Assessing and Formulating Personality Disorder

THE TALKING THERAPIES UK PRACTITIONER SERIES



Assessing and Formulating Personality Disorder

Dimensional assessment, risk and shared formulation

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

Copyright © 2026 Talking Therapies UK. All rights reserved.

The moral right of the author has been asserted. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means without the prior written permission of the publisher, except for brief quotations in a review, and except that a purchaser of the accompanying course may print a single copy for their own study.

First edition, 2026.

This manual accompanies the Assessing and Formulating Personality Disorder course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 Part 1: Conducting a dimensional assessment 3

1. Conducting a dimensional assessment 4
2. The assessment as a therapeutic act 10

How to use this manual

Assessment is where personality disorder care either becomes therapeutic or repeats the harm, and this course teaches it as a craft in its own right. Built on the ICD-11 dimensional model, it trains you to assess severity and trait presentation rigorously, to read the assessment relationship itself as data, and to formulate in a way the person can recognise, use and keep.

The first module works the dimensional assessment at practitioner depth: structuring the interview, rating severity from functioning and consequence rather than drama, eliciting the trait picture through lived episodes, and conducting the whole process as a therapeutic act, because people with these histories have usually been assessed often and helped rarely, and the difference is in the conduct. The second module takes on the territory services most often get wrong: risk assessed and formulated without exclusion, chronic and acute-on-chronic patterns distinguished, protective factors audited honestly, and power, stigma and cultural context written into the formulation rather than around it. The course closes with the shared formulation itself: co-written, staged, bearable, and precise enough to route treatment to the person's actual severity and stage.

Substantial written lessons with key points and practice tasks that build real assessment craft, with a study tutor throughout, a final assessment, and a personalised certificate on passing. For practitioners who want their assessments to be the beginning of treatment rather than the gate in front of it.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to

supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Assess personality difficulty with structured tools alongside clinical interview
- Distinguish personality-level difficulty from mood, trauma and neurodevelopmental presentations that mimic it
- Formulate using severity, traits, attachment style and relational patterns together
- Assess and formulate risk, including chronic suicidality, without reflex escalation
- Share a personality-difficulty formulation with the client compassionately and usefully
- Write formulations that help teams hold, rather than reject, the client

PART 1

Part 1: Conducting a dimensional assessment

Lessons 1 to 4 of the course.

CHAPTER 1

Conducting a dimensional assessment

Dimensional assessment of personality disorder represents a fundamental shift in contemporary clinical practice, moving the focus from categorical labels to a nuanced mapping of enduring trait patterns that cut across diagnostic boundaries. In the United Kingdom, the most widely endorsed framework for this approach is the International Classification of Diseases, Eleventh Revision (ICD-11), which delineates five core trait domains – Negative Affectivity, Detachment, Dissociality, Anankastia and Disinhibition – and grades each domain on a severity continuum ranging from mild to severe. Parallel developments in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) have introduced the Personality Inventory for DSM-5 (PID-5) and the Alternative Model for Personality Disorders, both of which converge on a similar five-domain structure rooted in the Five-Factor Model of personality (McCrae & Costa, 1997). The evidence base for dimensional models is robust, with meta-analytic work by Krueger and colleagues (2012) demonstrating superior predictive validity for functional outcomes compared with traditional categorical schemes, and longitudinal studies indicating that trait severity predicts treatment response and relapse risk (Bender et al., 2020). Consequently, clinicians tasked with assessing personality disorder must master a structured interview that elicits each domain reliably, apply a calibrated rating system, and translate the findings into a formulation that directly informs therapeutic planning.

The interview begins with a warm-up phase designed to establish safety and collaborative intent. A clinician might start by inviting the client to describe a typical day, thereby gathering baseline information about routines, relationships, and emotional tone without imposing diagnostic language. This initial rapport-building is essential because the subsequent phases require probing into potentially sensitive areas such as interpersonal conflict, impulsivity, and self-perception. Throughout the interview, the therapist must balance empathy with precision, employing open-ended prompts that encourage the client to narrate lived experiences while avoiding leading questions that could bias responses. For example, rather than asking, “Do you often feel empty?” the clinician asks, “Can you tell me about moments

when you feel a lack of purpose or motivation, and what you do in those moments?" Such phrasing respects the client's narrative agency and yields richer data for trait appraisal.

A systematic structure for the interview typically follows four interlocking stages: (1) contextual orientation, (2) exploration of each trait domain, (3) severity rating, and (4) synthesis into a formulation. In the contextual orientation stage, the clinician gathers developmental history, current psychosocial stressors, and any prior mental-health contacts. This information provides a backdrop against which trait expressions can be interpreted, distinguishing between situational reactions and pervasive patterns. The second stage is the core of the dimensional assessment and requires the clinician to move deliberately through the five trait domains, using a set of empirically derived probes for each. For Negative Affectivity, the clinician explores the frequency and intensity of emotions such as anxiety, dysphoria, and anger, asking the client to describe situations that trigger strong affective responses and the coping strategies employed. Detachment is examined by inquiring about the client's desire for social contact, capacity for intimacy, and affective expressivity, often through questions about friendships, romantic involvement, and emotional sharing. Dissociality is probed by assessing empathy, respect for social norms, and propensity for exploitative or manipulative behaviour, with prompts that explore the client's reactions to others' suffering and adherence to rules. Anankastia is investigated by focusing on perfectionism, orderliness, and rigidity, inviting the client to discuss routines, standards, and the distress caused by perceived imperfection. Finally, Disinhibition is explored through inquiries about impulsivity, risk-taking, and difficulty delaying gratification, encouraging the client to recount episodes of spontaneous decision-making and the consequences thereof.

Reliably rating severity across these domains demands a calibrated approach. The ICD-11 recommends a four-point scale: 0 (absent), 1 (mild), 2 (moderate), 3 (severe), and 4 (extreme). To apply this scale consistently, clinicians should anchor each rating to observable behavioural indicators and functional impairment. For instance, a rating of "moderate" Negative Affectivity might be assigned when the client experiences frequent intense emotions that interfere with work performance but are not pervasive across all contexts, whereas "severe" would be reserved for pervasive emotional volatility that disrupts multiple life domains, including relationships,

occupational functioning, and self-care. Inter-rater reliability can be enhanced by using structured rating guides, such as the ICD-11 Personality Disorder Severity Rating Manual (World Health Organization, 2022), and by seeking collateral information from family members, medical records, or validated self-report instruments like the PID-5-BF (Bach et al., 2016). When discrepancies arise, clinicians should discuss the case in supervision, referencing concrete examples from the interview to reach consensus.

Recording the findings in a manner that drives treatment planning is a critical final step. The formulation should succinctly link each domain's severity rating to specific functional impairments and therapeutic targets. A concise format might read: "Negative Affectivity (severe) – marked emotional lability, frequent anxiety episodes, and difficulty tolerating distress, leading to occupational absenteeism; Disinhibition (moderate) – impulsive spending and substance use, contributing to financial instability; Detachment (mild) – limited social support network, increasing risk of isolation." This formulation not only captures the trait profile but also highlights the areas where intervention is most needed, guiding the selection of evidence-based modalities such as Dialectical Behaviour Therapy for emotion regulation, Cognitive-Behavioural Therapy for impulsivity, or schema-focused approaches for perfectionism.

To illustrate the full process, consider the case of a 29-year-old client, Emma, who presents to a community mental-health service after a series of interpersonal crises and self-harm episodes. Emma reports that she often feels "on edge" and "like a bomb waiting to explode," especially when she perceives criticism at work. She describes a pattern of intense arguments with her partner, followed by periods of withdrawal in which she isolates herself for days, avoiding all contact. Emma also admits to frequent binge-eating episodes and occasional reckless driving when she feels "out of control." During the contextual orientation, the clinician learns that Emma's difficulties began in adolescence, with a history of academic perfectionism and a fear of failure that intensified after a recent promotion. Collateral information from Emma's sister confirms that Emma's mood swings and impulsive behaviours have escalated over the past year.

When exploring the five trait domains, the clinician asks Emma to recount a recent episode of anger. Emma describes a meeting where a colleague questioned her report; she felt a surge of rage, shouted, and later threw a

coffee mug, breaking a window. She reports feeling “empty” after the incident and spending the night binge-eating to “fill the void.” In probing Detachment, Emma notes that after the argument she “just stayed in my room, didn’t answer anyone’s texts,” and that she rarely feels comfortable in large social gatherings. Regarding Dissociality, Emma acknowledges that she rarely thinks about how her outbursts affect others, but she does not report a pattern of deceit or exploitation. In the Anankastia domain, Emma describes an obsessive need to have all her work documents perfectly organised, leading to sleepless nights when she perceives any deviation. Finally, in the Disinhibition domain, Emma recounts a recent episode of reckless driving, stating, “I just wanted to feel something, anything, and the speed gave me that rush.”

Applying the ICD-11 severity scale, the clinician rates Negative Affectivity as 3 (severe) because Emma’s emotional volatility is pervasive, leads to self-harm, and significantly impairs occupational functioning. Detachment is rated 2 (moderate) given her pattern of social withdrawal that contributes to isolation but does not preclude all social contact. Dissociality receives a rating of 1 (mild) because while Emma shows limited empathy during conflict, there is no evidence of systematic disregard for others’ rights. Anankastia is rated 3 (severe) due to her perfectionistic standards that cause chronic insomnia and distress. Disinhibition is rated 2 (moderate) because impulsive behaviours such as binge-eating and reckless driving are present but not constant. The clinician cross-checks these ratings with the PID-5-BF, which yields comparable domain scores, enhancing confidence in the assessment.

The formulation records: “Severe Negative Affectivity – emotional lability, frequent anxiety, self-harm, leading to occupational absenteeism; Severe Anankastia – perfectionism, insomnia, functional impairment; Moderate Detachment – social withdrawal, limited support network; Moderate Disinhibition – impulsive eating and risky driving, contributing to health risks; Mild Dissociality – limited empathy in conflict.” This synthesis directly informs a treatment plan that prioritises emotion-regulation skills through Dialectical Behaviour Therapy, addresses perfectionistic cognitions with Cognitive-Behavioural Therapy for perfectionism, and incorporates harm-reduction strategies for impulsive behaviours, including a structured eating plan and a driving safety contract. The formulation also flags the need for adjunctive sleep hygiene interventions and potential liaison with

occupational health services to support workplace accommodations.

In practice, the dimensional assessment must be documented in a manner that is both clinically meaningful and accessible to multidisciplinary teams. The record should begin with a brief contextual summary, followed by a tabulated presentation of each domain's rating, a concise narrative linking ratings to functional outcomes, and a clear statement of therapeutic priorities. This structure ensures that the assessment does not become a decorative artefact but rather a living document that guides case formulation, informs supervision, and facilitates outcome monitoring. Moreover, by anchoring the assessment in observable behaviour and functional impact, the clinician safeguards against the stigma that can accompany categorical labels, fostering a therapeutic stance that respects the client's individuality while maintaining scientific rigour.

Finally, it is essential to recognise that dimensional assessment is an iterative process. Trait severity may fluctuate over the course of treatment, and re-rating at regular intervals – for example, every three months – allows the clinician to track change, adjust the formulation, and modify the treatment plan accordingly. Research by Tyrer and colleagues (2021) demonstrates that systematic re-assessment predicts better long-term outcomes, as it encourages a dynamic therapeutic alliance and reinforces the client's sense of agency. By embedding these practices into routine clinical work, practitioners not only align with the contemporary evidence base but also enhance the precision and effectiveness of personality-disorder care within the UK mental-health system.

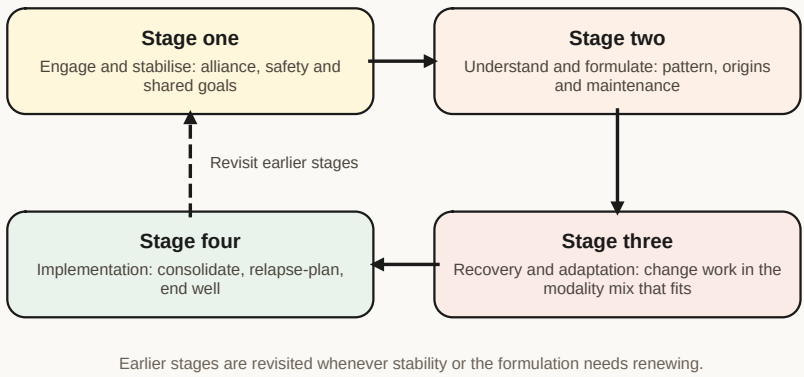


FIGURE 1.1 The IPTF pathway at a glance

The integrative pathway taught across the IPTF courses moves through four broad stages: engaging and stabilising, understanding and formulating, working for recovery and adaptation, and implementing gains so they hold in everyday life. Progress is cyclical rather than strictly sequential; earlier stages are revisited whenever the work requires it.

Points worth keeping

- Structuring the interview
- Rating severity reliably
- Eliciting the five trait domains
- Recording findings so they plan treatment

PRACTICE TASK

Draft the section headings of a dimensional assessment report.

CHAPTER 2

The assessment as a therapeutic act

The people this pathway serves have usually been assessed many times, and assessment has usually gone badly: questions experienced as interrogation, disclosures met with form-filling, verdicts delivered without the person recognising themselves in them. So they arrive at yours braced. That fact is not an obstacle to a good assessment; it is the assessment's first finding, and the first opportunity, because an interview conducted well is, for this population above all, the first intervention. It models the three things treatment will ask them to believe are possible: curiosity about their experience, containment of what that experience does in a room, and respect that survives disclosure. This lesson teaches how to conduct the dimensional assessment so that it does all three without losing the structure the last lesson built.

Engagement begins before the first question, with the frame stated plainly: what this meeting is for, how long it lasts, what will happen with what is said, and, said explicitly, that the aim is to understand how life works from inside their experience, not to catalogue what is wrong with them. Then let the person begin where they are. The structured content of the last lesson is a destination, not an itinerary; the skilled assessor holds the map in mind and lets the route be conversational, banking domains as the person's own narrative passes through them and steering only when whole territories would otherwise be missed. Questions carry the stance in their grammar. Open, experiential framings, what happens inside you when someone gets close, walk me through how that friendship ended, yield both better data and better relationship than criterion translations, and the habit of asking what happened rather than why, what did that protect rather than what is wrong, keeps the interview descriptive in exactly the sense the foundations course argued diagnosis should be.

Validation is the engagement's active ingredient, and it has a precise meaning that stops well short of approval: communicating that the person's responses make sense given their history and their present perception. It can be offered at increasing depths, reflecting accurately, acknowledging the feeling, and, most powerfully with this population, validating in terms of the

life: given what you learned about what happens when you rely on people, checking up on them makes complete sense. That sentence, delivered honestly mid-assessment, frequently produces the interview's turning point, because it demonstrates the thing the person has stopped expecting: that their behaviour can be understood rather than judged. Validate the valid, though; empty affirmation reads as technique and confirms the suspicion that professionals perform care rather than feel it. The genuinely invalid, distorted perceptions, harmful strategies, get curiosity instead, and the distinction, validate the response, stay curious about the appraisal, is one to practise until it is native.

Containment is the third craft, because a history that includes trauma, shame and rage will bring all three into the room, and what you do with them is the demonstration that matters. The tools are pacing, you do not need to open every door today, and it is a strength of the assessment, not a failure, to say so aloud: we can note that there is something painful there and leave it until there is more safety around it. Grounding when arousal climbs, slowing, orienting, breathing with the person, models affect regulation as something two people can do together. Your own steadiness under disclosure, neither flinching nor performing unshockability, answers the question the person is really asking, which is whether their inside is bearable to another mind. And containment includes the interview's edges: a middle that does the deep work, an ending that deliberately descends, returns to the present, names something of what was managed together, and says clearly what happens next, because how the hour ends is read as evidence of how the treatment would end.

A closing fragment shows the doubled craft holding under pressure. Forty minutes in, describing the end of her last therapy, the person's voice hardens: you people always do this, you get me talking and then you write your little notes and disappear like the rest of them. The interrogation reflex would defend or redirect; the drift reflex would abandon structure and soothe. The assessor does neither: she puts down the pen, and says, so being asked to open up, by someone who might then leave, is exactly the situation that has hurt you most, it makes sense that doing this with me feels dangerous. Validation in terms of the life, offered at the moment the pattern entered the room. Then, and this is the part trainees miss, she keeps the structure visibly alive: I want to understand that properly, and I also want us to end today with you feeling we did this safely, so tell me as much of that

story as feels right for today. The person settles, gives twenty minutes of the best material of the interview, and the assessor has both the alliance and the data, plus a live observation of the abandonment schema she will later write into the formulation. The moment illustrates the lesson's whole claim: with this population the threats to the assessment are the findings, and the response to them is the intervention. Practise that reframe alongside your prepared sentences: when the interview wobbles, ask silently what pattern is being enacted and what response would disconfirm it, then make that response, out loud, while keeping the map in hand.

Structure and warmth are not rivals; structure, held visibly and flexibly, is itself containing, the demonstration that strong material does not disorganise the professional or the process. The failure modes sit at the corners: the interrogation, all structure, extracting data at the cost of the very functioning it claims to measure, and the drift, all warmth, an hour of empathic conversation from which no ratable finding emerges, which is its own disrespect, because the person came, at cost, to be finally understood with precision. The craft is the third corner: a conversation the person experiences as being met, from which you emerge able to write the sentence and its three lines. Rehearse the constituent moves before your next assessment: draft, in your own words, one experiential opening for each of the two functioning domains, one life-anchored validation you could honestly offer a person you know, and one door-closing sentence for material best left shut today. Assessors who have those sentences ready do not have to choose between the person and the procedure, and the next module takes the same doubled craft into the harder territory of risk.

Going deeper: the feedback conversation as first intervention.

The moment assessment most often becomes therapeutic, or most often repeats old harm, is the feedback conversation, and it deserves preparation equal to the interview itself. Its architecture is simple: findings offered as a draft understanding, not a verdict; the person's corrections actively solicited and visibly incorporated; and the plan derived in front of them from the shared account rather than announced from the file. The language discipline carries most of the weight. Compare 'you have a moderate personality disorder with prominent negative affectivity' with 'what I have understood is that feelings hit you harder and stay longer than they do for most people, that this has made close relationships frightening in a particular repeating

way, and that it is currently taking up most of your life; on the formal system services use, that picture is called moderate severity, and it points to a specific kind of help'. Both sentences carry the same rating; only one of them can be recognised, checked and owned by the person it describes.

Diagnosis disclosure itself should be a conversation the person steers. Some people find the formal name a profound relief, an existence proof that they are not uniquely broken and that treatment literature exists; others find it a brand. Offer the name alongside the description, be honest about why services use it (routing, entitlement, a shared literature) and about its contested history, and let the person decide what vocabulary they will use for themselves. Their file will need the formal terms; their self-account does not have to.

Epistemic trust, introduced earlier in this pathway, gives the deepest reading of why this conversation matters: it is the person's live test of whether information from this service is going to be about them or merely about people like them. Feedback that demonstrably incorporated their corrections passes the test in a way no warmth alone can, because it proves the channel runs both ways. Assessors who treat feedback as the first session of treatment, rather than the last act of assessment, are usually right about what follows: engagement decisions are mostly made here, not at referral.

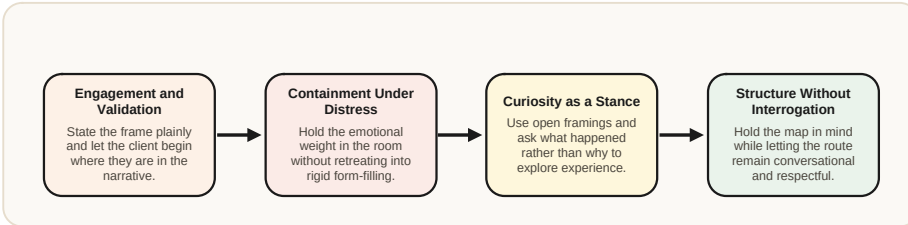


FIGURE 2.1 The Assessment as a Therapeutic Act

A four-step sequence transforming the assessment from an interrogation into an initial intervention. Each phase models safety, containment, and respect from the outset.

Points worth keeping

- Engagement and validation in assessment
- Containment under distress
- Curiosity as a stance

- Structure without interrogation

PRACTICE TASK

Write two opening questions that are structured yet validating.