 91-101, 2014.
10. Tyrer P "Accurate recording of personality disorder in clinical practice," *BJPsych Bulletin* (2018) 42 (4), pp. 135-136
11. P. Moran, E. Walsh, P. Tyrer, T. Burns, F. Creed and T. Fahy, "Does co-morbid personality disorder increase the risk of suicidal behaviour in psychosis?", *Acta Psychiactrica Scandinavica*, vol. 107 (6), pp. 441-8, 2003.
12. M. C. Fenton, K. Keyes, T. Geier, E. Greenstein, A. Skodol, B. Krueger et al, "Psychiatric comorbidity and the persistence of drug use disorders in the United States," *Addiction*, vol. 107 (3), pp. 599-609, 2012.
13. H. B. Lee, O. J. Bienvenu, S. J. Cho, C. Ramsey, K. Bandeen-Roche, W. W. Eaton and G. Nestadt, "Personality disorders and traits as predictors of incident cardiovascular disease: Findings from the 23-year follow-up of the Baltimore ECA Study," *Psychosomatics*, vol. 51 (4), pp. 289-296, 2010.
14. J. M. Oldham, "Borderline personality disorder and suicidality," *American Journal of Psychiatry*, vol. 163 (1), pp. 20-26, 2006.
15. ML-Y Fok, RD Hayes, C-K Chang, R Stewart, FJ Callard, P Moran, "Life expectancy at birth and all-cause mortality among people with personality disorder", *Journal of Psychosomatic Research*, vol. 73 (2), pp.104-7, 2012.
16. A. E. Skodol, M. E. Pagano, D. S. Bender et al, "Stability of functional impairment in patients with schizotypal, borderline, avoidant or obsessive-compulsive personality disorder over 2 years," *Psyhological Medicine*, vol. 35 (3), pp. 443-451, 2005.
17. M. S. Soeteman, L. Hakkart-van Roijen, R. Verheul and J. J. V. Busschbach, "The economic burden of personality disorders in mental health care," *Journal of Clinical Psychiatry*, vol. 69 (2), pp. 256-265, 2008.
18. A. Chanen et al, "Early intervention for adolescents with borderline personality disorder: quasi-experimental comparison with treatment as usual," *Australian and New Zealand Journal of Psychiatry*, vol.43 (5), pp. 397-408, 2009.
19. M. C. Zanarini, F. R. Frankenburg, D. B. Reich and G. Fizmaurice, "Time to attainment of recovery from borderline personality disorder and stability of recovery: a 10 year prospective follow-up study," *American Journal of Psychiatry*, vol. 167 (6), pp. 663-667, 2010.
20. J. M. Stoffers, B. A. Vollm, G. Rucker, A. Timmer, N. Huband and K. Lieb, "Psychological therapies for people with borderline personality disorder. Cochrane Database Systematic Review," vol. 15 (8), 2012.
21. I. A. Cristea, C. Gentili, C. D. Cotet, D. Palomba, C. Barbui and P. Cuijpers, "Efficacy of Psychotherapies for Borderline Personality Disorder: A systematic Review and Meta-analysis," *JAMA Psychiatry*, vol. 74 (4), pp. 319-328, 2017.

The Royal College of Psychiatrists is the leading medical authority on mental health in the UK and is the professional and educational organisation for doctors specialising in psychiatry. Visit our website where you will find lots of information about mental health: www.rcpsych.ac.uk and follow us on Twitter @RCPsychscot.

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).