

Excerpts from the book:

Vocational Impact of Psychiatric Disorders: A Guide for Rehabilitation Professionals

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Table of Contents

Sample Chapter - Introduction: Psychiatric Disorders and Vocational Functioning

Sample Chapter - The "Dramatic" Cluster

Table of Contents

Introduction: Psychiatric Disorders and Vocational Functioning

The Role of DSM-IV

Table 1: Psychological Factors in Job Performance

About this Book

Figure 1: General Diagnostic Decisions

Disorders Left Out

Case Examples and Treatment Issues

A Final Word

Figure 2: Current Understanding of Interactions within the ICDH-2 dimensions

Part One: Feeling Bad

Chapter One: Mood Disorders

Major Depression and Dysthymia

Jack

What Depression is Like

Depression's Effect at Work

Working with Depression

Summary: Depression's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Bipolar Disorder, Manic Phase

Paula

What a Manic Phase is Like

Effect of a Manic Phase at Work

Working with Bipolar Disorder

Summary: Bipolar Disorder's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Chapter Two: Anxiety Disorders

Agoraphobia and Social Phobia

Ron

What Agoraphobia and Social Phobia are Like

Effect of Agoraphobia and Social Phobia at Work

Working with Agoraphobia and Social Phobia

Summary: Agoraphobia's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Post-Traumatic Stress Disorder

Susan

What PTSD is Like

PTSD's Effect at Work

Working with PTSD

Summary: PTSD's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Obsessive-Compulsive Disorder

Larry

What Obsessive-Compulsive Disorder is Like

Obsessive-Compulsive Disorder's Effect at Work

Working with Obsessive-Compulsive Disorder

Summary: OCD's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Chapter Three: Somatiform Disorders

Somatization Disorder

Marianne

What Somatization Disorder is Like

Somatization Disorder's Effect at Work

Working with Somatization Disorder

Summary: Somatization Disorder's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Part Two: Problems Getting Along

Table 2: Costa and Widiger's Five-Factor Model

Chapter Four: The "Odd" Cluster

Paranoid Personality Disorder

Martin

What Paranoid Personality Disorder is Like

Paranoid Personality Disorder's Effect at Work

Working with Paranoid Personality Disorder

Summary: Paranoid PD's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Schizotypal Personality Disorder

Shelly

What Schizotypal Personality Disorder is Like

Schizotypal Personality Disorder's Effect at Work

Working with Schizotypal Personality Disorder

Summary: Schizotypal PD's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Schizoid Personality Disorder

Ed

What Schizoid Personality Disorder is Like

Schizoid Personality Disorder's Effect at Work

Working with Schizoid Personality Disorder

Summary: Schizoid PD's Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Chapter Five: The “Dramatic” Cluster

Borderline Personality Disorder

Carol

What Borderline Personality Disorder is Like

Borderline Personality Disorder’s Effect at Work

Working with Borderline Personality Disorder

Summary: Borderline PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Antisocial Personality Disorder

Rocky

What Antisocial Personality Disorder is Like

Antisocial Personality Disorder’s Effect at Work

Working with Antisocial Personality Disorder

Summary: Antisocial PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Histrionic Personality Disorder

Peggy

What Histrionic Personality Disorder is Like

Histrionic Personality Disorder’s Effect at Work

Working with Histrionic Personality Disorder

Summary: Histrionic PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Narcissistic Personality Disorder

Gerald

What Narcissistic Personality Disorder is Like

Narcissistic Personality Disorder’s Effect at Work

Working with Narcissistic Personality

Summary: Narcissistic PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Chapter Six: The “Anxious” Cluster

Avoidant Personality Disorder

Connie

What Avoidant Personality Disorder is Like

Avoidant Personality Disorder’s Effect at Work

Working with Avoidant Personality Disorder

Summary: Avoidant PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Dependent Personality Disorder

Bill

What Dependent Personality Disorder is Like

Dependent Personality Disorder’s Effect at Work

Working with Dependent Personality

Summary: Dependent PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations

Obsessive-Compulsive Personality Disorder

Judy

What Obsessive-Compulsive Personality Disorder is Like

Obsessive-Compulsive Personality Disorder’s Effect at Work

Working with Obsessive-Compulsive Personality Disorder

Summary: Obsessive-Compulsive PD’s Effect on Vocational Abilities

Summary: Vocational Strategies and Accommodations
Passive-Aggressive Personality Disorder
Ray
What Passive-Aggressive Personality Disorder is Like
Passive-Aggressive Personality Disorder's Effect at Work
Working with Passive-Aggressive Personality Disorder
Summary: Passive-Aggressive PD's Effect on Vocational Abilities
Summary: Vocational Strategies and Accommodations

Part Three: Problems with Reality

Chapter Seven: Schizophrenia

Kelly
What Schizophrenia is Like
Schizophrenia's Effect at Work
Working with Schizophrenia
Summary: Schizophrenia's Effect on Vocational Abilities
Summary: Vocational Strategies and Accommodations

Conclusions and Implications: The Role of Psychological Assessment
Beyond Diagnosis
Personality Factors
The Case for Supported Employment
Disclosure of Disability

Appendix A: Summary of DSM-IV
References
About the Authors
Index

Introduction: Psychiatric Disorders and Vocational Functioning

Psychological and psychiatric disabilities -- disorders involving emotion, behavior, cognitive ability, and interpersonal skills -- present a unique set of challenges for employees and employers, and for professionals who work in the field of vocational rehabilitation. Unlike physical disabilities, mental health, behavioral, and emotional problems are rarely visible. The criteria for defining them are complex, and their impact in the workplace can be difficult to understand. Nevertheless, such disorders are extremely common, and their effect on job performance can be profound.

The Role of DSM-IV

The Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, known as DSM-IV (American Psychiatric Association, 1994), is the latest classification of mental disorders, continuing an evolving system of defining diagnostic categories which began with the appearance of the first Manual in 1952. It offers specific diagnostic criteria based on a consensus of current thought and understanding. It serves as a guide to making diagnoses of mental disorders, and as an aid to research, communication, and treatment.

DSM-IV defines mental disorders by means of a multi-axial system, which attempts to map the complexity of factors relevant to mental health. A diagnosis may be made on one or all of the five axes:

Axis I refers to clinical syndromes, such as depression or anxiety, and to learning disorders.

Axis II refers to personality factors -- long-standing patterns of thinking about and relating to other people, the environment, and oneself -- and to mental retardation.

Axis III refers to physical conditions.

Axis IV describes current psychosocial stressors, such as unemployment, the death of a family member, or being a crime victim, which can affect mental health and level of functioning.

Axis V contains a rating scale for Global Assessment of Functioning (GAF), on which a rating of 1 indicates overwhelming and debilitating symptoms, such as the imminent threat of hurting self or others, and 90 indicates almost no symptoms.

Psychiatric disorders are assigned number codes on Axis I and Axis II, and one individual may have several diagnoses on each. When clinical syndromes and personality disorders occur together, the conditions are known as comorbid, and this is often the case; research indicates that up to 90% of mental health patients who have an Axis I disorder also have a personality disorder coded on Axis II.

A summary of DSM-IV appears in Appendix A. Looking at it, one notes that Axis I disorders are organized from the broad to the specific. Within a broad category, such as Mood Disorders, appears a specific disorder, such as major depression. Each disorder is then further specified with descriptions of its severity and associated features, for example, major depression, moderate, without psychotic features.

The relevance of such diagnostic information for vocational rehabilitation professionals becomes obvious when we look at some of the dimensions on which a psychological or psychiatric disorder can adversely affect job performance, as in Table I, below.

Psychological Factor	Effect on Job Performance	Diagnostic Examples
Cognition	Intelligence, memory, academic skills, and the ability to use these skills.	Mental Retardation, brain injuries, schizophrenia, depression, anxiety.
Pace	The ability to perform tasks at a reasonable speed.	Depression, obsessive-compulsive disorder, passive-aggressive personality disorder.

Persistence	The ability to stay with a task until it is complete.	Bipolar disorder manic phase, attention deficit hyperactivity disorder, histrionic personality disorder, somatization disorder, schizophrenia.
Reliability	Coming to work every day in spite of personal or emotional problems.	Agoraphobia, somatization disorder, avoidant, antisocial and borderline personality disorders, major depression, bipolar disorder manic phase.
Conscientiousness and motivation	Wanting and trying to do a good job; persisting until it is accomplished.	Antisocial, schizoid, and passive aggressive personality disorders, major depression.
Interpersonal functioning	The ability to accept supervision, to get along with coworkers or the public.	Bipolar disorder manic phase, post-traumatic stress disorder, antisocial, passive aggressive, schizoid, borderline, and narcissistic personality disorders.
Honesty, trustworthiness	The ability to be truthful, direct, and straightforward, to refrain from such things as lying and theft at work.	Anti-social personality disorder, borderline personality disorder, chemical dependency.
Stress tolerance	The ability to withstand job pressures such as deadlines or working with difficult people.	Schizophrenia, post-traumatic stress disorder, somatization disorder, agoraphobia, major depression.
Job-specific requirements	e.g., typing speed, conflict resolution skills, "people skills."	Depends on requirement.

Cognition refers to intelligence, memory, academic skills, and the ability to use these skills. It is the ability to acquire knowledge, to plan, to make use of one's perceptions, and to reason out problems or difficulties. Some jobs require high levels of cognitive ability, while others require relatively little, but its absence or impairment is problematic in any work setting. The effect on cognitive ability is obvious in mental retardation and brain injury. A depressed or anxious person may not be mentally retarded, but the symptoms of major depression, anxiety, and other psychological disorders often include problems with memory and concentration, which in turn adversely affect cognitive ability.

Pace is the ability to perform job tasks at a reasonable or competitive speed, or at a steady and predictable rate. It is the ability to get the job done on time, and to work at a rate that is in accordance with the needs of coworkers and the work place. An employee who cannot keep up the pace, who slows other workers down, who is sometimes fast and sometimes slow, affects performance and morale for everyone. A depressed person may lack the energy to keep up the pace, an obsessive-compulsive person may be paralyzed by the need

to perform the task perfectly, and a passive-aggressive person might respond to a requirement by delaying and procrastinating.

Persistence means staying with a job or task until it is complete, even if one is distracted, frustrated, or bored. Throwing up one's hands in an impulsive rejection of the work, procrastinating, avoiding, cutting corners, leaving parts undone, all show lack of persistence, and all adversely affect the workplace. Someone in the manic phase of a bipolar disorder is simply too disorganized and distracted to be persistent. A person experiencing the symptoms of somatization disorder may feel physically unable to go on. Attention deficit hyperactivity disorder impairs a person's ability to stay focused on a task. People with histrionic personality disorder tend to become easily bored and frustrated.

Reliability means coming to work every day and staying all day, in spite of personal or emotional problems, stress, or psychological or physical symptoms. It means being honest and straightforward. A reliable person is one others can count on and trust to show up, to do the work, to take responsibility. An unreliable person causes extra work for others and delays in getting work done. People with agoraphobia struggle every day to get out of the house and get to work, and some days they don't make it. Those with avoidant personality disorder also sometimes feel overwhelmed by ordinary life, and don't make it to work. Those with borderline personality disorder may become so involved in their own internal conflicts that the needs of the work place are secondary, while those with anti-social personality disorder have little regard for rules and schedules.

Conscientiousness and motivation translate into wanting and trying to do a good job, and persisting until the desired result is accomplished. A motivated, conscientious person not only does the work, but does it as well as he or she is able, and takes pride in a job well done. Many people become less conscientious when troubled by psychological disorders or personal problems. Those with antisocial or schizoid personality disorder, however, seem indifferent to the needs of others and to what others think of them, and may show little interest at any time in doing a good job. Motivation is the will to succeed, the belief that one can succeed despite difficulties, the belief that doing one's best is important. An unmotivated worker sees little reason to make the effort to do well. Depression has a major effect on motivation; someone who feels hopeless and wants to die is unlikely to believe that trying hard will make a difference. Similarly, people with dependent personality disorder think very little of themselves, do not believe they can succeed, and are unmotivated to try.

Interpersonal functioning has to do with the ability to accept supervision, criticism, and directives, to get along with coworkers, to work effectively with the public. Poor interpersonal skills cause major problems in the workplace, even if the worker is exemplary in every other way. Personality disorders by definition often involve interpersonal difficulties, some more than others; someone with a dependent or avoidant personality disorder is likely to be easier to get along with than someone with a passive aggressive, anti-social, or schizoid personality disorder, though he or she may still present difficulties in the work place. The manic phase of bipolar disorder also creates interpersonal problems because the person can become unreasonable and extremely irritable. People with post-traumatic stress disorder may have learned not to trust, either other people or their own perceptions, and may have difficulty getting along with others as a result.

Honesty and trustworthiness reflect the ability to be truthful. Honest employees can be trusted not to pilfer from the till and not to embezzle from the business. They can be

trusted to keep accurate account of their time and to do the work they are paid to do. They are direct and straightforward in their workplace relationships and can be trusted not to engage in manipulation or harassment of others. Anti-social personality disorder, borderline personality disorder and chemical dependency all involve traits which compromise trustworthiness. A chemically dependent person may lie, manipulate others, or steal to support a drug or alcohol habit. People with borderline personality disorder experience highly unstable emotions, leading them to manipulate others in order to meet their own emotional needs. Those with anti-social personality disorder have little regard for laws, rules, or any other structure meant to keep order in society; they are likely to lie, cheat, steal, and use other people as they please.

Stress tolerance is the ability to withstand the every day pressure of job demands, such as meeting deadlines, or of the interpersonal environment, such as working with difficult people, without significant decline in job performance or an exacerbation of psychological or physical symptoms. Some work places are more stressful than others, but an inability to handle moderate or fluctuating levels of stress causes problems for the worker in any workplace. Most psychological disorders involve a reduction in stress tolerance, and are made worse by stressful situations. A person with schizophrenia in its residual phase may become actively psychotic again under stress, even ordinary work day stress. Anxiety disorders and somatoform disorders are also vulnerable to the effects of stress.

Job-specific requirements include such traits as above average judgment required of human service professionals, above average conflict-resolution skills required of law-enforcement professionals, high "people skills" required of public relations personnel, high typing speed requirements for word-processing personnel, high intelligence required of rocket scientists, and so on. Many jobs have such requirements, and many psychological disorders preclude meeting them. Helping the client find the right fit is a crucial part of a rehabilitation counselor's role.

Whether an employee's disorder affects these psychological dimensions severely or only mildly, it can have major implications for all involved in the workplace, including supervisors, coworkers, and troubled employees themselves. Understanding a disorder's expression allows for effective planning and a better outcome in the vocational rehabilitation process.

About this Book

This book offers a guide to many of the DSM-IV diagnoses that vocational rehabilitation professionals are likely to encounter in their work. Its organization is congruent with DSM-IV's classification, but it includes only those disorders which best and most clearly illustrate the difficulties encountered by these clients and the professionals who serve them.

Variables, such as severity, comorbid psychiatric conditions, personality factors, and general intelligence, can combine to create an almost infinite number of nuances and permutations, which is why diagnosis is art as well as science. No exact formula exists, or can exist, for helping or working with a particular person with his or her individual take on a certain diagnosis. However, the framework offered here can serve as example and guide to decisions about how to provide effective rehabilitation services.

Insert Figure I here: General Diagnostic Decisions

Part One describes disorders characterized by subjective distress; the client feels bad. DSM-IV classifies these disorders on Axis I. They have been popularly known as neuroses, and are very common. Chapter One addresses mood disorders: Major Depression, Dysthymia, and Bipolar Disorder. Chapter Two is devoted to the anxiety disorders, including Agoraphobia and Social Phobia, Post-traumatic Stress Disorder, and Obsessive-Compulsive Disorder. Chapter Three discusses the Somatoform Disorders, which involve unexplained physical symptoms.

Part Two describes disorders characterized by a chronic pattern of problems in relating to others, acting impulsively, or engaging in illegal behavior. The client may or may not feel bad, but experiences significant problems in situations that require dealing with other people. These disorders often go unrecognized. Their effect is insidious and pervasive, and their ability to disrupt the workplace and the work experience is extensive. They are the Personality Disorders, classified on Axis II. Part Two covers each personality disorder identified in DSM-IV, grouped in clusters based on similar traits. These are the "Odd" Cluster, found in Chapter Four; the "Dramatic" Cluster, in Chapter Five; and the "Anxious" Cluster, in Chapter Six.

Part Three addresses Psychotic Disorders. Schizophrenia and Related Disorders are discussed in Chapter Seven. These are Axis I disorders, characterized by difficulties in accurately perceiving reality. They have a profound effect on a person's ability to function at work, and in every other aspect of life.

Disorders Left Out

Several very common conditions, including learning disorders, organic disorders, and substance abuse disorders, are not discussed here. People who have such disorders do not comprise a homogeneous group, and cannot be described or understood as such. Diverse factors cause these disorders and affect their expression. Recognizing them and responding to them in the work place, however, can be a fairly straightforward process.

Learning disorders, of which dyslexia, or reading disorder, is the most common, show themselves as deficits in one or more specific cognitive or academic abilities. They are not necessarily related to general intelligence, or to mental or emotional health. A person of average or above average intelligence might have difficulty learning to read or write, learning a foreign language, or learning arithmetic. Once identified, such deficits can be readily dealt with either through appropriate vocational planning, or through relatively simple work place accommodations.

Organic disorders, called cognitive and amnesiac disorders in DSM-IV, are caused by neurological damage or insult, such as head injury, stroke, or toxic reactions to substances like drugs and alcohol. Different organic causes lead to different intellectual, cognitive, or memory deficits. The term "organic disorder" refers to a diverse set of intellectual and personality problems, including lasting or permanent changes, which are not consistent from person to person. Identifying the particular deficit in a particular individual is an essential step in vocational planning for that person.

A great deal has been written about substance use disorders and their effect at work (cf. Falvo, 1991). Those who struggle with such disorders are an extremely diverse group, some of whom function quite well, and others not at all. Many mental health and personality disorders are exacerbated by substance abuse, and in those cases, the

underlying disorder must be addressed. When substance use is the primary factor affecting vocational planning, issues such as absenteeism and lack of reliability are usually at the fore front. A straightforward approach, relying on clear expectations and consequences, is often the most useful. In general, however, people who are actively abusing chemicals cannot benefit from vocational rehabilitation until they experience a sustained period of sobriety and make a commitment to a sober lifestyle.

Case Examples and Treatment Issues

Illustrative case material in each chapter describes specific psychological and psychiatric symptoms and their vocational impact. Drawn from actual cases, the examples represent composite pictures, with personal details changed to protect privacy, and clinical details selected to provide clarity. Each case study consists of a description of the disorder, details of its effect on vocational functioning, and an example of how a rehabilitation professional might respond to the difficulty in order to bring about a successful resolution.

In reading through the cases, one notices that each of the people presented is in great need of mental health care, and would seemingly benefit from psychotherapy, medication, or a combination of the two. If such a referral were accepted, and if the treatment were highly successful -- if, for instance, Jack (Chapter One) never had another major depressive episode, or Carol (Chapter Five) stopped her self-destructive behavior -- the workplace difficulties that these or any of the other disorders create would be considerably less problematic.

Unfortunately, some people with the disorders described here either refuse to accept a referral for psychotherapy or psychiatric medication, or are unable to benefit significantly from treatment. Those who cannot change, and the professionals who work with them, must instead learn to cope with and accommodate to their symptoms and their interpersonal problems as best they can. The right work setting and the right kind of support on the job can help them do so, and this book is meant as a guide in that regard. An interdisciplinary team approach, including a vocational rehabilitation professional, a psychologist, a work place supervisor or human resources representative, and perhaps a social worker, psychiatric nurse, psychiatrist, or other helping professional familiar with the situation, is invaluable.

A Final Word

Psychological and psychiatric disorders often occur in combination with each other, and they always occur in the context of the client's life. Axis I and Axis II diagnoses can mask each other, so that a Major Depressive Episode might hide an underlying Passive-Aggressive Personality Disorder, or a Substance Abuse Disorder might develop as an attempt to cope with anxiety. Making effective use of diagnostic information requires looking closely at all factors affecting a client's life and mental health. To this end, the World Health Organization (1997), offers a model of factors affecting "disablement," a concept formerly referred to as "disability." The model suggests that disablement is a complex interaction between the disorder and environmental and personal "contextual" factors. The interaction is not always predictable, and it is reciprocal, with the contextual factors affecting the disorder and vice versa.

Insert Figure 2 here: Current understanding of interactions within the ICIDH-2 dimensions

For example, if a person with generalized anxiety disorder avoids others because of embarrassment, and has trouble concentrating when experiencing stress, certain contextual factors could be altered to reduce the impact on participation (formerly referred to as “handicap”) in the workplace. Changes could include relaxation techniques or medication to reduce anxiety (a personal factor), or allowing the person to take a time-out when feeling especially anxious and encouraging coworkers to be tolerant and supportive (environmental factors).

Incorporating this model along with the DSM-IV multi-axial system provides a biopsychosocial perspective that is broader and more useful than a strictly medical model. It places the emphasis not on the psychiatric diagnosis, but on the interaction between diagnostic symptoms, work environment, and personal factors. Such an inclusive view, while recognizing limitations in a realistic and pragmatic way, focuses instead on strengths, coping ability, and creativity in structuring the work environment.

Just as effective vocational rehabilitation of people with physical disorders requires an understanding of the nature, extent, and effects of the disorder, effective rehabilitation of people with psychiatric disorders is best accomplished in conjunction with a thorough psychiatric or psychological evaluation.

Sample Chapter: The “Dramatic” Cluster

Borderline, Antisocial, Histrionic, and Narcissistic Personality Disorders

Inflated ego, swaggering, braggadocio, and capricious shifts in attitudes and loyalties characterize the “dramatic” cluster of personality disorders. Its hallmarks are intense emotional expression, sudden mood swings, low frustration tolerance, poor impulse control, and volatile interpersonal relationships.

Instability is the key feature of borderline personality disorder. Those who manifest it ride a rough sea of dangerous waves; mood, self-definition, and close relationships are all subject to mercurial shifts that occur with dizzying speed, staggering intensity, and behavior to match. Self-destructive acts and cruelty to others are as likely as obsequious displays of dependency and devotion, all of which can instantly give way to biting sarcasm or rageful tantrums.

Those with antisocial personality disorder act as though laws are for other people. They disregard rules, standards, and accepted social customs. Deception, ill-will, and brutality are their frequent companions. Thuggish intimidation and cool manipulation are the cornerstones of their relationship skills. They are never too far from violence, and can be a source of danger in the workplace.

Often attractive in appearance, extroverted, gregarious, witty, charming, and entertaining, people with histrionic personality disorder might be welcomed and admired -- at first. Unfortunately, their interpersonal interactions quickly betray them. They lack emotional depth, and come across as phony, affected, duplicitous, insincere, and shallow. They find relationships difficult to sustain, and are likely to blame others for the difficulty.

People with narcissistic personality disorder act like the only people in the world who matter; others exist only to endorse and amplify this fact. They feel exempt from the normal constraints of interpersonal interaction, entitled to special privileges and extra advantages, and they behave accordingly. They believe that they have unique talents and abilities, magnificent in scope and patently evident, but mysteriously unacknowledged by others.

People in the "dramatic" cluster are rarely capable of empathy. They are often self-centered and prone to temper tantrums. They tend to be irresponsible, impulsive, and remarkably free of remorse. Deceit, superficiality, and arrogance cloud all of their relationships. They have great power to create confusion, disruption, and violence in the workplace; their presence there is a stick of dynamite waiting for a match.

Borderline Personality Disorder

People with borderline personality disorder report a relatively high level of abuse, neglect, conflict, and early loss or separation from parents in their childhood histories. They are likely to experience mood disorders, substance-related disorders, eating disorders, or post-traumatic stress disorder. The risk of successful suicide increases in those with concurrent mood or substance-related disorders. About 75% of people diagnosed with borderline personality disorder are women. It occurs in about 2% of the general population, 10% in out-patient mental health settings, and 20% among psychiatric patients. It is about five times more common among close biological relatives of those who have the disorder than in the general population. The greatest impairment, instability, and risk of suicide is in the young adult years. The disorder tends to wane as the person ages; during their thirties and forties, most people who have it experience greater stability in both relationship and vocational functioning (American Psychiatric Association, 1994).

Carol

Carol lined up the pill bottles on her kitchen counter. She had about two weeks worth of anti-depressants, fifteen sleeping pills, two different prescriptions for pain, and an unopened economy-size bottle of Tylenol caplets. She wasn't sure if it was enough to really do the job, but it should get the message across to John, her boyfriend.

She opened all the bottles and poured herself a glass of wine. She took the anti-depressants and the sleeping pills, one pill at time, until they were gone. She refilled her wine glass, and went to the phone. She dialed John's number, and heard him answer. She didn't say anything. He said, "Hello? Hello? Who is this?" She let the hint of a sob escape her throat, then a sigh. John said, "Carol? Carol? Is this you? Is something wrong?"

"You did this," Carol said, letting her words slur together and her voice sound weak and far away. "I'm going to die because of you."

What Borderline Personality Disorder is Like:

Instability in relationships, sense of self, and mood

Lack of empathy and remorse

Impulsivity, irresponsibility, unreliability

Inappropriate expression of anger
Self-destructiveness

Fear of abandonment; hypersensitivity to rejection

Instability in relationships, sense of self, and mood. Earlier that evening, John and Carol had dinner together. She nestled close to him in the restaurant, stroked his back, and told him he was the most wonderful man she had ever met. He said gently that their relationship was moving a little fast for him. He had accepted a chance to attend a month-long training session in another city. He looked forward to starting fresh with her on his return, perhaps at a slower pace. Carol threw a drink at him, screamed that he was a no-good son-of-a-bitch, that she hoped his plane went up in flames, and that he'd better not dare to ever call her again. Then she left the restaurant.

In the three weeks since they began dating, Carol had twice before become enraged at John, once when he wanted to spend an evening alone at his own apartment, and once when he invited a friend to join them for dinner. On both occasions, he responded to her tears and anger with caring and equanimity. Both times, she quickly reversed herself, saying she was no good, she didn't deserve him, she didn't deserve anything good in life, and she wondered how could he put up with her. In response to his comforting words, she became playful and seductive, insisting that they just laugh and have a good time.

John was understandably confused. When Carol called him after taking her pills, he was packing for his trip; he had a plane to catch at six the next morning. Still, he rushed to her apartment, very worried about her condition. He bundled her into his car and raced to the hospital emergency room. He stayed until he was sure she would be all right. Carol was contrite and expressed gratitude. But as he was leaving, barely in time to make his flight, she said sarcastically, "I can see how much you care about me."

Instability is the basis of Carol's personality. Her treatment of John is typical of the way she treats anyone close to her. Everyone in her life is either wonderful or horrible; her assessment of them is ongoing, and it flips dramatically back and forth. Likewise, her sense of self also changes quickly, depending, in part, on others' responses to her. She has no inner core of self-understanding; her self-concept rests on constantly shifting sands. Her moods, from rage to grief to joy to shame to passion, are intense, unpredictable, and capable of doing great damage to her and to those around her.

Lacking in empathy and remorse. That her behavior towards John might cause him distress never occurred to Carol. That he, or anyone, has feelings or needs as valid as her own is an alien idea to her. That he, or anyone she depends on, has or deserves a life separate from her involvement in it, is something she has never considered. She does not experience empathy for other people because she finds her own feelings and needs overwhelming and all-consuming.

While she is prone to brief attacks of intense guilt, Carol does not experience true remorse in the sense of moral anguish over pain caused to others. This is partly because she can't conceive of others' pain, and partly because she does not take responsibility for her own behavior. Her actions, mistakes, and misdeeds are not her fault because someone else provoked her or otherwise caused her to act as she did. To her way of thinking, John's mistreatment of her forced her to take drastic measures. The emotional turmoil and disruption of his life that she caused mean little to her.

Impulsive, irresponsible, unreliable; inappropriate expression of anger. Carol's behavior is ruled by her emotions. She acts on impulse, without thinking and without considering consequences. She says whatever comes into her head, regardless of her motivation or of the circumstances. She makes commitments she doesn't honor and promises she doesn't keep. She refuses to be held accountable for anything she says or does; nothing is her responsibility or her fault. Her anger is intense and easily ignited. She doesn't feel a need to hold back in expressing it. Bitter sarcasm and violent rages are her frequent responses to ordinary, daily interactions with others.

Self-destructive. Carol's suicide "attempt" is not her first. She has twice before been hospitalized under similar circumstances, but on none of these occasions did she fully intend to die. Her primary intent was to communicate her anger towards someone else. Endangering her life in doing so is characteristic of her tendency to be self-destructive.

It shows up in other ways, too. She developed an eating disorder as an adolescent, and routinely starves herself or binges on junk food. She is a reckless driver, sometimes intentionally. She likes to go to bars alone and stay until closing. When she was eighteen, she allowed herself to be the "guest of honor" at a fraternity stag party, and her treatment there resulted in her first overdose and hospitalization. She drinks too much, and experiments freely with drugs. Once, when angry at a boyfriend, she burned his initial in her arm with a cigarette.

As result of her self-destructive behavior and her unstable moods, Carol has had years of psychotherapy and has tried many medications, all to no avail. She is either furious at or in love with her therapists, and her goal in therapy is to get attention and support. Towards this end, she pays lip-service to the stated goal of understanding and working on changing her own behavior, but she makes little attempt to do so. Her mood swings are the result of her personality structure, and so far no medication has had any effect on controlling them. She is likely to misuse prescribed medication, taking too much or too little, taking it haphazardly, and sometimes stockpiling pills for future suicide gestures.

Fear of abandonment; hypersensitive to rejection. The precipitant for much of Carol's self-destructive behavior and her treatment of others is a fear of being alone. She is terrified of being abandoned, of having no one. To her, it is imperative to control others so they don't leave her, and she is willing to go to great lengths to do so. She experiences the mildest put-off as complete rejection, which she sees as life-threatening, and responds accordingly.

Borderline Personality Disorder's Effect at Work:

Tense, unstable relationships

Frequent changes in career and training plans

Poor stress tolerance

Workplace danger

Tense, unstable relationships. Carol's relationships with her supervisors and coworkers are unsettled and turbulent, marked by intense and unpredictable ups and downs. The wonderful boss becomes a tyrant from hell in a matter of minutes. The friendly group in the lunchroom becomes a target for spite in the space of a break time. She experiences

supervisory input as a threat to her fragile sense of self, and is unlikely to accept it without argument.

She disputes decisions and assignments, bickers over perceived mistreatment, and demands that unfavorable performance reviews be changed. She agitates her coworkers against management and against each other, only to switch sides when her mood changes. She picks fights, and she is quick to cry abuse, harassment, or discrimination when such charges are far from warranted.

She once succeeded in getting a male supervisor fired for sexual harassment. She initially liked him and tried hard to impress him, but he treated her the same way he treated the other employees; he was enthusiastic and encouraging, but he showed no special interest in her. This infuriated her, and she complained to the division director that he looked at her in a sexual way. They were never alone together, and no coworker corroborated her story, but the supervisor was fired, largely due to the disturbance Carol caused and her threats to go to the press or take legal action.

Frequent changes in career and training plans. Carol is twenty-six years old. She has attended college and various technical schools off and on, but she has no career plans. She worked for the last six months as an assistant manager at a discount shoe store, but quit over a dispute about her hours. She has had a fairly consistent dream of becoming an actress, but has done nothing to make the dream a reality. She finds the process of setting goals difficult, and she lacks the self-discipline to follow through on plans.

Few things hold her interest for long, and boredom is not a condition Carol tolerates well. She has impulsively quit jobs and training programs, often when the training is nearly complete or her probationary period nearly over, to pursue something else that strikes her as more interesting. The ups and downs of her moods and her constantly shifting self-image have led her to start and then abandon seven different career paths since she graduated from high school. Her judgment is poor, and she does not plan ahead. Each time she quits a job, she creates a financial crisis for herself as well as staffing problems for her employer.

Poor stress tolerance. Carol leads a very stressful life. The constant turmoil of her emotional state and the continual conflicts with others take a great deal of time and energy. Work pressures and demands can increase her level of stress to a point she finds overwhelming, and she may respond by lashing out in anger, becoming self-destructive, or impulsively walking out.

Work place danger. Carol's temper tantrums can include breaking and throwing things, and lashing out physically as well as verbally. She has at times slapped, kicked, spit on, and pushed family members, boyfriends, roommates, and others. She has never done so at work, but the possibility exists that she might. Even in the absence of violent behavior on her part, her unpredictable and frequently unpleasant interactions with others set up dangerous and potentially explosive interpersonal situations at work.

Working with Borderline Personality Disorder

Carol's most recent suicide gesture and subsequent hospitalization occurred about a week after she impulsively quit her job in the shoe store. It was a stressful time for her, since she had no money saved and no idea what she would do next. She was pretty sure she had

not taken enough of an overdose to cause her death, but was characteristically careless and unconcerned about the outcome. On a conscious though unarticulated level, she hoped that John, her boyfriend of three weeks, would rescue her by offering her marriage or at least financial support. She felt that her neediness obligated him to care for her. Part of her fury at his leaving came from fear about how she would survive, pay her rent, and buy groceries, as well as fear of being abandoned.

At the time, Carol had not been in psychotherapy for about a year. She fired her last therapist in a snit over his refusal to engage in extended telephone conversations about her needs, outside of regularly scheduled appointments. She was a sporadic member of several support groups, and periodically made use of crisis hot lines and drop-in counseling centers, but had no ongoing therapeutic involvement.

She was released from the emergency room to the psychiatric unit. The social worker there knew Carol from her two previous suicide gestures. He knew that these were primarily cries for help rather than actual attempts to end her life, but he also knew how close to the line she came and how easily that line could be crossed. Though Carol insisted she was ready to go home, he was unwilling to consider discharge planning until she was established in a therapy relationship. Carol herself believed that she needed to go back into therapy, but something about the social worker's attitude rubbed her the wrong way. She refused to accept his referral, made a scene about being held prisoner on the psychiatric unit, and left the hospital against medical advice.

Each of her previous therapy relationships had started out with warm feelings and high hopes on Carol's part, and had ended in deep dissatisfaction, with a rocky trail of alternating idealization and demonization of the therapist in between. She entered therapy not with the intention of gaining insight or of changing her behavior, but with the expectation that the therapist would relieve her unhappiness and make her life better.

She quickly came to resent what she saw as the therapist's refusal to act on her behalf. She rejected most interventions a therapist might attempt. She usually ended the relationship at the point at which a therapist began to confront her behavior and hold her accountable. Regardless of whether this point came sooner or later, or was expressed gently and subtly or directly and pointedly, it meant to Carol that the gig was up and it was time to move on. She left feeling that the therapist didn't care about her, didn't listen to her, didn't understand her, didn't do enough for her, asked too much of her, and tried to control her.

One of the support groups that Carol sometimes attended met at a women's resource center, which provided basic medical care, job resources, support groups, AA and Al-anon groups, and psychotherapy for women. Carol had been involved there for several months. She had her conflicts with staff and with other participants, but the casual, relaxed atmosphere suited her mood at the moment. She arranged an initial psychotherapy appointment with the director of the center, a psychologist named Georgia.

Carol had heard good things about Georgia's warmth, her caring style, and her skill as a therapist. At their first meeting, however, she had strong doubts about the relationship. Georgia had been around for a long time. She had worked with many women with a wide variety of backgrounds, problems, and issues. She recognized borderline personality disorder in the history Carol gave her, as well as in Carol's approach to the interview and her attitude towards the therapy relationship. Georgia was unlikely to allow herself to be

manipulated, and she made that clear from the outset. Rather than starting out with her usual warm and fuzzy idealization of the therapist, Carol started out mad.

Several days after their first meeting, Carol called Georgia to say that she didn't think it was a good match. She wanted to cancel their next appointment. Georgia said she was sorry that Carol felt that way, and wished her luck. She was not surprised, however, when looking at her schedule for the following week, to see that Carol had rescheduled the appointment.

The night before the appointment, Carol called Georgia's answering service. When Georgia returned the call, Carol was in tears. She said she felt hopeless, alone, and suicidal. She had enough medication for an overdose, and she planned to take it. Georgia said she was sorry Carol felt that way. She would be happy to arrange for hospitalization, and she would send a squad car to pick her up to make sure she got to the hospital. After a pause, Carol said she thought she could probably make it until morning.

She began the next day's session by saying she wanted to express her anger about Georgia's lack of concern about her. Georgia listened without comment. When Carol finished, Georgia said she was sorry Carol felt that way. She suggested that they move on and set some goals and priorities for dealing with the immediate problems Carol faced, since living with such stress obviously made her life much more difficult than it needed to be.

Carol was annoyed at Georgia's reply; she craved an emotional response, and was used to getting one from most people she had relationships with. Still, the invitation to talk about her current woes was compelling, and she launched into a description of her pain and her needs. To Carol, her worst current problem was what she saw as John's defection. He was back in town, and although she had called him several times, he didn't want to see her. He had betrayed and abandoned her, left her to die, left her at the mercy of her landlord and her credit card companies. Georgia nodded sympathetically, and ended the session.

Again Carol called in the middle of the week, angry, tearful, and accusatory, threatening suicide, threatening to leave therapy. Georgia responded in the same way she had to the previous call. She was sorry Carol felt that way. Carol could leave therapy if she wanted to. If Carol felt suicidal, she could go to the hospital. Georgia cut the call short with a brief "Good luck."

Carol kept their next appointment. Georgia took charge of it from the beginning. She thought it was time to get serious about Carol's only solvable problem -- lack of a job, and lack of the necessary interpersonal skills to keep a job if she had one. She knew from experience that it would be useless to get bogged down in Carol's issues with men in general and John in particular. Likewise, she knew that Carol would try to keep the focus of therapy on the therapeutic relationship, and that this also would be a fruitless pursuit. She wanted Carol to understand her own behavior enough to see that it hurt her in the work world, though she knew how difficult a task that would be.

Georgia set a limit on the number of sessions that she and Carol would meet. She set a limit on the topics open for discussion. She set a limit on the number of between-session telephone calls that Carol could make, and on their nature. She said she would no longer return late evening calls to her answering service from Carol. She said that as far as she

was concerned, the best way to deal with Carol's pain was to focus on her need for a job, and on her workplace behavior once she got a job.

Carol was dumbfounded, then furious. She was holding an empty paper coffee cup, which she threw at Georgia. The cup landed harmlessly on the floor between them, but Georgia stood up, said that at no time would she tolerate such behavior, and ended the session.

Georgia didn't hear from Carol for several weeks. One day Carol called, appropriately during business hours, and asked if she could come back to therapy. She had been hired, and then quickly fired, from a waitress position, and she said she realized that she needed to deal with work issues. Georgia said that her limits and expectations had not changed, but that Carol was welcome back if she thought she could work within them.

Carol seemed like a different person at their next appointment. She was pleasant, appropriate, and on task. She knew she had an anger problem, she knew she needed to be a cooperative team player to keep a job, she knew she needed the kind of help that Georgia had offered to provide. Would Georgia please help her? Because of her years of experience, Georgia recognized that this transformation, while not false, was not permanent, either. It was simply the side of her personality that Carol chose to show at present, for reasons unknown perhaps even to her.

The balance of their work together was far from smooth. Carol continually pushed the limits. She had no more temper tantrums and made no more suicide threats, but she wanted extra sessions, she wanted to put aside the work issues because she felt sad and lonely, she became tearful and disarmingly remorseful when admitting that she knew she had personality problems. She often said that Georgia wasn't helping her and she was going to leave therapy. But Georgia stayed the course.

Carol is at her worst in close, on-going relationships with people who matter to her. She can appear friendly and vivacious in less significant, short-term interactions. She interviews well. Her experiences in retail, which include the shoe store, a women's clothing store, and a large kitchen-supply store, were her most successful. She is good at dealing with the public, she likes it, and it tends to hold her interest. It is her inability to deal with ordinary, day-to-day relationships with coworkers and supervisors that causes her problems, and this is what Georgia focused on.

Carol began applying for jobs before Georgia thought she was ready. By listing her experiences selectively, and by employing creative phrasing on her resume, she looked like a strong candidate for entry-level retail management positions. She was soon hired in the designer fashions department of a large department store. Her confidence was buoyed by what she considered a prestigious position, exactly the kind of job she wanted. She dismissed Georgia's misgivings and warnings, and left therapy.

Unfortunately, the environment in the designer fashions department turned out to be quite stressful, with much expected and little support provided -- just the setting in which Carol is likely to become unstable, unreliable, and hostile. Within a few weeks, she had a serious run-in with a coworker, and was confronted by the department manager about several aspects of her behavior. Shaken, and uncharacteristically concerned about keeping the job, she called Georgia for help.

Georgia agreed to work with her for a few more sessions, maintaining the focus on work place behaviors. Carol continued to blame those around her for her interpersonal problems, and Georgia saw trying to change that point of view as a waste of time. Instead, she tried to redirect Carol's attention to those things which she could control, such as whether she exploded in anger in front of customers, or chose to contain herself until she could express her concern in a way that wouldn't be self-destructive.

Georgia came up with the idea of explaining some of Carol's work place needs to the department manager, and Carol almost begged her to do so. With Carol's written permission, Georgia called the department manager. She explained a little about Carol's hypersensitivity to rejection, her moodiness, and her hostility. She noted that Carol tends to respond positively to efforts on the part of those around her to be supportive. She said that Carol would be more likely to succeed with some accommodations designed to meet her need for unusual interpersonal flexibility. Confronting her interpersonal problems would likely make things worse, while pointing out and supporting her strengths might help. In addition, flexible scheduling might give her a sense of self-direction and autonomy, and help her cope with her mood swings.

Georgia went on to say that as important as a supportive attitude is in helping Carol succeed, firm supervision with clear expectations, boundaries, and methods of evaluation, is essential. Carol needs to know in no uncertain terms what kinds of behavior will not be tolerated, what level of performance is required, what the limits of her role are, and how her work will be assessed. She needs concrete consequences for misbehavior. Being sent home for the day, or being docked pay, for example, might be useful tools to deal with less than acceptable behavior.

Because of her instability and unpredictability, and her propensity for acting out towards herself and others, monitoring her behavior and insisting on behavioral standards is important not only to help her succeed, but to ensure her safety and the safety of the entire workplace. A direct and straightforward approach on the part of a supervisor, firm but supportive, focused on her work and her behavior rather than on her as a person, could help.

Borderline personality disorder can cause such severe and intractable interpersonal problems that a competitive work setting may not be possible. Carol is able to work, and even to experience success at work, to the extent that she can maintain her sources of emotional and social support, exercise self-control when necessary, and make an effort to keep her job, rather than throwing it away over a perceived slight or because her mood changes. Unfortunately, given her unstable history with regard to career planning and long-term vocational goals, significant longevity, even at a job she likes and is successful at, is unlikely.

If she continues to work in therapy with Georgia, and if she talks about her plans before acting impulsively on them, Georgia will have a chance to encourage her to reflect, consider her options, and consider her long-term self-interest. If Carol slows down enough, the impulse to quit and move on to something else might pass. On the other hand, Carol is unlikely to stay in a stable therapy relationship, either. In the end, her chances of long-term vocational success are subject to the dictates of her personality problems.

Summary: Borderline Personality Disorder's Effect on Vocational Functioning

Level of Impairment:

1 -- no impairment

2 -- mild -- minimal impairment with little or no effect on ability to function

3 -- moderate -- some impairment which limits ability to function fully

4 -- serious -- major impairment which may at times preclude ability to function

5 -- severe -- extreme impairment

Understanding and Memory

Remembers locations and basic work procedures

1 X 2 _____ 3 _____ 4 _____ 5 _____

Understands and remembers short, simple instructions

1 X 2 _____ 3 _____ 4 _____ 5 _____

Understands and remembers detailed instructions

1 X 2 _____ 3 _____ 4 _____ 5 _____

Concentration and Persistence

Carries out short, simple instructions

1 X 2 _____ 3 _____ 4 _____ 5 _____

Carries out detailed instructions

1 X 2 _____ 3 _____ 4 _____ 5 _____

Maintains attention and concentration for extended periods of time

1 _____ 2 X 3 _____ 4 _____ 5 _____

Can work within a schedule, maintain attendance, be punctual

1 _____ 2 _____ 3 X 4 _____ 5 _____

Sustains ordinary routine without special supervision

1 _____ 2 _____ 3 X 4 _____ 5 _____

Can work with or close to others without being distracted by them

1 _____ 2 _____ 3 _____ 4 _____ 5 X _____

Makes simple work-related decisions

1 X _____ 2 _____ 3 _____ 4 _____ 5 _____

Works quickly and efficiently, meets deadlines, even under stressful conditions

1 _____ 2 _____ 3 X _____ 4 _____ 5 _____

Completes normal workday and workweek without interruptions due to symptoms

1 _____ 2 _____ 3 _____ 4 X _____ 5 _____

Works at consistent pace without an unreasonable number or length of breaks

1 _____ 2 _____ 3 X _____ 4 _____ 5 _____

Social Interaction

Interacts appropriately with general public

1 _____ 2 _____ 3 X _____ 4 _____ 5 _____

Asks simple questions or requests assistance when necessary

1 _____ 2 _____ 3 X _____ 4 _____ 5 _____

Accepts instructions and responds appropriately to criticism from supervisors

1 _____ 2 _____ 3 _____ 4 _____ 5 X _____

Gets along with coworkers without distracting them

1 _____ 2 _____ 3 _____ 4 X _____ 5 _____

Maintains socially appropriate behavior

1 _____ 2 _____ 3 _____ 4 X _____ 5 _____

Maintains basic standards of cleanliness and grooming

1 _____ 2 X _____ 3 _____ 4 _____ 5 _____

Adaptation

Responds appropriately to changes at work

1 _____ 2 _____ 3 X 4 _____ 5 _____

Is aware of normal work hazards and takes necessary precautions

1 _____ 2 _____ 3 X 4 _____ 5 _____

Can get around in unfamiliar places, can use public transportation

1 X 2 _____ 3 _____ 4 _____ 5 _____

Sets realistic goals, makes plans independently

1 _____ 2 _____ 3 X 4 _____ 5 _____

Summary: Vocational Strategies and Accommodations

To optimize the chances for vocational success, a person with borderline personality disorder needs...

Help from a rehabilitation or mental health professional in explaining to a supervisor the need for unusual interpersonal flexibility, in order to reduce tensions and receive necessary accommodations.

Strong support for vocational strengths, rather than constant emphasis on inappropriate interpersonal behaviors.

Flexible scheduling to accommodate mood swings.

Clearly spelled out behavioral and work expectations, unambiguous interpersonal and job-related boundaries, and unambiguous methods of evaluation, to help reduce arguments and disagreements.

Firm supervision with concrete consequences for misbehavior, to help control potential danger to self or others.

A direct and straightforward approach on the part of the supervisor, firm but supportive, focused on work and on concrete behaviors.

Social support both within and outside of the workplace to help reduce attention-seeking and self-destructive behaviors.

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