

From Opposition to Opportunity: Adaptations for Engaging Individuals with Personality Disorders

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Objectives

- Appreciate the relevance of Personality Disorders (PDs) to ACT
- Understand what personality disorders (PDs) are and why they arise
- Differentiate Personality Traits from Personality Disorders
- Identify the most common trait-related challenges
- Learn how to work effectively with clients with PDs

Getting to know each other

Where do you work?

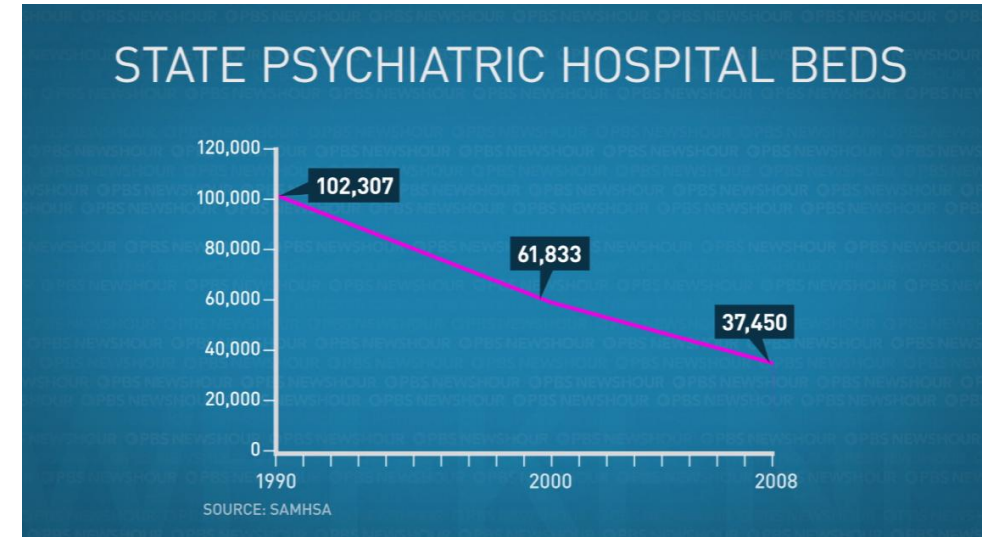
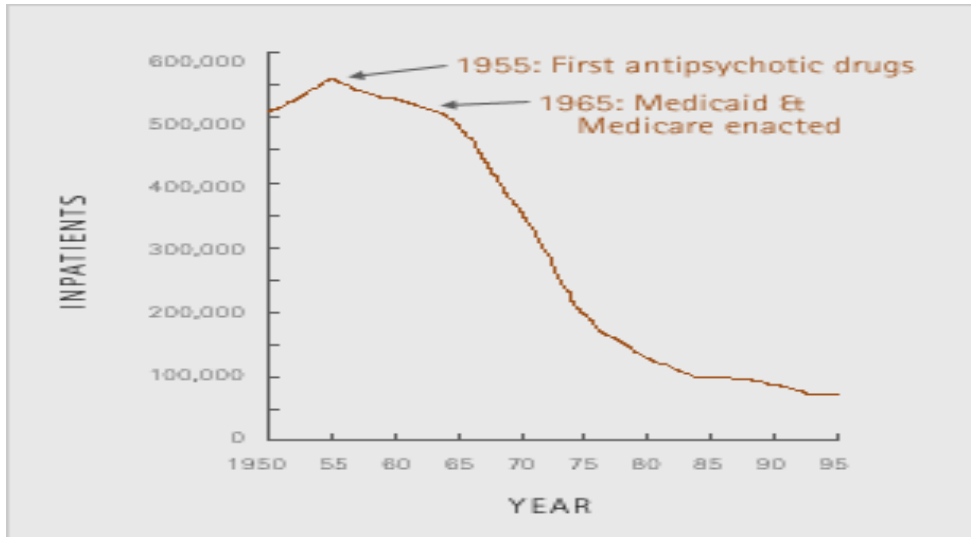
What is your role?

Getting to know each other

What are your biggest challenges in working with people with personality disorders?

In the beginning

- Decreased reliance on inpatient care for individuals with SMI
 - Community mental health movement
 - Changing legal landscape
 - Waves of deinstitutionalization



Assertive Community Treatment (ACT)

- Maintain contact
- Assertive outreach
- Provide direct services (multi-disciplinary)
 - Medication
 - Rehabilitation
- Indefinite time frame

Next Gen ACT

- Changing Inpatient Client Characteristics
- Clinical Features
 - Personality Disorders
 - Substance Use
 - Forensic History
- Part of a continuum of care
- "Flexible ACT"

Prevalence of PD on ACT Teams

- **Ranges from about one-quarter to one-half of clients**
 - One U.S. study of ACT for homeless individuals with SMI found prevalence of 23%
 - 52% of clients on a London ACT team met criteria for 1–2 personality disorders
- **BPD is the most common among participants**
 - ASPD is also common and relevant for FACT teams, although prevalence is uncertain
 - Possibly a higher prevalence of cluster C disorders/traits in more rural areas and more emotionally unstable/impulsive pathology in urban centers

(Beach et al., 2013; Keown et al., 2002; Newton-Howes et al., 2010; Rosenheck & Dennis, 2001)

Challenges PD Pose

- Chronic suicidality in BPD is more difficult to manage than acute episodes, and they may resist the DBT goal of independence from services
- For FACT teams, ASPD is a key risk factor for poor outcomes
- Traits & behaviors affecting engagement:
 - SMI, SUD
 - Lifestyle instability, overuse of emergency services, criminal justice involvement
 - Mistrust, avoidance, impulsivity, cognitive rigidity, low language proficiency

(Erickson et al., 2009; Frisman et al., 2009; Horvitz-Lennon et al., 2009; Marquardt et al., 2021)

Challenges PD Pose for ACT teams

- Same?
 - Traits affect engagement, treatment adherence, and long-term outcomes
 - Additional complicating factors:
 - Cognitive impairments, lack of structured activities, and fragmented support systems
- Different?
 - ACT supportive model vs. PD accountability approach
 - Active resistance vs. Passive non-adherence
- Stigma
 - “Complex Emotional Needs”

Erickson et al., 2009; Frisman et al., 2009; Smeekens et al., 2021; Wolff et al., 2013), Ledden et al., 2022

CUCS



JANIAN
Medical Care
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Service Eligibility	Service Description
Intensive Mobile Treatment (IMT): • 18 years of age or older • Reside in NYC shelter, live on the street or experience other housing instability in the NYC area • Recent and frequent interaction with mental health (MH) and criminal justice (CJ) systems • Recent behavior that is unsafe, and which is escalating or occurring with greater frequency • Traditional forms of care and support have not met needs of client or engagement has been unsuccessful	• Provides MH and substance use treatment, including medication and support to people with significant behavioral health (BH) concerns, complex life situations, transient living situations and/or involvement with CJ systems who have been poorly served by traditional forms of care • Teams are staffed by BH clinicians and peers • Typically operates during business hours with on-call availability for clients • Teams have variable frequency and duration of contact with their clients, depending upon clients' current needs
Assertive Community Treatment (ACT)*: • 18 years of age or older; and • Serious mental illness (SMI) diagnosis; and • Extended functional impairment due to mental illness; or reliance on psychiatric treatment, rehabilitation and support • Prior authorization required for people with Medicaid Managed Care	• Provides MH and substance use treatment, including medication and support • Staffed by BH clinicians and sometimes peers • Typically operates during business hours with on-call availability for clients • Sees clients six times a month

Personality Disorders (PDs)

Categories of PDs

A: Odd; eccentric

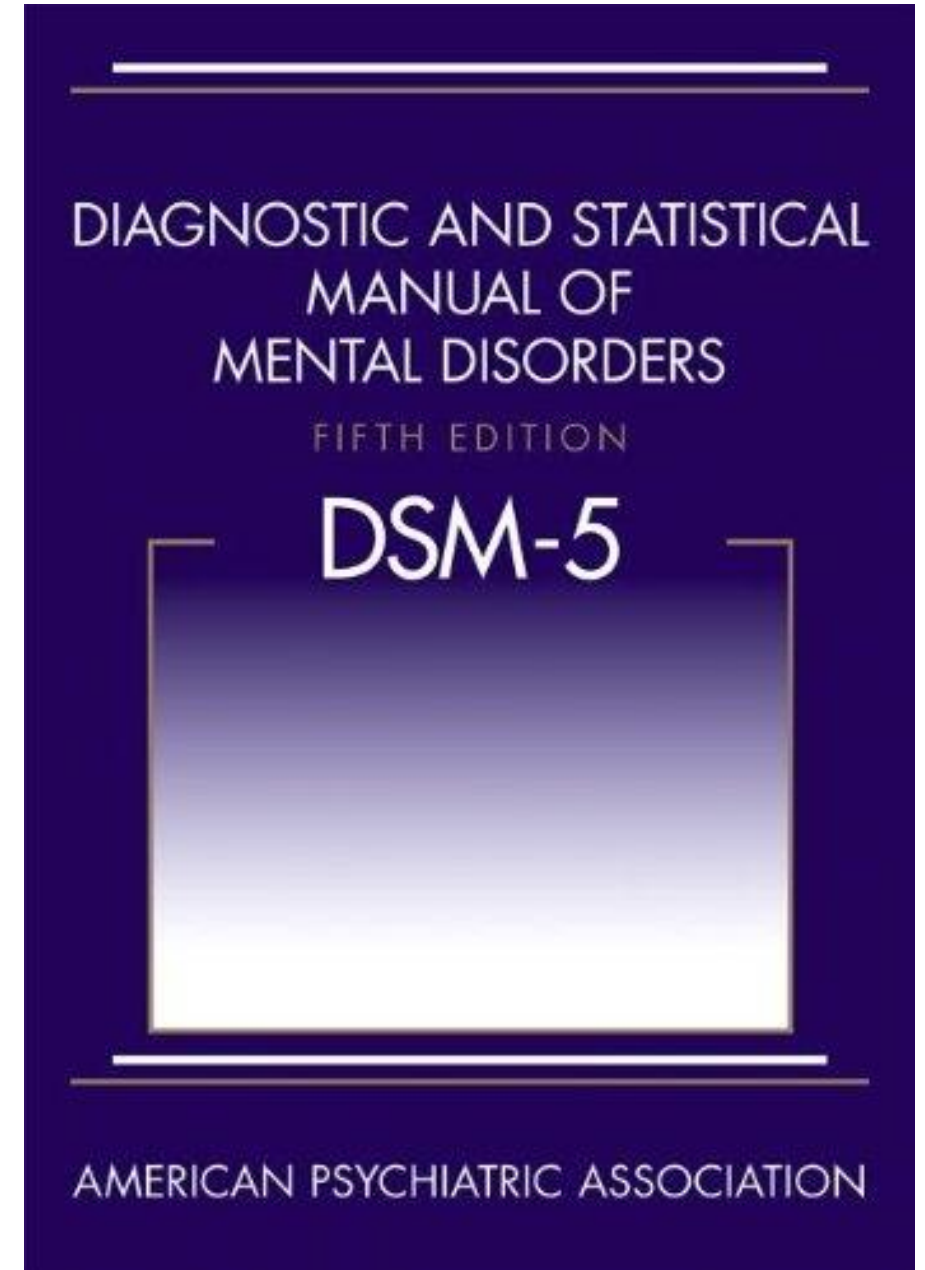
- Paranoid, Schizoid, Schizotypal

B: Wild, dramatic, erratic, emotional

- Borderline, Antisocial, Narcissistic, Histrionic

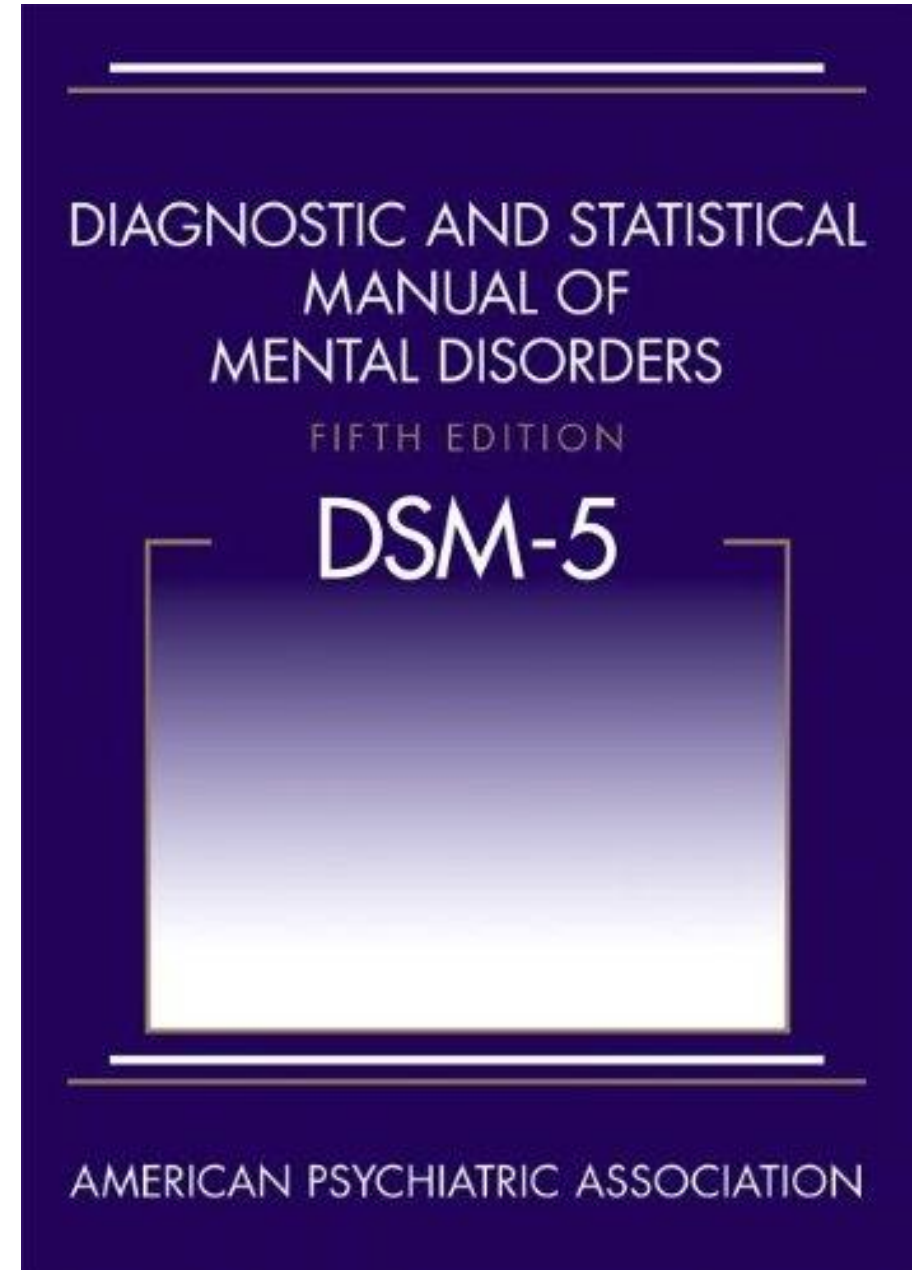
C: Fearful, anxious

- Avoidant, Dependent, Obsessive-Compulsive



Categories of PDs

- **Borderline** (volatile, impulsive)
- **Antisocial** (rule-breaking, aggressive)



Prevalence

Personality disorders

In the general population ¹ :	11%
In the clinical population ¹ :	64%
In the justice-involved population ² :	up to 47%

Borderline PD

In the general population ³ :	1 - 2%
In the clinical settings ⁴ :	20–22% inpatient 10–12% outpatient

¹Skodol, A. Overview of Personality Disorders. In: UpToDate, Stein, M (Ed), Wolters Kluwer. (Accessed on March 7, 2024.)

²Metzner J, Cohen F, Grossman L, et al: *Treatment in prison and jails, in Treatment of Offenders with Mental Disorders*. Edited by Wettstein RM. New York: Guilford Press, 1998, pp 211–64

³Chapman, A. L., & Ivanoff, A. (2018). Forensic issues in borderline personality disorder. In B. Stanley & A. S. New (Eds.), *Borderline personality disorder* (pp. 403–419). Oxford University Press.

⁴Ellison et al. (2018). *Psychiatr Clin N Am* 41 (2018) 561–573

History of Trauma Very Common in People with PDs

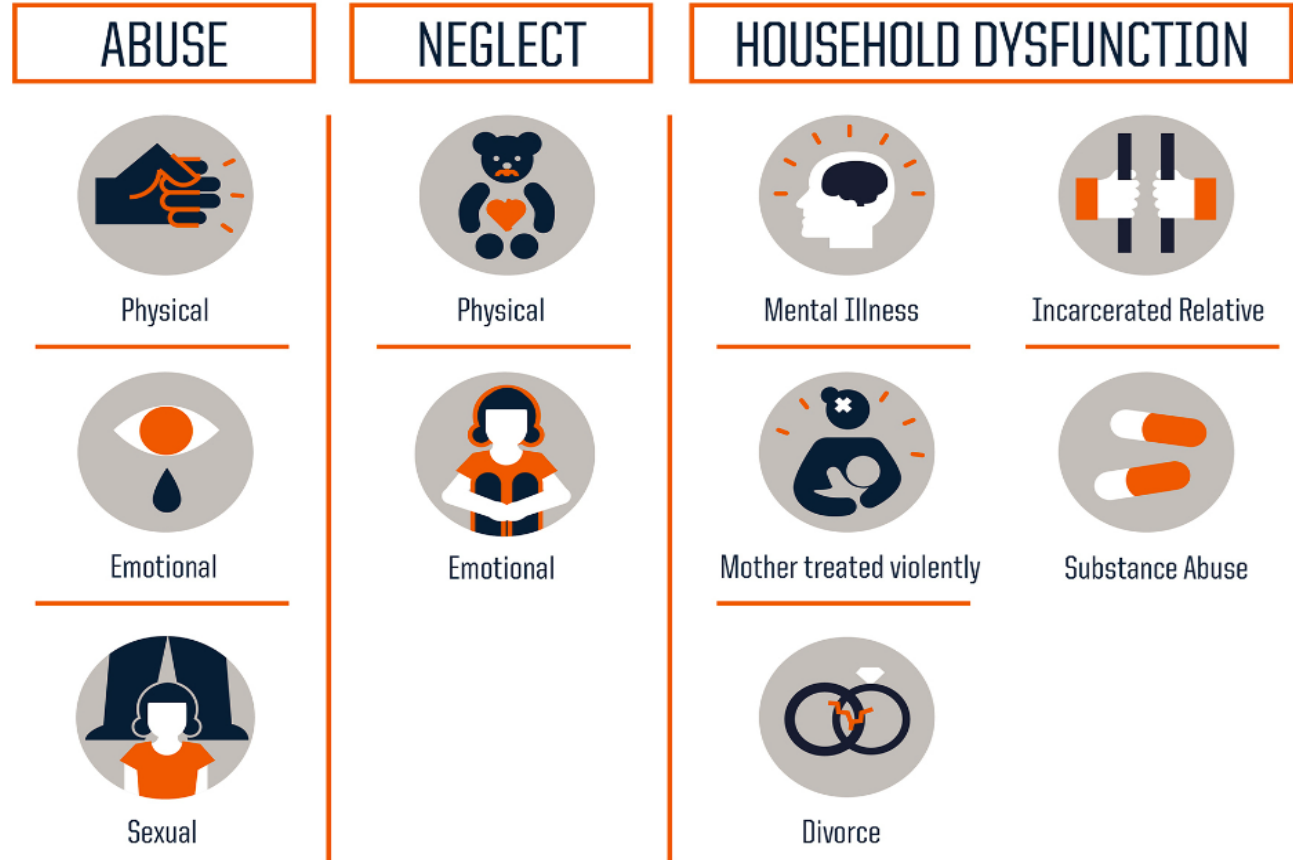
Trauma

- Childhood factors that lead to borderline personality disorder¹
 - sexual violence (65%)
 - physical violence (60%)
 - neglect (40%)
- Physical, sexual, emotional abuse, emotional neglect
 - Leads to difficulty with sense of self and others
 - Challenges with behavioral control

¹Helgeland M.I., Torgersen S. Developmental antecedents of borderline personality disorder. *Compr. Psychiatry*. 2004;45:138–147.

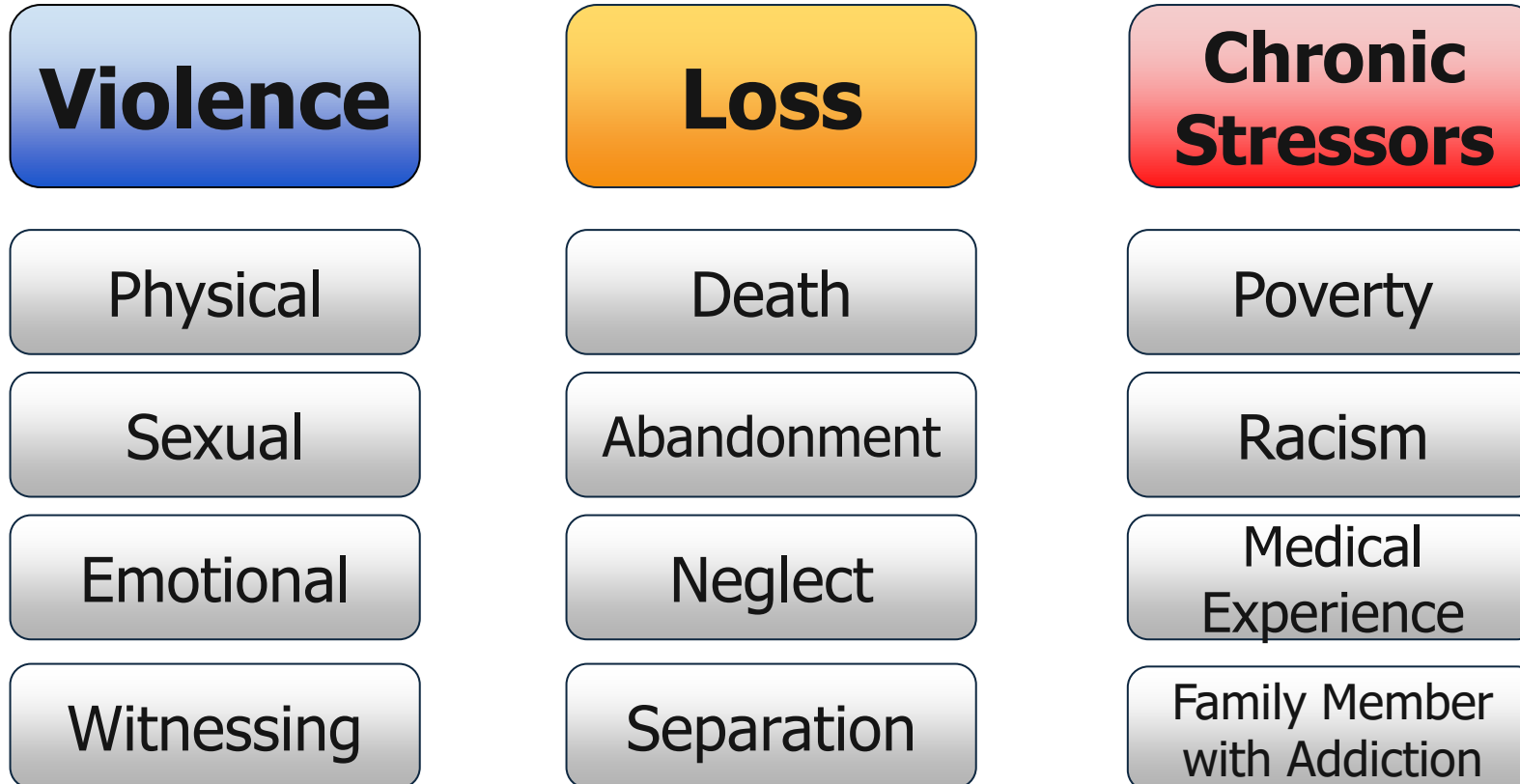
Trauma is More Than Violence

ACE Study –
Three Categories of
Trauma

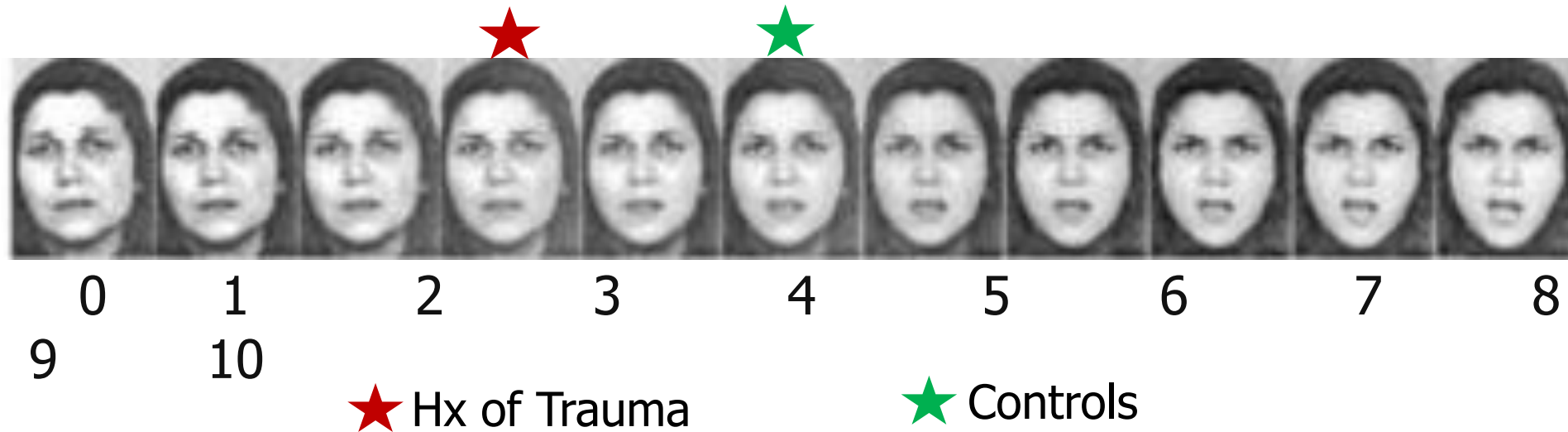


Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

Trauma is More Than Violence



People with trauma perceive threat earlier



→ Feeling unsafe triggers survival mode

Trauma: The invisible assailant

- Chronic and developmental trauma can be difficult to spot
- Behaviors such as:
 - Irritability, hyper-reactivity, and aggressivity
 - Impulsivity and irresponsibility
- Lead to labels such as:
 - Acting out and disruptive
 - Faker, malingerer, and predator

Borderline PD

What is Borderline Personality Disorder?

- 1. Trouble with tolerating and managing emotions**
- 2. Difficulty having realistic sense of themselves and others**



What is Borderline Personality Disorder?

Trouble with tolerating and managing emotions

- Leads to
 - Intense emotions, mood swings
 - Serious issues with relationships
 - Cause severe issues for treatment providers/teams
 - “I hate you, don’t leave me”
 - “You’re the only person who knows how to help me, leave me alone”



What is Borderline Personality Disorder?

Difficulty having realistic sense of themselves and others

- Leads to
 - Idealizing and devaluing
 - Difficulty evaluating positive and negative experiences
 - Experiences, people, systems are all good/all bad
- Often occurs with other mood, eating, and substance use disorders



‘Splitting’

- All good or bad/black or white
- Some people on a team are perfect and revered, others are horrible and rejected
- Happens when the patient cannot form a realistic view of another person
- Defense mechanism
- Puts you in a bind - if you do A, it’s wrong and if you do B, it’s wrong

How BPD affects others

- Make you experience feelings they don't want to experience
- Question your capability or character in piercing ways
- Therefore treatment for BPD is in teams - very difficult for one person alone to withstand

Borderline PD – treatment options

Psychotherapy

- **Dialectical behavioral therapy (DBT)**
- Mentalizing-based therapy (MBT)
- Transference-focused psychotherapy (TFP)

Medications

- No medications for borderline PD per se
- BUT use medications to treat symptoms

Psychosocial Interventions

- Supportive social interventions
- Basic and other needs
- Build community
- Psychoeducation

- Trauma-informed care

Antisocial PD

Antisocial PD

- **socially irresponsible, exploitative, and remorseless**
- behave with **recklessness, not caring about the safety and well-being of others**
- begins in childhood or early adolescence
- fully manifest by the late 20s or early 30s.
- usually lifelong and causes issues with functioning (eg, family relations, school, and work)

Antisocial PD – treatment options

Psychotherapy

- Cognitive-behavioral Therapy (CBT) for ASPD
- Psychosocial interventions can work

Medications

- Treat any comorbid diagnosis first
- Treat aggression

Psychosocial Interventions

- Supportive social interventions
- Basic and other needs
- Psychoeducation

Effective Treatments on ACT Teams

- InterACT (ACT + DBT):
 - ↓ hospital days, ↑ vocational participation, ↑ consumer satisfaction
- DBT-SUD (DBT adapted for substance use) effective for BPD + SUD
- DBT also effective for clients with intellectual disabilities
- ACT + Integrated Dual Diagnosis Treatment helped those with ASPD:
 - ↓ alcohol use, ↓ incarceration risk

(Burroughs & Somerville, 2013; Frisman et al., 2009; Reynolds et al., 2007)

DBT Integration Approaches

- ACT teams refer to community DBT; provide support with:
 - Crisis calls, on-call providers for DBT coaching
- Limited access to full DBT programs; teams may use:
 - Partial DBT (skills groups only) → limited evidence for effectiveness
 - Individual therapy, residential, or partial hospitalization program → can lead to provider-team tension

(Burroughs & Somerville, 2013; Dimeff & Koerner, 2007; Reynolds et al., 2007)

DBT Integration Challenges

- Engagement with therapy & low motivation
 - Reluctance **due to fear of the goal: independence from intensive mental health services**
- Certain PD traits, like splitting and coerciveness, complicating therapeutic alliance
- High caseloads and crisis-driven workflows
- Lack of time and formal appointments -> adaptive nature of treatment

(Dimeff & Koerner, 2007; Wolff et al., 2013)

Disorder vs. Trait

No absolutes - Disorder vs. Trait



TRAIT?  DISORDER?

- It is a fallacy that a PD is either present or not present
- Personality features occur on a spectrum
 - No clear demarcation between “normal” or “abnormal”

Personality disorder vs. traits

Important to distinguish

- Disorder:
 - Seen as fixed and unchangeable
- Traits:
 - Something everyone has
 - Can be changed
 - Not a characterological flaw but a feature that can change and grow

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Unconscious Bias and the Diagnosis of Disruptive Behavior Disorders and ADHD in African American and Hispanic Youth

Commentary | Published: 11 November 2019

Volume 44, pages 95–102, (2020) [Cite this article](#)

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Diagnostic evaluation of psychiatric disorders in children and adolescents relies in part on subjective interpretations of information from a clinician. Clinicians must interpret and contextualize information obtained from family caregivers and educators in order to

Sections

References

[Disruptive Behavior Disorders and ADHD: Prevalence and Risk Factors](#)

[Disruptive Behavior Disorders and ADHD: Challenges in Diagnosis and Treatment](#)

[Unconscious Bias](#)

[Disruptive Behavior Disorders: Clinician Biases, Stigma, and Cultural Considerations](#)

[ADHD and Diagnostic Biases](#)

Risks of Diagnosis - ASPD

Among 17,100 children:

- African Americans were 69%
- Hispanics 50%
- and children of “other races/ethnicities” 46% **less likely to receive a diagnosis of ADHD compared to white children**

And **more likely to receive diagnoses of ODD and CD**

→ adult dx of ASPD → poor clinical tx, poor clinical outcomes, jail

Risks of diagnoses: BPD and ASPD

- Promotes negative bias
 - Diagnosis may influence teams, treatment providers
- Missed opportunity to treat a potentially reversible condition
- Places blame on individuals rather than seeing the whole picture
 - Discourages curiosity about causes of behavior

A note about personality disorders

This is not a choice

- People do not *choose* to behave in these ways
- Feeling overwhelmed by things which feel out of one's control
- It is distressing and frightening to experience these feelings and behaviors

“Just don’t do it” does not work

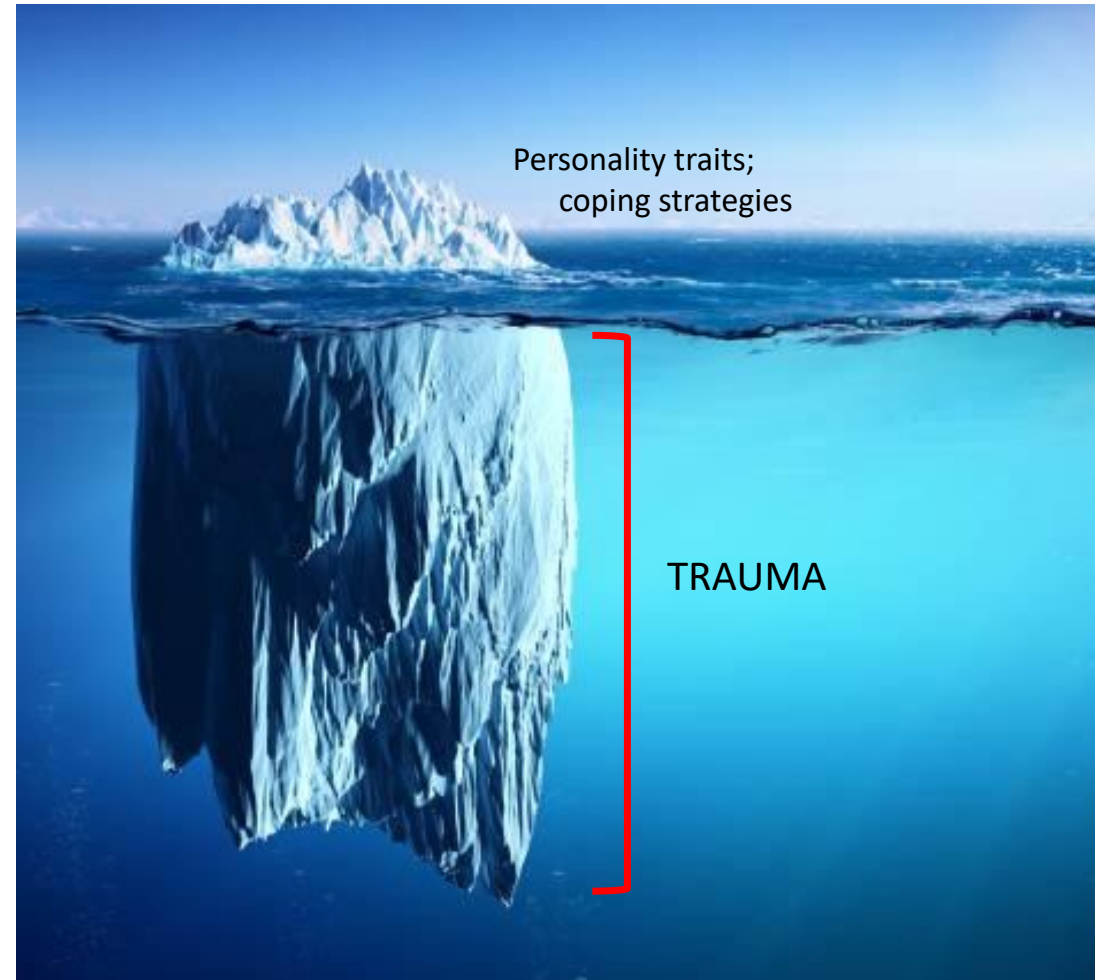
Strategies for Working With PDs

Problematic behaviors

The behavior is the tip of the iceberg

Unstable behaviors come from two sources:

1. Feeling unsafe and going into survival mode
2. Testing boundaries



What happens when a client feels unsafe?

- Survival mode – ‘thinking brain’ shuts off
- Fight, flight, freeze, fawn
 - Behaviors such as:
 - Irritability, hyper-reactivity, and aggression
 - Impulsivity and irresponsibility
- Important to assess how you are doing and respond effectively
 - Stop, calm, activate thinking brain



Trauma-informed approaches

1. Clarity and transparency

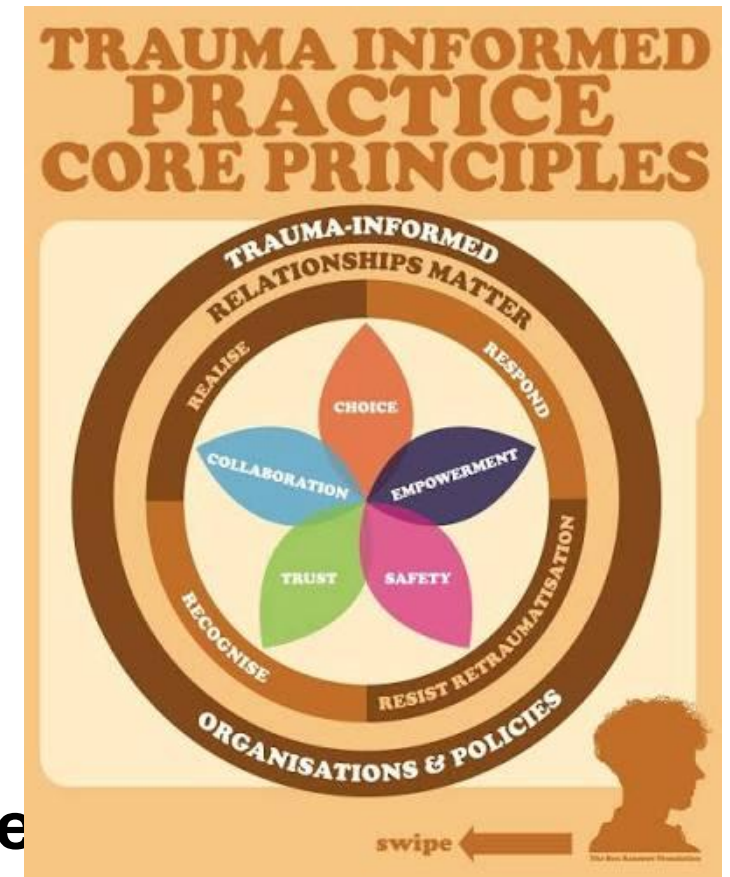
2. Collaboration and mutuality

- Collaborative problem-solving
- Offering choice
- Meeting the patient where he/she is at

3. Empowerment, autonomy, voice, & control

- Exercising authority vs. being authoritarian
- Avoiding coercion

4. Respect for cultural, historical, & gender issues



Safety creates conditions for trust

Change and growth happen when there is trust

Boundaries are critical in PDs

Why are boundaries important?

Because people with BPD

- Often come from environments without healthy boundaries, or any boundaries, and often sexual abuse
- Test for **safety**
- “Are you going to break the boundary and molest me?”



How to set boundaries effectively

- **Consistency** – the entire team has to enforce
- **Transparency** – so that participants understand why we are setting them
- **Collaboration** – ask participant for input
 - Ex: coming up with a list of agreements
- **Boundaries have to fit the individual**

Conflict is a given in PDs: learn to repair

Most people with PDs don't have models of repairing from conflict

- Conflict meant being abused, ignored, or abandoned
- They usually get kicked out of systems
- ACT teams can provide a safe model that conflict is ok and repair is possible



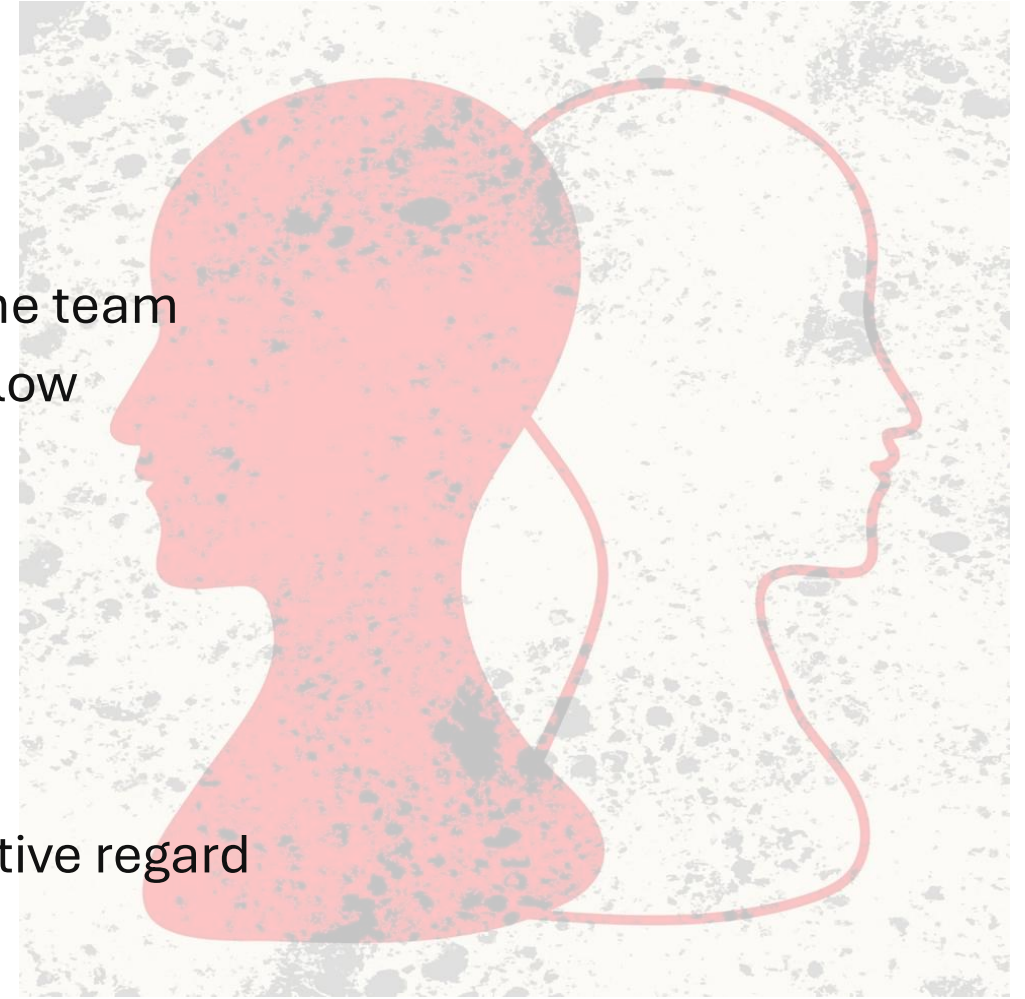
How to repair conflict effectively

- **Consistency** – the entire team has to collaborate
- **Transparency** – so that participants understand how repair will be possible
- **Collaboration** – ask participant for input – why conflict arose and how it should be resolved
- **Restriction has to fit the individual**
 - What can they understand?
 - What is going to work? - set up for success

How to manage ‘splitting’

Commit to preserving team unity

- Recognize splitting, name it
- Discuss what is happening explicitly within the team
- Formulate a plan for all team members to follow
 - Boundaries
 - Limits
 - Requirements
- “Let me ask the team”
- Splitting is normal in PDs
- Humility - give each other unconditional positive regard



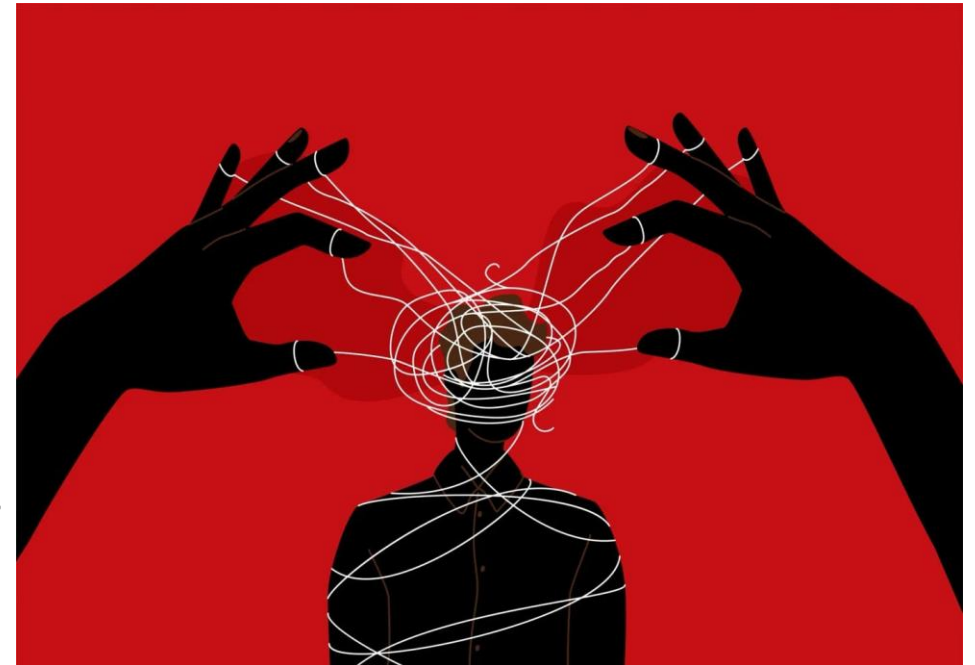
Managing Antisocial traits

- Omnipotent control/devaluation – manipulating others to maintain the illusion of superiority

- Cause/effect consequences
- Consistency

- Safety is key

- Strong, objective risk assessment
- Trust your gut
- Take care, remove yourself by taking breaks
- Concrete boundaries
- Work in pairs



Buffering Ourselves

Protecting against trauma

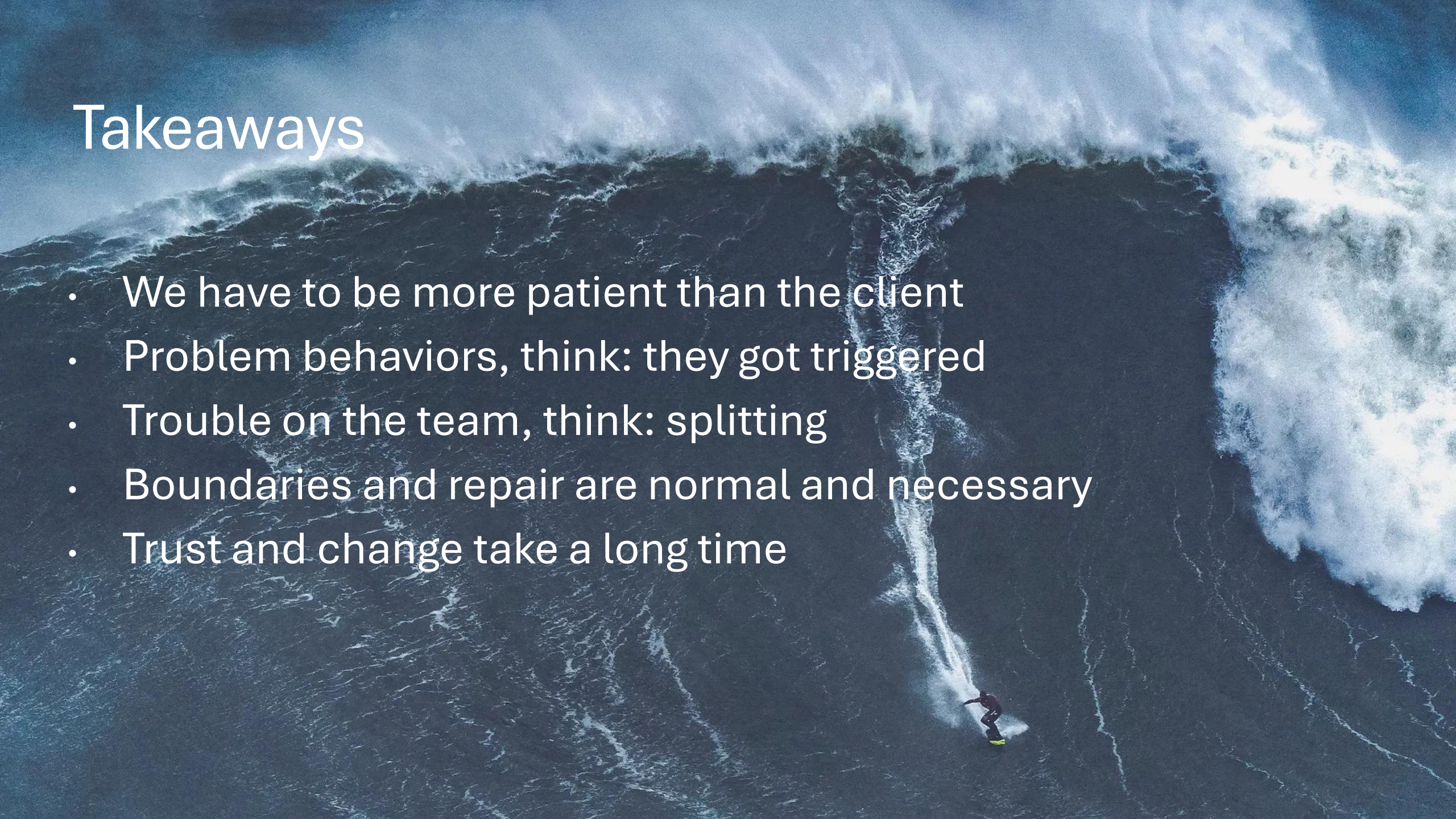
- Adequate supervision
- Peer support
- Reflecting
- Maintaining personal boundaries around work
- Pursuing professional development (training)

Be good to yourself



Takeaways

- We have to be more patient than the client
- Problem behaviors, think: they got triggered
- Trouble on the team, think: splitting
- Boundaries and repair are normal and necessary
- Trust and change take a long time



Thank you

Questions?