

Psychiatric Disabilities in the Workplace: Implications for Community Rehabilitation Providers - Transcript

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Lynda Leach, Facilitator: Welcome to the RSA Region V CRP-RCEP monthly teleconference. I am Lynda Leach here at the University of Illinois. It is my pleasure to introduce Dr. David Strauser, who is an Associate Professor in the Department of Kinesiology and Community Health. David will be talking about *Vocational Implications of Psychiatric Disabilities and an Introduction to Personality Disorders*.

David Strauser: Welcome everyone. I may have seen some of you throughout the region this past summer and if I did I appreciate your joining us again here. What I want to talk about today is *Personality Disorders* and I am going to focus on a couple specific personality disorders that are the more common ones, such as paranoid personality disorder and borderline. In my work with state agency counselors throughout the country and primarily in the Southeast, these are the personality disorders that tend to come up quite a bit as being issues for the counselors. So I am going to talk about these disorders in a little bit of detail.

I am going to start the presentation by giving you an overview of work and the changing nature of work. I start this way in every session because I think it is really important, especially with psychiatric disorders, on how work is changing, what is being done in the work environment, how is it different than what it was ten or fifteen years ago, and what implications this has for people with psychiatric disorders. We are going to lay that foundation. Then we are going to get into personality disorders and talk about the specific personality disorders. We will wind it up with some intervention strategies. When we talk about intervention strategies in this case I am really focusing on developing a good counseling relationship with the individual and what that means. When we go out again, hopefully this summer, we will be talking more about specific strategies such as supported employment, supportive education, and some of these other strategies that are coming into light as being very effective. In addition I am going to try to leave some time at the end for questions and comments. I am going to wrap my presentation up at

about quarter to three so that people who do have questions or comments can feel free to ask those questions.

For those of you who are on your computer with the PowerPoints I am going to try to give you the numbers of the slide so that you can follow along. Right now I am going to slide two which is entitled *Work Foundations*. Again I think it is worth spending some time here talking about work foundations and what this means for people with psychiatric disorders. This isn't just people with personality disorders. This is in general. Work is changing. Work is changing significantly. Within the last two weeks a very significant announcement regarding the labor market has appeared. The *Wall Street Journal* had an article about the biggest sector of the labor force, the service sector. It used to be the production sector. We have now made a significant change in work and how it is done globally. The service-type jobs are the predominant occupational area or category or sector compared historically to the two strong ones, production and agriculture. This is going to have some implications for psychiatric disorders. The service sector is now the predominant sector in the labor market employing the most people worldwide and that is true here in the United States as well. That impacts how work is being done and the type of work that is being done and who is working.

In addition to the service sector we are also seeing technology – a huge infusion of technology into the workforce and technology influencing work productivity, how work is done, and where people can work. It is very evident from our conference call today, as Lynda mentioned that I am up the street. I am about a mile away from her on the University of Illinois campus, but again our ability to telecommunicate, to have a session like this would have been very difficult to do probably ten years ago. Video conferencing and different things along those lines have certainly changed things. Work has become more global. It has become more global and markets are not just bound to the United States or specific regions of the United States. That means that people have to deal with a lot of diverse people and a lot of different things. That is going to be a skill set that will be hard for some people with psychiatric disabilities to deal with as well.

I have talked quite a bit at length about how work is becoming more flexible. This means as jobs continue to evolve and continue to be changing in our labor market there tends to be more flexibility with how work is done and where work is done. So there are a lot of advance-type jobs, professional-type jobs, ones that provide a fair amount of flexibility and a fair amount of autonomy in how work is being performed. Now, the one exception to that is the service-sector job. The service-sector job continues to be fairly demanding as far as time and allocation, especially in the lower tier service-sector jobs such as housekeeper, janitor, hotel workers, and restaurant workers. They tend to be a little less flexible or a lot less flexible. There are still some portions of the service sector, especially the more skilled service people, who are able to work from a variety of places. Let me stress again why I always lay this foundation for work. How work is changing has certainly helped a broader group, people with disabilities, and given more access to the labor market, especially as technologies come more into place. However, the advancing nature of work for people with psychiatric disabilities has not been a good thing. It has been a very negative thing for the most part. It has made it harder and more demanding for people with psychiatric issues to enter the labor market and maintain jobs.

I am now looking at slide three which is entitled *Problems with Work Behavior*. What I have listed here are some general areas in which people with psychiatric disabilities, including people with

personality disorders, tend to have problems on the job. They tend to have problems with authority figures, supervisors, and coworkers who might be team leaders. They tend to have problems with getting along with authority, taking directions and instructions. Along those same lines they tend to have problems with coworkers. For many of you who might be working with some people who have some psychiatric disabilities or some mental health problems you might have experienced this quite a bit – problems with coworkers and getting along on the job. Another problem that is commonly cited for people with psychiatric disabilities tends to be poor work quality, not being able to meet the demands of the job as far as quality and production quality. These tend to be commonly cited as major problems.

The first one– inability to modify behavior to meet standards and increase productivity. That is directly related to what I talked about just a minute ago in the flexibility of the job market and how jobs are changing and continuing to evolve. Technology has been fused into the job, changing how work is done. People with psychiatric disabilities have a very hard time making that change. When we talk about paranoid personality situations this will come into play quite a bit. The last one I want to mention is the inability to create effective boundaries between work and non-work issues. As the labor market becomes more integrated and more diverse it places more and more of a premium on interpersonal interaction even at the low, unskilled level. The inability of people to keep the boundaries of work and home life and personal clear tends to be a major problem for people with psychiatric disorders. This is something that can really negatively impact the person’s ability to maintain employment. I wanted to bring those in as specific problems counselors are facing.

I am looking at slide four entitled *Conceptualizing Problems of Work*. If you joined me this summer we talked about these quite a bit in detail in some of our presentations. There are basically four broad categories in which people with disabilities and people with psychiatric disabilities tend to have problems. We are going to talk about these today as a model to organize this presentation. I want to cover a variety of disorders to get you familiar with some different personality disorders and talk about them more in detail versus going through each one of these in a lot of detail. Basically, occupational adjustments, performance adjustments, personal and social adjustments, and overall work adjustments. Right now I am on slide four.

Let me go ahead to slide five and let you catch up with me here. I am going to talk about these in a little bit of detail for each one. Slide four shows four areas – occupational adjustments, performance adjustments, personal and social adjustments, and work adjustments. Specifically on slide five now we are talking about occupational adjustments. When we talk about occupational adjustments what do we mean? We talk about the person’s ability to follow work rules, along with coworkers, deal with the public, use judgment, interact with a supervisor, deal with work stress, function independently, and maintain attention and concentration. You will see this in a lot of people with psychiatric disorders of all types – affective disorders like depression, bi-polar, anxiety disorders like PTSD, obsessive compulsive disorder, or personality disorders. Occupational adjustments tend to be a major problem for these individuals when it comes to maintaining employment.

Going to slide six – *Performance Adjustments*. These are obviously very different because they deal more with performance and following instructions. Can the person follow instructions from very simple job instructions to more complex job instructions? People with personality disorders don’t struggle as much here as far as cognitively following the job instructions. The instructions tend to get broken down

quite a bit by the person's unwillingness to follow the instructions or lack of desire to follow the instructions. When we start talking about personality disorders as it relates to performance adjustments, it is going to be more along the lines of a person not willing to follow versus a person not being able to follow. The third group of performance adjustments are again personal and social where we talk about a person's ability to maintain appearance. The ones that we are going to talk about today – paranoia, anti-social, borderline are not as much an issue as grooming and hygiene. For the most part across personality disorders grooming and hygiene and making a personal appearance are not issues. These last three are big issues – emotional stability, a person's ability to behave in an emotionally stable manner, and predicting a social situation. Then the last one is demonstrating reliability. This means it can be continuous and continuous work performance at a steady pace to meet the demands of the job. People with personality disorders don't fare well there. The last one is work adjustment. Working eight hours a day, five days a week, without excessive breaks and maintaining regular attendance. The issue for people with personality disorders is going to be again maintaining that regular attendance.

What I have done so far here is lay of the ground work for how work is done in the labor market and how we can conceptualize problems with work. Again if you saw me last summer we used this model of occupational adjustments, performance adjustments, social adjustments, and work adjustments. If you see me again this upcoming summer we will use the same model. Today I am not going to have that because I want to start now to break into specific disorders. This is a model you should remember as a fall back to how we can conceptualize problems with work and how your clients of all types, psychiatric as well as people who might have physical or neurological impairments, might be responding in these areas.

Let's talk about personality disorders. Right now I am referring to slide nine. Let's talk about a definition of personality. This is going to start the rest of our session. What are they? How do they look? How can we field them and notice when someone has a personality disorder so you can refer someone for an evaluation if you determine that they might need it. How can you work with this person so that you reduce your frustration in working with people with personality disorders? In my experience personality disorders are by far the least favorite psychiatric disorder to deal with out of any of the psychiatric disorders because these people tend to be very difficult. They can be aggressive. When I say aggressive not necessarily physically. Just very demanding, very verbally hostile, and they can be very degrading. They can really make it seem like they are in control of everything and that you are the one who has the problem. Personality disorders, needless to say, are a challenge.

When we talk about personality disorders there are three major types of personality disorders and we will cover those in just a minute. The major overarching definition of the personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of an individual's culture that is pervasive and inflexible, has an onset in adolescence or early childhood and is stable over time and leads to distress or impairment. Let me just spend a little bit of time breaking this down so that you understand the major components of a diagnosis of personality disorder. First of all, it is an enduring pattern of behavior. That is a very, very critical piece. Unlike other disorders in the DSM, when we talk about enduring pattern of behavior we mean over many, many years that this pattern of behavior has existed. And again the onset of this behavior pattern usually is in adolescence. We start to see this pattern develop, persist, and continue on into adulthood. The other important piece of this definition is that the person's behaviors again deviate from cultural expectations. That is a very key part

because if they don't deviate from our expected cultural traditions or don't deviate enough to be an impairment then we don't consider that person to have a personality disorder. This person's condition needs to be such that they are noticeably different, remarkably different than what we expect the average person to be. That is the other part of it. We mentioned the childhood onset or onset in adolescence. We talk about the enduring pattern of behavior. This would also imply that it is stable and continues for some extended period of time.

The last thing is that this condition, this development of a personality disorder, tends to lead to stress or impairment. Again if there is no stress or impairment then why would the person be experiencing problems or deviating from the norm? Those are the key components of any personality disorder. Personality disorders have those key components – enduring pattern, deviation from culture, onset at adolescence, and causing significant stress or impairment.

There are four areas that people with personality disorders typically have problematic functioning. Where do they tend to get bogged down? Where do they tend to have problems expressing themselves? I am looking at slide ten right now. How do they express themselves? How do they deal with their emotions, their interpersonal conduct – getting along with themselves and others, their interpersonal style? Sometimes when we are talking about a paranoid personality disorder they tend to be very linear and very straightforward in how they deal with things. They have a very hard time regulating themselves in what is appropriate and what might be inappropriate. So, those are components of problematic areas.

Now, personality disorders can be divided up into three major categories in the DSM. The DSM has a whole bunch of personality disorders but they tend to be categorized into three major clusters. For example, on slide 11 you see cluster A is called the odd cluster and that tends to consist of paranoid personality, schizoid, and schizotypal personality disorders. Those are three discrete personality disorders that exist under this odd cluster. Now, you might have heard me talk this summer about a dimensional model versus a categorical model. Let me just take a second to define those differences. The DSM which is the text that we will use as the basis for discussing these conditions falls under what we call a categorical model. What that means is that a person has to reach a certain threshold for a person to be diagnosed with the problem. By reaching that criteria for diagnosis you go from having no problem to having a problem based on whether or not the criteria is met. That is in contrast to what we call the dimensional model. This would imply that it is not necessarily that a person has to meet a certain criteria to have a problem, but that basically it is seen on a continuum. It is that a person who might not meet the full criteria for example of the DSM but has some of these behaviors and patterns might still have a significant problem getting a job and maintaining a job, even though they don't meet the full criteria for the categorical model. As rehabilitation professionals we are going to come from the more dimensional model meaning that we are not going to be as concerned about treating the person's diagnosis as their behaviors. We are not going to be concerned about whether the person has been diagnosed with PTSD, depression, or anxiety. We are going to want to find out from the person's perspective what it is that they think and how do they think and what type of resources might they need to become successful, even if they don't meet the full criteria for a specific diagnosis. That is my little sidelight on "dimensional and categorical" models.

Let me talk about the odd cluster— paranoid, schizoid, and schizotypal. I am going now to slide 12. I want to talk about a specific type of odd personality disorder right now or part of a category from the odd cluster. This is one that you might see quite a bit in your work – paranoid personality disorder. This is not consistent with or part of psychosis which has a paranoid component to it. It is not in any way related to psychosis. This is a personality disorder that has an enduring pattern of behavior, that has resulted in late childhood, and is causing significant impairment in life areas. This is not to be confused with psychosis and paranoid psychosis.

What are paranoid personality disorders like? There are some key components of what constitutes a paranoid personality disorder. One is that a person with a paranoid disorder tends to misinterpret interpersonal situations quite a bit. They tend to have problems reading people, have a hard time understanding what interpersonal relationships are, interpersonal behaviors of coworkers, supervisors and things along those lines. As a result they tend to think that people might be out to get them, might be out to exploit them and take advantage of them. This is what we talk about commonly in interpersonal situations or misinterpretation of interpersonal situations.

The second one is that a person tends to be viewed as having inherited this hostile and aloof-type feeling. That is related to the person with the paranoid disorder – tends to never feel like they got a fair shake. They are a lot better than what they are. It is because someone is trying to bring them down, make them look bad, or that if they would have had all the information they could have done a lot better – things along those lines. That is another key component – this hostile and aloof-type feeling that goes with it. People who have paranoid personality disorders talk about marriages or relationships that they have been in where they get overly involved about what everyone else did wrong, or what their spouse did wrong. They don't talk a lot about what it is themselves that they have done wrong. That can be a major, major issue for people with paranoid personality disorder. The third thing is that they tend to be blaming and vindictive. They tend to blame others for their failure. They don't tend to view themselves as being failures – meaning they are not going to say, “Well I failed at this. I failed at that. That was my responsibility and I failed.” They will always try to divert it to someone else, particularly to people who have lesser power, a different gender, or cultural minority. They might try to resolve that issue. There is some of that still going on with the paranoid personality part – blaming and avoidance component. Overly rationale is another one. Meaning that they can very clearly lay out to you why it is that they should be doing what they are doing and why it is that what they are doing is correct and then how other people are doing it incorrectly. They tend to always blame other people and they might talk about relationships that they have had with people and how they were always the fault. That is the blaming and vindictive part. Overly rationale – can rationalize a lot what their problems are and be very logical and litigious. They tend to be overly involved in litigation or bring up lawsuits or threaten lawsuits. I hope I was clear on that.

Those are some key components of a personality disorder. Now, this doesn't mean that everyone with a personality disorder has to have those components. There could be different components of where a person has a stronger trait than others, but these tend to be generalized characteristics.

How does this play itself out into the workplace? My guess is that most of you are working with people who have personality disorders - people who have a work history, who have worked some but they have had problems on the job and these might have been the factors that have gotten them fired on the job. For example, paranoid personality disorder – they have a hard time getting along with coworkers,

hard time getting along with supervisors, and following supervision. Those two go together. A lot of interpersonal problems. A lot of being overly involved in other people's business and feeling that people are overly involved in their business. That makes them very difficult to supervise. It makes it very hard to work with them as part of this work team. As I mentioned earlier on service-sector type jobs tend to be a major, major problem. Also paranoid personality disorders can be very dangerous in the work place. They can be hostile verbally and physically. They might not be the person who is going to come back with a gun in a work setting. I am not implying that as much as they will be at times very verbally abusive and they can at times be physically abusive if they get agitated. We need to find environments that are not as demanding socially and cognitively for them.

On slide 14 vocational strategies that we can use to work with people with paranoid personality disorder. Working alone is a good strategy. What does that mean? Get to be as isolated as possible and work alone. This is not a person who you want to place in a collaborative work environment. You want this person to be working primarily alone on a task or job. Be very clear with these people. Provide directions that are straight forward, clear, preferably in writing or constantly monitored regarding work expectations. Involve them in decisions. Now this sounds a little bit counter intuitive but what I have found is that when they get involved with a decision, they are part of the decision process, they feel somewhat empowered about the decisions that they are making. I am not saying that they get involved with every decision, but to the extent that they can be involved in some basic decision making. It is probably not bad to get them involved. It is going to be much harder for them to feel disengaged and feel like this is put upon them if they have some involvement and some say.

Again emphasize the specific task. You might want to praise this person quite a bit, talk to them quite a bit about what their strengths are their abilities are, when work is well done. You as the counselor, placement specialist, transition specialist, whoever you are, your relationship with the employer is going to be critical. We talked about supported employment just as a sidelight. When we talk about supported employment for people with psychiatric disabilities we are not talking about your going out to the work site and holding the person's hand while they do the job. What we are going to talk about is this support that we have with employers. Can we work with the employer? Can we keep the employer informed? When we go out to the job site do we talk to the employer and the employee and try to do some conflict resolution pieces? This is part of what you will see here and what I will be stressing in all these disorders. You need to have a good relationship with the organization.

Let me move on here to cluster B. We talked about cluster A being the odd cluster paranoid. We did not cover schizotypal or schizoid personality. I am not going to get to that. I just wanted to highlight a couple of these more common ones. Cluster B is really defined as the dramatic one. These are people I guarantee you have on your case load. You know them that way. I am going to talk about two different disorders – anti-social personality disorder and borderline personality disorder. What is borderline personality disorder? Unstable relationships and instable sense of self. These are people who are always up and down in their relationships. One day, "Oh, I am so in love with this person." The next day, "I can't stand this person. They are the scum of the earth." They are just back and forth. Lack of empathy and remorse – they have a real hard time being empathetic and I say genuinely empathetic and remorseful with other people. That makes it very hard for them to be in deep, meaningful relationships with other people. This gives them a lack of depth as a person. It makes them very shallow, hard to get along with, and superficial. They tend to be very impulsive, irresponsible, and unreliable. Because of

their instability in their relationships and their lack of depth as individuals they tend to be very, very impulsive, hard to get along with, and don't want to be responsible for anything that they have done – work and personal. These people have bouts of anger that are expressed externally that can be very hard to tolerate in the work place. They tend to be really overt in their anger and they will make that very well known in the workplace. For some of you who have worked with these people this type of disorder might be the piece that got them fired on the job – having a real anger outbreak at the work site. They tend to be very self destructive. They tend to have an intense fear of abandonment. How does this impact their work? I am looking at slide 17 now. How does this manifest itself in work? Their unstable relationships get brought in and they wear those relationships on their sleeves and they carry them over to supervisors and coworkers. They will talk about coworkers and talk about supervisors. One minute they like them and the next minute they can't stand them. The other characteristic of this group – they tend to have a lot of career changes and organizational changes. They got fired from jobs, they have had to leave jobs. I quit this job because I couldn't get along with the supervisor. Those are things that you might hear quite a bit. For the borderline personality they can't handle stress very well. They don't get along with people. That creates stress. They can't handle the demands of the job because of the stress. Stress tends to be a very significant issue for them. These people can become dangerous as well on the job.

What are strategies that we can use for people with psychiatric or borderline personality disorders? Really try to find their strengths. I know that vocational testing and career testing are not necessarily in vogue now. I am still a very strong proponent of vocational evaluations for people especially, people with borderline personality disorders – really trying to find their strengths. What they do well is critical to their success. Flexible scheduling might be something that we want to look at – not locking them into a set schedule but maybe looking for more of a flexible job. That has become easier as the labor markets change. Clearly spelled out behavior expectations, firm supervision, and a direct and straightforward approach. We can put all those three together. Clear objectives, clear supervision structure, and clear expectations of what is to be done and how it should be done. You don't want to mince words with these people. You don't want to sit here and have a lot of ambiguity on how things should get done. It should be very clearly spelled out so that everyone knows clearly what is happening. Social support from you and key others both at the work site and outside the work site is important. What do I mean by significant others inside the work site? If you can get a manager, a supervisor, a line supervisor, or coworker who might be able to work with this person or befriend this person, or is willing to work with this person that could be a very, key asset for you. The other thing is family members, significant others, and you as a counselor working with this person outside of the job to provide them with ongoing support – these are all going to be a key part of this. Again, good communication with the employer and other service providers is going to be really key.

The last one – anti-social personality. I wanted to spend some time with this because I think frankly in the work that I have done with people, probably borderline and anti-social personality disorder are the two most common personality disorders that most people see. Let's talk about anti-social personalities. Backing up a little bit, borderline personality disorder historically has been viewed as more of a female dominated disorder with more females diagnosed than males with borderline personality disorder. In contrast anti-social personality disorder is more of a male disorder. It tends to be diagnosed more with males than females. These are kind of brother-sister type diagnoses if you want to put them that way,

borderline personality disorder predominantly female and anti-social personality disorder predominantly male.

What does anti-social personality disorder look like? What might you see with someone you are working with who has borderline personality disorder? A complete disregard for any rules, laws, or norms. They don't care about rules, laws, or norms. They march to their own drummer and they willfully break laws, rules, and norms. They steal. They lie. They don't follow directions. They don't follow the typical course of action. They don't have any regard for that and it just frankly doesn't bother them at all that they don't do that. Alcohol and drugs are major problems for this group. These are people who might have been in your caseload, got fired from a job, or were asked to leave a job because of alcohol and drug use. These are people on your caseload who might be involved in some type of alcohol or drug treatment, have a history of alcohol or drug abuse. Anti-social personality disorder might be something that you might be looking at for that particular group. Like borderline personality disorder there is no empathy, nor remorse. This is not someone who is going to care that you had a death in the family or your kid is sick. They just really have a hard time understanding that and caring about that. It requires too much depth for them as individuals to really be able to absorb what that means. Impulsive, irresponsible, and unreliable – very much again like borderline personality disorder. Physical and verbal aggression. This is going to be a major area that you are going to see with these people. You might have been working with people who were fired from jobs because of becoming verbally or physically aggressive on the job. You might see some of that – fights in the workplace – both physical and verbal.

The last one – they tend to have very poor relationships with authority figures in leadership positions, supervisory positions, even in lead coworker positions. How does that look at work when we talk about anti-social personality disorder? What does that mean at work? We tend to see a lot of troubled relationships with coworkers, supervisors, and some family. There is a difference in how the family might view the work environment. You might see that quite a bit. People who have anti-social personality disorders tend to get very easily bored and as a result use poor judgment. “I became bored on the job.” The one question I always ask is, “Why did you leave your previous position? What was it that made you want to leave that previous position.? The good answer is, “I got a better job. I didn't want to work the night shift and wanted to get something on the day shift.” What you will find with people with the anti-social personality disorder is that when you ask them why they left, “I found it to be boring. I was bored on the job. People were boring. The tasks were boring. It was extremely boring. It was just a boring job.” If you get someone who is telling you in the initial interview and diagnostic interview that they had problems on the job where they got bored this should trigger your thinking, “Okay, I wonder if this person might have anti-social issues?” Being bored might be a red flag for you. Danger in the workplace as I mentioned – they become verbally abusive, physically aggressive. The key part of this though is this last point here. It is not unusual for you to like these people. There is something about these people that tends to be charming, nice – someone who you don't overtly dislike immediately. They actually have some endearing qualities that might draw you close to them and might help them get in the door. But it is that pervasive pattern of behavior that tends to wear over and over and over again that tends to cause problems for them.

Those are the three that I wanted to cover in detail. We talked about paranoid personality disorder from the odd cluster. From the dramatic cluster we talked about anti-social and borderline personality disorder. Let's go into to the vocational strategies for this group – close supervision is going to be key.

You want to keep an eye on these people closely. You want to work closely with the supervisor. I would also advise you to keep family members informed if they are willing to let you do that. Again you have got to follow your procedures and your HIPPA regulations. If you already have this person in a family counseling type setting or family therapeutic type setting informing the family of what you are doing with them vocationally is very important. Constantly remind them about limits and that can be done pretty diplomatically. Do not be flexible with these people because they will take advantage of it. Now that is a little bit different from some of those other disorders or borderline personality disorder. With borderline personality disorder flexibility might be something that you might consider. With anti-social I would not recommend that same thing. I would want a more structured work environment. You might want to employ extended periods of monitoring especially on the front end of your placement. You might do it for two reasons. One might be that you want to keep an eye on the person and make sure that he/she is doing the job, getting there, and displaying a good work ethic and keeping the job moving. You also probably want to cultivate a relationship with that supervisor so that there can be some natural support built into the work environment as you start to withdraw over that period of time. You might want to monitor for constant alcohol and drug use, again because this is a major problem. The last thing I would say is this... a lot of work outdoors, fast-paced, manual labor tends to be very good for this group. They tend to really thrive on that. If you see anti-social personality as part of a case consider an outdoor work environment – physical activity might be something that is really really good for them and could really enhance the placement opportunities.

Cluster C is the anxious cluster and there tend to be clusters that fall in there like avoidant, dependent, and obsessive compulsive. Due to our time here I don't want to talk about those. Let me preface this. Passive aggressive personality disorder is not a formal DSM diagnosis at this time. These slides should give you some additional information. At this point I am going to end it and open it up for questions.

Lynda Leach, Facilitator: Okay, that was great David. I am going to unmute everyone's line. Are there any questions for David? David will you give them your e-mail address so if they have questions later and want to be thoughtful about them they can just e-mail you directly.

David Strauser: My e-mail is strauser@uiuc.edu.

Caller: David, we have a young man from Iraq with nightmares and thoughts of his friends there. He went to the local hospital over the weekend and he was number 25 on the list. He called back a couple of days later and he was still number 25 on the list. That man was close to suicide.

Caller: What else could have been done for this young man?

David Strauser: I think that is a whole issue that we are going to see more and more of – post-traumatic stress disorder (PTSD). If you noticed, the other night CNN had a special about. It is a major issue when we talk about people coming back from Iraq. I think that is an area that I would like to cover this summer in more detail. In our mental health system we are not sufficiently prepared to deal with those issues right now. The VA is going to have to play a pretty significant part in providing help to that group.

Caller: If he goes to the VA he can receive OEF training and be hooked up with support.

David Strauser: That is a good recommendation. I appreciate that. The other thing that you need to be aware of here too is you might have a lot of people coming back from Iraq who have a lot of physical impairments as a result of injuries. They might not be initially diagnosed with PTSD but in your work with those people you might notice some PTSD type tendencies. Referring someone to a psychologist or psychiatrist for evaluation is imperative.

Caller: I have a question. What would be the one item that would be the contrast between the borderline personality and the anti-social personality given the borderline is more female and the anti-social is more male?

David Strauser: I think what you will see in borderline from the predominately female group is a lot of drama revolving around relationships. One day, “Oh, I am so in love. He is absolutely great.” And the next day, “Oh that son-of-a-bitch I can’t stand him. He did this, that, and whatever.” That is going to be the female version of borderline. That predominant anti-social trait I would say is just anger. You will just feel a lot of anger and not necessarily anger about one thing.

Caller: Why would there be a contrast in the anti-social who is bored? What if you have a female who is bored a lot? Would that be a confusing diagnosis?

David Strauser: You can’t necessarily get too hung up on whether or not that is borderline or anti-social. I think there are going to be some traits. I look for answers when I interview. Did they say they were bored with the job? That is going to be one who will be a challenging client for you.

Caller: One quick one about the flexibility. Why would borderline be flexible yet with the anti-social you find inflexibility?

David Strauser: I think it goes again with the anger level. I think men are the anti-social and have more blatant anger underneath them and they tend not to be wanting to do different things. In contrast females apparently tend to be a little bit more open to different experiences, different activities, and can handle that. It is not going to be as much of a problem.

Lynda Leach, Facilitator: David we are out of time. Thank you so much for a great presentation. Before we go everyone I would like to remind everyone that our next monthly teleconference is with Maria Anderson who will be talking about ex-offender rehabilitation. This will be on February 27. Feel free to go to our Web site to register or contact Betty Taylor here at our office. I want to thank everyone for being on today. We’ll talk to you next month. Thanks again David.