

Working with Individuals Diagnosed with Personality Disorders

Presenter: F. Malcolm Horn

Could you talk about how these behaviors affect parenting/relationships with significant others? Particularly what behaviors we might see in the children of PD parents.

A: Fabulous question. Depending on the personality disorder, children of PD parents typically grow up to develop their own PD (remembering that it is the “ultimate attachment disorder”—therefore the pattern often repeats itself). Children of narcissists often grow up to be narcissists (they grow up learning that they are only as important as their accomplishments or outer appearance). Children often grow up feeling very mixed feelings about love/affection. I have a kiddo right now that has a narcissist for a parent – he’s very, very angry but can’t figure out why — he recognizes that his dad doesn’t find him to be important but tries to just “be ok” with it when really he’s pretty pissed. These children do not learn that it is ok to make mistakes, they see the world as very black/white, and they don’t learn to manage emotions or what true love/affection is (there’s always an underlying agenda).

Have you any sense of the average length of treatment for individuals with SUDs and PDs until adequate recovery stabilization is established?

A: Depends on the severity of each disorder and the amount of insight. I have individuals that are very insightful and they get stable relatively fast. It also depends on their resources: are they able to access adequate SUD treatment of appropriate length and is it co-occurring? Also key: does the counselor help them connect their PD issues to their SUD? I often find that patients get labeled with a PD because they’re “acting crazy” and the “acting crazy” is often a side effect of dealing with the SUD. I always hesitate to give someone a diagnosis of PD—I want to see what else is there first.

How do you distinguish between individuals who commit crime and are very self-centered related to their addiction from those with anti-social personality disorders? Isn't the thinking and behaviors a characteristic of addiction that can be addressed with the 12 Steps?

A: Yes—see the answer above. Many behaviors that people with SUD engage in are personality disorder traits. That’s one of the reason I hesitate to diagnose (or even use the diagnosis, if it’s been previous diagnosed) a personality disorder until someone has been clean/sober for at least 6 months—I want to see what is truly there and is a side effect of the SUD.

How do you feel about applying Schema Focused Therapy to personality disorders?

A: I am not very familiar or trained in this; however, based on what I do know, it would be very good for working with PDs as it seems to use a CBT foundation to try to complete unresolved developmental tasks (which is what we try to do with PDs.....create safety and structure so that they can identify and safely explore their emotional wounds that typically are the origin of a PD).

I have read research that states BPD symptoms remit for many people as they get older. Have you read this research and, if so, can you comment on whether this is true for other types of BPDs?

A: I have read that. One of the reasons that BPD will “resolve” itself is because the ability to manage emotional states improves as we age (i.e. the reactivity of a teenager vs. adult, or the ability for the frontal lobe to better manage the reactivity of the limbic system improves); thus, some BPD’s “grow out of it.”

I work in a crisis stabilization unit and we frequently see patients who are diagnosed with personality disorders; what is the best short term approach with these patients?

A: Solution-Focused Brief Therapy (SFBT). This modality is always appropriate for any crisis patient; it focuses on calming down and being proactive. Whenever a patient is in crisis, calming them is priority. For personality disorders (primarily Borderline Personality, the PD that most often ends up in crisis), after they are calmer, providing DBT skills. Help them identify proactive steps that they are in control of; if they are repeatedly in crisis, and you build a rapport with them, then you may be able to be more firm—I have 2 patients that come to mind that are consistently in crisis-mode. I am not soft with them; I get blunt “Malcolm, I see that you are feeling overwhelmed/reactive/depressed/suicidal again. Last time when this happened, we made the plan for you to follow through with starting counseling. Did that happen? If not, let’s go back to getting that done.” When I have rapport and a relationship with them, I barely acknowledge their emotion (the 2 patients that I am thinking of do it as “attention-seeking” and a way to deflect from underlying issues) and focus on behaviors. I find that they sometimes use “being in crisis” to avoid dealing with underlying issues, or a way to avoid that they didn’t follow through on something, so I don’t feed the emotion. Unfortunately, there are also patients that have significant mental illness and the PD is only part of it; these patients often fall through the cracks and end up in a revolving door of crisis. In Montana, those patients typically continue to cycle down and the system fails them.

Is there a particular personality disorder that has a high incident of substance use disorder?

A: Good question. I don’t have data to back this up, but I see a lot of people with anti-social and borderline personality disorders.

Teens display some of these behaviors. How much of the behavior is just what’s typically seen in a "normal" teen?

A: This is why I do not ever diagnose a teen (or even into early 20s) a personality disorder. Particularly when a SUD is also involved, teenagers (and early 20s) often look like they have a PD. If they have a previous diagnosis, I will often ask them about the diagnosis and (always) request records from whoever made the diagnosis. Remember that one of the key diagnostic criteria for PD is that it is “pervasive.” I don’t consider teenagers as being old enough for something to be “pervasive.” If I can, I try to work with the family as well—sometimes parents would rather have their kid have a “disorder” than to actually change the way the family interacts; teenagers “acting up” is often a mal-adaptive way of communicating that there is a problem in the family. I try to validate the teenager in what they are feeling and then help them determine if they want to change their behaviors regardless of what mom/dad do or don’t do.

Which books do you recommend to clients? Do you have a list?

A: Absolutely!

I Hate You Don't Leave Me by Hal Straus and Jerold Jay Kreisman is the classic Borderline Personality Disorder tome.

The Sociopath Next Door by Martha Stout is fascinating

Stop Walking on Eggshells by Paul Mason is a great "survival guide" for people that love someone with BPD

New Hope for People with Borderline Personality Disorder by Neil Bockian is a really good manual for individuals with BPD and for families and therapists. It breaks down the fundamentals the etiology of BPD, early intervention skills and great examples of how to cope.

Borderline Personality Disorder Demystified, Revised Edition: An Essential Guide for Understanding and Living with BPD by Robert O. Friedel is an excellent, user-friendly guide for those working with BPD and families.

Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change by Valerie Porr (I have not read this one but am told it is good)

Get Me Out of Here: My Recovery from Borderline Personality Disorder by Rachel Reiland (again, I have not read yet but looks promising)

I may have missed this -- are you emphasizing "tough love" in your approach to personality issues? This could mean a danger of some emotional empathy is involved, right?

A: For some of my patients, yes (see one of the above answers). Sometimes my patients with Borderline will just stay in a place of emotional reactivity in order to avoid accountability, get attention, or something else. If I have a strong rapport with them, then I (practically) ignore the emotion. Example: one of my patients literally curled up in her chair and pretended to cry so that I would not talk about her behavior the week before. I just sat there and watched her (even though part of me thought "go hug her! Give her a Kleenex! She's hurt and in pain!"). After 5 minutes she uncurled herself and started talking about something else. I then brought it back around to her behavior that I was concerned about. When I know the person and their behavior pattern, it's much easier to not feed into the emotion; think of a toddler having a temper tantrum, if you feed into it gets worse, whereas when you "ignore" it and they calm down, you can then talk to them. That also gives you the opportunity to show them that they can act their worst and you are not going to judge them or abandon them. It's a balancing act of validating their feelings, but not allowing them to "benefit" from being reactive.

What is the difference or relationship between personality disorder and ADD/ADHD?

A: They are two totally different diagnoses. ADD/ADHD is often treatable with medication (you can do all the therapy in the world but if they can't sit still, focus on what you're saying or pay attention then you are wasting your time). PDs, on the other hand, are not treatable from a pharmacologic perspective (granted, there are medications that can help with the symptoms, such as anxiety) but are responsive to DBT and other therapeutic strategies. A person can have both; I am not sure what the statistics are about comorbidity. Both seem to be overly diagnosed.