Condition Insight Report (CIR)

Personality Disorders (PD)

Version 1.1

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Overview

Brief overview of the condition

Personality disorders are conditions where the individual differs significantly from an average person, in the way they think, perceive, feel, or relate to others.

Personality disorders can affect how individuals cope with life, manage relationships, and feel emotionally.

There are several recognised personality disorders that are distinguished by their symptoms and these can be grouped into one of three clusters: A, B or C.

Examples of Cluster A personality disorders include:

- Paranoid: significant suspicion of others and lacks trust,
- Schizoid: prefer to be alone,
- Schizotypal: thought disorders and delusions. This PD can develop into Schizophrenia.

Examples of Cluster B personality disorders include:

- Antisocial (ASPD): impulsive without consequence,
- Histrionic: anxiety around being ignored, seek attention,
- Narcissistic: inflated sense of self,
- Emotionally unstable (EUPD) also known as borderline personality disorder (BPD): strong emotions with limited control.

Examples of Cluster C personality disorders include:

- Dependent: seek to be with others due to low sense of self,
- Avoidant: uncomfortable in social situations, fear rejection,
- Obsessive-compulsive: over cautious and pre-occupied with detail. Different to Obsessive compulsive disorder due to feeling actions are justified.

Presenting Symptoms

There is much variation in the type and range of functional restrictions in people with personality disorders. Some of the symptoms expressed are, but not limited to:

- Ritualistic behaviour
- Reduced motivation
- Anxiety, panic and overwhelming distress
- Distraction owing to poor concentration/attention (this could include hallucinations, delusions, paranoia, compulsions)
- Impulsive thoughts which can impact on insight and cognition

Cluster A: difficulty relating to others and usually shows patterns of behaviour that most people would regard as odd and eccentric.

Cluster B: struggle to regulate their feelings and often swing between positive and negative views of others. This can lead to patterns of behaviour that could be described as dramatic, emotional, erratic and disturbing.

Cluster C: struggle with persistent and overwhelming feelings of fear and anxiety. They may show patterns of behaviour that most people would regard as aloof and withdrawn.

Emotionally Unstable Personality Disorder is the most common PD that we come across in PIP. EUPD, in cluster B, can cause a wide range of symptoms, which can be grouped into 4 main areas:

1. **Emotional Instability:** Experiencing a variety of often negative emotions such as rage, low mood, panic, anxiety, fear, emptiness, and suicidal thoughts. Whilst also experiencing severe unpredictable mood swings over short spaces of time.
2. **Disturbed patterns of thinking or perception:** Cognitive or Perceptual distortions such as auditory hallucinations which may or may not be commanding and distressing beliefs e.g. That friends and/or family are trying to harm you.
3. **Impulsive Behaviour:** Suicidal thoughts and Impulses to self-harm, such as cutting, picking, or burning skin. A strong impulse to engage in reckless behaviour such as drug misuse, binge drinking, gambling, or spending money irresponsibly.
4. **Intense but unstable relationships with others:** The fear of abandonment may lead to feelings of extreme anxiety & anger towards others. This may cause close relationships to break down or may lead to a reliance on others for support in their day to day life.

Symptoms of people with personality disorders may be exaggerated in unfamiliar surroundings or stressful circumstances.

Fluctuations

PDs are long-term conditions. The presentation of the condition can vary over longer periods of time, and the condition and symptoms can also be reactive to stress and situations like a consultation.

Think about exploring things like:

- **Impulsivity**: Can they provide some examples? Has it caused them difficulties/injuries in the past? How often does it occur? How do they manage this emotion? Is there anything/ anywhere this seems worse/better?
- **Treatment:** Have they tried previous (historic) treatments to any success? Are they expecting, or have they discussed any future treatments (to include therapy/medication changes etc.)?
- **Distorted thinking:** Do they have any specific thoughts that they've had support to talk through? Do they hear voices, if so how often, and what do they say, do they act on them? Do they worry intensely about anything and if so what, and what do they do about this?
- **Compulsions**: Are these ritualistic in nature? How long do they take to complete? How does this impact upon routine? Do they always give in to these, how do they manage them?
- **Motivation:** Do they have motivation for any tasks? Does this change? How do you they manage this?
- **Panic attacks:** How long do they last? How are they managed? How often do they occur? What triggers?
- **Other symptom triggers**: Is there anything that brings specific symptoms on, or a pattern such as when faced with a new situation, leaving the house or engaging with others? If there are triggers, sensitively explore these.

Reliability

What specific areas should be covered to ensure a complete, reflective report?

SAFETY	TIMELY	ACCEPTABLE STANDARD	REPEATEDLY
Do they have any symptoms which could cause a safety consideration?	For any activities where restriction is reported how long does it take them to complete these activities? Has how long it takes them changed over time?	How have they adapted to completing tasks over time – is this different to what might be considered 'normal'?	Are they able to repeat a task as often as required? Is this the same every day?
Where there is any distraction due to hallucinations, delusions, extreme paranoia or compulsions explore this in detail. Consider if they have safety awareness into their actions. For any suicide and/ or self-harm risks with plans and no protective factors the claimant may require safeguarding.	Completing any compulsive actions or having intrusive obsessions can be very time consuming and affect an activity being completed. This should be explored where relevant. Other distractions such as hallucinations can also affect time frames. Whilst there is no set time frame of what is 'normal' consider how long it takes them and why to help you determine if this is reasonable.	Consider how they describe completion of tasks and the management of their condition/symptoms to determine whether this might be deemed appropriate. If this is acceptable – is it only because of extensive support networks in place, or do they self manage these symptoms.	Individuals may not experience the same emotions each day. They may have triggers or have better days than others which mean that the way they describe a task may not be typical for them. It should be explored what the impact any task has on their mental health and how they manage this to determine if it is repeatable as often as required.

RISK and Initial Review

Before making a decision on the route of a case please make sure you:

Consider the following in the information available:

- Severity of condition, and stability of claimant
- Previous hospitalisation
- Intensity of support in place
- Whether there is/has been service disengagement
- Insight of claimant into their condition
- Aggression/violence indicators
- Indication of suicidal thoughts/intent
- The presence of an additional support (AS) marker (and if not present, consider should there be one?)

Then proceed to:

1. Review the **decision matrix for clinical and non-clinical risk**
2. Attempt to contact most relevant contact for further information e.g. Community Psychiatric Nurse (CPN)
3. Where additional information is not available or forthcoming, ensure support is in place for TA/F2F for those who require it and are appropriate for this route.

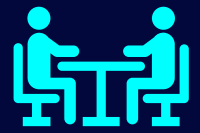
Watch this Mind video which shows two individuals talk about their lived experience of living with EUPD/BPD **HERE**

Customer Care

How is it best to ask about any sensitive topics and what are the common courtesies?

In general

- Be direct, empathetic and professional
- Make it clear you acknowledge they may find certain things difficult to discuss but you are not there to judge but instead need to understand the extent of any paranoia, compulsions or other thoughts they display or experience. Ask questions in an open and frank manner
- Be sensitive and give them time to respond to questions. Whilst there may be no expected impairment to communication, they may struggle to engage due to anxiety, be distracted or struggle to verbalise what they experience due to their own insight
- Look/listen for cues of any distress or discomfort with the discussion, reassure them and offer breaks as needed
- Ask them if they have any initial concerns about the consultation and see if you can address these
- Ask if there are any adjustments that would make them more comfortable e.g. if they would like a companion present for support
- **If they do not have a physical condition please do not ask them about their physical ability to complete tasks but instead focus on the psychological ability**



Sensitivities

What areas might they find difficult to mention or perhaps understate the impact of?

- The nature of their delusions/thought disorder can be upsetting for some people to talk about and describe to others
- Any demonstration of misconceptions about their condition may cause frustration. Showing knowledge of their condition and willingness to listen to their lived experience can support information provision

Functional Impact

A brief summary of the functional impact those living with this condition may experience

Activity 1: Preparing food

May be difficult due to getting 'distracted' by paranoia, compulsions, or hallucinations. Some may have little to no motivation for this task and disregard it, or be impulsive and make unsafe decisions.
Consideration should also be made to increased risk of self-harm through cutting oneself or another person due to their condition.

Remember in PIP…

Specifics around whether they complete this task, how often and under what circumstances is required. Any restrictions need to be explored such as compulsions, triggers for any impulsivity and how they manage this. Explore the extent of any support provided.

Activity 2: Taking nutrition

May be difficult due to getting 'distracted' by hallucinations or refusing to eat due to delusions. For some, food can be the source of their anxiety and can cause limitations with their initiation of eating and having enough nutrition.

Remember in PIP…

You need to have established the individual's ability to be nourished. You need to explore extent of any weight loss, motivation levels, how diet is managed and what any support does.

Activity 3: Managing therapy and monitoring a health condition

Many could lack insight into their condition. They are unlikely to believe anything is wrong so may stop taking medication/attending other therapy.

Remember in PIP…

Therapy input in a domestic setting, which covers majority of weeks and where they require supervision, assistance or prompting to complete should be explored and considered.

Ensure to explore how any medication is managed including compensation strategies like alarms to combat restrictions where there is severe anxiety around medication management.

Functional Impact

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Activity 4: Washing and bathing

Some may be distracted from personal care all together, others may become obsessive over being clean, or even refuse to wash and bathe appropriately. This could be due to paranoia, compulsions, anxiety or other related symptoms.

Remember in PIP…

Consider the specifics of what, if anything impairs their ability to get washed. You must explore management strategies and what might happen without any reported support in place i.e. how long might they leave this task, or how often might they complete it. Where there are compulsions be clear about what these are and whether it is a factor here.

Activity 5: Managing toileting needs and incontinence

Consider any comorbidities.

Remember in PIP…

Whilst there might not be a restriction here consider that some may have extreme anxiety and compulsive behaviour about toileting and cleaning themselves or whether it is hand hygiene in general which is addressed in A4. You need specific detail to determine if it can be considered here.

Activity 6: Dressing and undressing

Some may report reduction in their concern for appearance and getting dressed regularly, whilst for others they are fixated on it.

Remember in PIP…

Consider the specifics of what, if anything impairs their ability to get dressed and how this is managed with specifics. Consider what might occur without any support in place. Do they have understanding of what is appropriate? Does their impulsivity play any part here? Are there any examples of intervention from others? How long does it take them? Do they do this every day?

Functional Impact

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Activity 7: Communicating verbally

Hallucinations and delusions may cause someone to use a communication style that cannot be understood by others (e.g. speaking in tongues). May not be able to properly interpret others due to delusions.

Remember in PIP…

That there are specific boundaries for what is considered basic and complex. How their emotions impact on their ability to manage relationships and respond to individuals is likely to be managed in A9. Ensure to explore for specifics where a restriction is reported to determine if simple and/or complex criteria is met.

Activity 8: Reading and understanding signs and symbols

Consider if there is any impaired cognitive function.

Remember in PIP…

That there are specific boundaries for what is considered basic and complex. Ensure to explore for specifics where a restriction is reported to determine if simple and/or complex criteria is met.

Activity 9: Engaging with others face to face

Likely to be very difficult for some. They may find another's behaviours unacceptable and be easily triggered into aggression or even violence. For some delusions and paranoia can result in a fear of others and social situations, whilst others actively seek it out and are inappropriately familiar/dependent. This can affect an individuals ability to form relationships with others and effectively engage in social situations.

Remember in PIP…

Cover where specific restrictions are reported how they manage this. Detail of any support provided and whether this support can be provided by anyone or only specific individuals, and why – what is it they do for the individual?

Functional Impact

A brief summary of the functional impact those living with this condition may experience

Activity 10: Budgeting

May be made more difficult due to cognitive impairment. Delusions and hallucinations can be about money which can cause the person to make unwise decisions they wouldn't otherwise make. Some may find themselves worrying all the time about things that are part of their everyday life or about things that are unlikely to happen, which can impair their ability to plan and budget for the future.

Remember in PIP…

That there are specific boundaries for what is considered basic and complex. Ensure to explore for specifics where a restriction is reported to determine if simple and/or complex criteria is met.

Activity 11: Planning and following a journey

There are lots of symptoms which could impact the ability to plan and follow a journey. There could be difficulty due to distraction in form of hallucinations, or extreme paranoia. Paranoid delusions may mean making journeys will cause distress, which can vary in level and how this manifests. Individuals with impulsive behaviour may put themselves in unnecessary risk and have no care or consideration for consequence. Some may have anxiety which can cause panic attacks in crowds, or where journeys do not go as expected.

Remember in PIP…

Where there are associated conditions you must explore the 4 stages to a journey 1. Frequency and type of outings 2. before a journey 3. during a journey and 4 post a journey.
Any social anxiety and/or anxiety related to change? If so to what extent, how and when does this manifest, how it is managed, is it present on all journeys or just unfamiliar ones? Is there any impulsive behaviour or safety concerns which could affect their ability to plan and follow a route? How do they get to appointments for specific times, do they attend them?

Activity 12: Moving around

Consider any comorbidities.

Remember in PIP…

Individuals may struggle to provide specific information. Try to use examples to help or things in their area they might be able to refer to. You must explore whether any journey discussed is repeatable, where possible how long it takes them, how they feel whilst doing it, and any incidents of note such as falls in the past 12 months?

Additional reading or other resources

EXTERNAL

- https://www.nhs.uk/conditions/personality-disorder/
- https://pathways.nice.org.uk/pathways/personality-disorders
- https://www.rethink.org/advice-and-information/about-mental-illness/learn-more-about-conditions/personality-disorders/
- https://www.rcpsych.ac.uk/mental-health/problems-disorders/personality-disorder?searchTerms=personality%20disorder
- https://www.mind.org.uk/information-support/types-of-mental-health-problems/personality-disorders/types-of-personality-disorder/
- http://personalitydisorder.org.uk/about/

INTERNAL

- Desktop Aid – MSE, Mental Health
- CPD: Personality Disorders

Version control

Version	Date	Signed off by	Comments
1.1	09/02/2021	Dr Shah Faisal / Karl Donaldson	New re-banded document
1.1	30.03.23	Rebecca Sparks	2 year document review. Amendments made to 12 PIP Activities.