

**WORKING WITH PERSONALITY  
DISORDERS IN ADDICTION  
TREATMENT**

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## GENERAL DIAGNOSTIC CRITERIA

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in 2 or more of the following areas:
  - A. Cognition (ways of perceiving and interpreting self, other people and events)
  - B. Affectivity (the range, intensity, lability and appropriateness of emotional response)
  - C. Interpersonal functioning
  - D. Impulse control
2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
3. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
4. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
5. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
6. The enduring pattern is not due to the direct physiological effects of a substance (drug abuse or medication) or a medical condition (e.g. head trauma).

### IN GENERAL:

- Clients with a co-occurring Personality Disorder have difficulty forming therapeutic alliances.
- They are limited in their ability to receive, accept or benefit from corrective feedback.
- They have limited abilities to do "feelings" work.
- The best structure tends to be the therapeutic community model and group therapy, rather than trying to work with them on an individual basis.

## PERSONALITY DISORDERS

"A P.D. is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." (DSM5)

**Paranoid PD** is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.

**Schizoid PD** is a pattern of detachment from social relationships and a restricted range of emotional expression

**Schizotypal PD** is a pattern of acute discomfort in social relationships, cognitive or perceptual distortions, and eccentricities of behavior.

**Antisocial PD** is a pattern of disregard for, and violation of, the rights of others.

**Borderline PD** is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.

**Histrionic PD** is a pattern of excessive emotionality and attention seeking.

**Narcissistic PD** is a pattern of grandiosity, need for admiration, and lack of empathy.

**Avoidant PD** is a pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation.

**Dependent PD** is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.

**Obsessive-Compulsive PD** is a pattern of preoccupation with orderliness, perfectionism, and control.

## GENERAL PERSONALITY DISORDERS

### Paranoid, Schizoid, and Schizotypal.

- Individuals often appear odd or eccentric.
- Work on the structure of recovery (meetings/sponsor, etc.) and increasing trust with those who can help them in their recovery.
- Encourage their talking about their issues and offer behavioral interventions that will aid them in addressing the feelings and behaviors that hinder them.

### Antisocial, Borderline, Histrionic, and Narcissistic.

- Individuals often appear dramatic, emotional, or erratic. (See other sheets)

### Avoidant, Dependent and OCD.

- Individuals with these disorders often appear anxious or fearful.
- Seemingly unrealistic fears of situations/objects/people that often produce physical symptoms.

### Suggestions:

- Provide safety, reassurance, and calmness in the treatment setting.
- Help them talk about their fears, beliefs and behavior.
- Need goals that are attainable and assurance/hope that they are capable of being in recovery and living in spite of their fears and behaviors.
- Provide recovering skills and community that help them cope with anxiety rather than using.
- Be willing to take time with them
- Follow up if there are medications involved (ask them directly if they are taking their meds, *especially* with OCD)
- OCD - Lots of structure for healthy behaviors
- Dependent – Work on anxieties/fears and self-esteem

## HISTRIONIC PD

**Characteristics** – Typically have difficulty relating to others on anything but a superficial level. They can, however, be highly seductive, flamboyant, dramatic with exaggerated emotions, attention seeking, consider relationships more intimate than they really are, and easily influenced by situations and circumstances. This can create problems for them as they may get into situations that are out of their control or be easily manipulated by others.

## **General Problems for Treatment**

- A lot of times I'm sure that we may miss Histrionic PD because we will diagnose it, or think of it, as either Borderline PD in women or Narcissistic PD in men.
- But, while there are many traits that are similar in all three, Histrionic PD (and most of the time, Narcissistic and Borderline will contain Histrionic features) will not contain the self-destructiveness that Borderline PD has or the careful manipulation that Narcissistic PD carries with it.
- Generally, they will appear shallow emotionally and will have difficulty responding to insight-oriented therapeutic approaches. They tend to have a fairly fragile ego-strength and are needy, desiring attention and special care.
- Will respond negatively to interventions that challenge their self-perception.

## **Suggestions for Treatment**

- Take a behavioral approach with them, providing a solid structure for their recovery and tools to manage their emotions. They need a support system with strong boundaries.
- Cannot handle intense emotional therapeutic interventions (don't get into a lot of feelings work with them).
- Stick with the structure of their Treatment Plan.
- You don't necessarily need to confront their exaggerations/distortions (unless they're about you, the program or a peer) because you will probably not be able to convince them of the unrealistic nature of the belief.
- Need a strong, well-developed Relapse Prevention Plan that includes how to manage emotions when they arise (e.g. peer/sponsor support).
- You need strong boundaries! They can be very seductive.

## **Building the Therapeutic Relationship**

- Stay calm
- Be respectful
- Hold your boundaries
- Be welcoming
- Don't enable perceptions
- Tolerate tension

## **NARCISSISTIC PD**

**Characteristics** – Love to be the center of attention and have power. This can be manifested either positively or negatively. They are grandiose and will over-emphasize their importance and abilities. They tend to see themselves as superior to others and will look on anyone else who is not as smart, good-looking, or privileged as inferior (even though they are deeply empty).

## **General Problems for Treatment**

- They have a lack of empathy for others and their problems.
- They have their own agenda and will try and force it on staff.
- They will try to manage their own course of treatment.

- Can be compliant within a tight structure but will never “surrender” as we typically understand and use the term.
- May include you in their plans (e.g. will want to see you as a part of their Aftercare Plan) to make you think they’re working or as a way to use flattery to get their way.

### **Suggestions for Treatment**

- Point out their distortions of reality and how those will isolate and harm them.
- Get group feedback, (reality check) and experiences of other group members. Perhaps have exercises that illustrate the client’s denial (e.g. a role play).
- Set your boundaries and treat them the same as everyone else in the community, no special favors or attention.
- NPD will not only have an over-inflated idea of themselves, but also of their ideas about recovery. Even when the fallacy of their thinking is pointed out logically.
  - This is a very powerful expression of their denial, which is really a defense mechanism protecting their core issues of shame and they are very reluctant to give that up, because of the fear of emotional collapse.
  - So, point out the distortion (but don’t get caught up into trying to “break them” that only feeds their need to be the center of attention) and how that idea may actually lead to a relapse due to denial of the severity of the problem.
- Develop a strong behavioral plan for relapse prevention focused on “possible” tasks that will support recovery.
- Detach! Set boundaries and limits. Stop reacting to them and giving them power (there may be feelings or urgency to react because they will “destroy” the community). Don’t buy into the urgency of the other clients or the client’s own projections of wanting to be the center of attention.
  - Clues: Feelings of urgency, staff splitting, wanting to protect the community from them, fear, anger at the client.
- Don’t act out their stuff. Listen to the community’s feelings and issues without trying to “fix” the problem.
- Insight may indeed eventually come for them but our task in treatment is to help them know how to live within the context of a supportive community and use that community for recovery.

### **Building the Therapeutic Relationship**

- Stay calm
- Smile
- Don’t try to “break” them
- Maintain personal boundaries and program structure
- Don’t be defensive
- Don’t engage in power struggles
- Be very aware of your feelings

## **BORDERLINE PD**

**Characteristics** – They do not feel safe in the world. While there is some evidence that cases of Borderline PD may have genetic components (drawn from adoption studies), in general they have been damaged by abuse and have organized their personality on a borderline level. Everything is black or white, good or bad and they either love you or hate you. There is no middle ground. They have consistent problems with relationships and intimacy, wanting closeness but pushing others away. They tend to be confused about their state with little tolerance for their mood swings. Projection is their primary defense mechanism because acknowledging their internal state and unacceptable feelings is too threatening.

### **General Problems for Treatment**

- They will test the rules and you to find out if you mean what you say, so that they can feel safe and do the work they need to do.
- They will try to split the staff by talking about one staff member to another or questioning the appropriateness of techniques or competency of other staff.
- They can bring a staff, group, and sometimes a community, into chaos. This is because their internal world is in chaos, so they need to “equalize the pressure.”
- They have very little tolerance for others’ problems.
- They like to be the center of attention and will often act out in order to be the center of attention.
- Peers end up avoiding them or forming alliances with them.

### **Suggestions for Treatment**

- Provide a safe environment. This is accomplished through structure and boundaries; not by giving them what they want!
- Treat them the same as everyone else—no special favors. You may have to insist that they be quiet so that others can do some work. If they try to hold the group “hostage,” confront them and ask them what they need from the group. The key here is to set very clear and strong boundaries that you do not change for them.
- They may begin talking about something “horrible” from their past in order to test the group to see if the group will stick with them and be a safe place for them to process. You can point this out and assure them of the safety of the group.
- They may try to throw you off track with other issues to avoid dealing with the real reason they are in treatment. Confront the cognitive distortions and point out the traps in their defenses.
- Don’t use the diagnosis as an excuse. They are very damaged but definitely can heal. You can be compassionate and still hold to your boundaries.
- Focus on the process of the group and interactions with others rather than on the content of what they’re saying. Avoid individual therapy within the context of the group. They will capitalize all the time in the group if allowed.
- Point out the projection (externalization) of their internal process. If you are doing a group and the group seems to be in chaos (all except the client who is borderline) ask them what they see going and then ask them how what they see may describe

what is going on inside. Helping them to integrate their unwanted projections is a key element in their healing.

- Don't get "flustered" if they get angry, cuss you out or tell you that you're the worst therapist they ever had. Tomorrow you may be the best (don't get seduced by that one either). Stay calm and even-tempered with them. Don't get caught in the projective identification and act out their feelings for them. Your ability to tolerate tension is an invaluable model for their recovery.
- Enforce the rules. Have the rules as detailed as possible.
- When they push against the rules, if it is not a dischargeable offense, then warn them that the next time they will be discharged. Make it very clear. And then, if they do it again, discharge them. Follow through with your consequences.
- Approach them at the beginning of the day and ask how they are doing. This may reduce attention seeking behavior later.
- Give straightforward Treatment Plan objectives with little room for interpretation.
- Progress will be slow and uneven
- Assess the risk of self-harm and intervene quickly and definitively if necessary
- Maintain a positive but neutral professional relationship, avoid over involvement in the client's perceptions, and monitor the counseling process frequently with colleagues and supervisors
- Set clear boundaries and expectations regarding limits and requirements in roles and behaviors
- Assist the client in developing skills to manage negative emotions and feelings
- This is where Dialectical Behavior Therapy (DBT) is very helpful:
  - Mindfulness
  - Distress Tolerance
  - Emotional Regulation
  - Interpersonal Effectiveness

### **Building the Therapeutic Relationship**

- Consistent calm
- Steady emotions
- Tolerate tension
- Be a safe person for them
- Be welcoming, respectful and accepting
- Awareness of your feelings

## **ANTISOCIAL PD**

**Characteristics** – They absolutely cannot empathize with others or form any type of social bond, no matter how dysfunctional (e.g. they cannot even fit into a motorcycle gang). They are unable to function as a responsible member of a community or group. They will violate the boundaries and rights of others (sometimes deliberately just to see the reaction). Also, they are unable to see any problem with any of their behaviors.

## **General Problems for Treatment**

- They may make fun of the work that others do (or the counselor) because they do not understand it (this is different than a narcissistic client making fun—they do it because they feel uncomfortable and fear exposure).
- They probably do not feel the need for treatment. They may have agreed to come into treatment, but that was only to avoid harsher consequences.
- Other clients will be unable to form any bonds with them and may become confused or frightened by them.
- They will quickly either charm others (to get something they want) or become isolated from the community.
- Another client, who has poor impulse control and is stronger, may get frustrated by the manipulation and harm the client.
- They may break rules without any forethought regarding rules or consequences.

## **Suggestions for Treatment**

- Maintain strict program and group rules with them. They are masters at finding the way around the rules for their benefit.
- Enforce the rules. Even if you go over the rules in the beginning of group, they are unable to extrapolate something from the past (even if it's 10 minutes ago) for application in the present. They will see a similar situation as a new circumstance, not as a continuation of unacceptable behavior.
- If they are sarcastic or make fun of another group member (they have no empathy and can make very callous statements), confront them and remind them of the rules. Let them know that if they do it again, they will be asked to leave the group. Then, if they do it again, follow through! Don't worry, you will not hurt their feelings (even if they display an infantile rage), although they may not understand.
- When they process, watch your boundaries! They can be very charming and convincing. They will try to draw you in to their way of thinking by making comparisons between their behavior/thoughts and your behavior/thoughts. Do not be drawn in. Focus on them and their behavior.
- Do not try to challenge their denial or their bizarre rationalizations for their behavior, merely point out your view. They will have difficulty understanding the concept of denial.
- Have clear and concrete Treatment Plan objectives. Focus on behavior, not insight. Focus on how continued drug use will affect them negatively and how remaining sober will benefit them.
- If they are discharged for rule violations, stick with your decision. They may continue to show up. Explain clearly that your structure is not sufficient for their needs and refer them elsewhere. They will not understand.
- Be wary of them, but do not show fear or sympathy for them, even though they can be very sad cases, unable to get along with others, participate in community activities, yet not understanding why others don't like them.
- Be particularly careful of the projections you feel. While a borderline will project negative feelings in order to "equalize the pressure" an APD will use feelings displayed by others to manipulate them or get the attention off of themselves.



- Use the emotions you feel as indicators of the feeling states of the client (or, at least, how others typically feel around them). Your feelings are the best tool you've got!
- With APD, use your feelings to allow you to set boundaries and increase your clinical objectivity (e.g. if you are feeling angry or anxious, use that as your cue to become calm and objective. If you are fearful ("creepy," or uncomfortable) remain calm and confident).
- They cannot empathize or appreciate feeling states as something of value. In general, feeling states, and other people, are objects to be manipulated.
- Do not try insight-oriented therapy with them. They will not get it, but may use it to manipulate the counselor into thinking they are making progress.
- Using consequences to help them understand the benefit of sobriety may be helpful, but they do have difficulty with impulse control and extrapolating learning into everyday situations. The consequence of prison isn't even useful because many will not view prison as any special circumstance to be avoided.
- There is no cure for antisocial personality disorder (don't try).

### **Building the Therapeutic Relationship**

- Stay calm
- Smile
- Don't try to "break" them
- Maintain personal boundaries and program structure
- Don't be defensive
- Don't engage in power struggles
- Be very aware of your feelings

## **SPECIAL CONSIDERATIONS FOR PD CLIENTS**

### **Group Work**

**Preparation for group:** You need to prepare for the group experience. In addiction counseling and particularly with Personality Disordered clients, group therapy is very intense and there is projection and family issues constantly being thrown out there. Do what you need to do to relax and free your mind from all other distractions so that you can be present.

**You are the container of the group process:** What is going on inside of you? Our feelings are the best tool we have as indicators as to what's happening in the group. W.R. Bion proposed that, as the therapist, we "contain" the emotional issues and projections in the therapy process long enough for the clients to be able to work on them. This is particularly true with addicts, but we have to be very careful with Personality Disordered clients. Being aware of what we are feeling will help us understand their projections, manipulations, and seductions, and give us information on how they feel about themselves and/or how those close to them feel about them. We need to become more aware of our feelings and listen to the information we are being given. Then, by tailoring our response and not acting on the feelings, we can give them a different experience and promote healing. Remember, *A good group therapist knows what's going on in the group, but a great group therapist knows what's going on inside themselves.*

**Questions to keep in mind:**

- What are the expectations and rules of the group?
- What are the themes of the group?
- What are the feelings of the group?
- Why is what's happening, happening at this time?
- How do I feel?

**Projection** is when the client tries to get rid of unwanted negative bits of themselves by seeing it in/giving it to others. **Projective Identification** is when we act out those negative feeling "bits" the client projects onto us. This process is most clearly experienced with borderline clients.

**Tolerating tension**—When there is tension in the group from issues and feelings that are being presented, one of the best things we can model for the clients is the ability to tolerate tension. This shows that we can live through it without acting out or using.

**Trauma Work/Containment**—In general I would say that we should not do expressive trauma work with Personality Disordered clients. There is a tendency to relive rather than remember and feel the feelings. Also, Personality Disordered clients may use the intense emotional experience of trauma work as mood alteration rather than a movement towards resolution. Antisocial PD clients may use the work to manipulate staff and the group.

**Reasons for Containment:**

- Prevention of re-abuse or experience of abuse within the group
- Concerns regarding client's ego strength and orientation to the present
- Modulation of affect to permit cognitive processing and possible resolution

**Techniques for Management/Containment**

- Safety, comfort, assurance
- Breathing techniques (steady and regular)
- Focus on the present and those around the person (stay grounded in the present)
- Touch if necessary (doesn't have to be you, could be a trusted peer)
- Ask the client what they need to feel safe
- Education on what is happening to them and why (Note: Working with abuse survivors requires some degree of teaching therapy. It is essential that survivors learn the effects of abuse, and the process of recovery and how relapse occurs.)
- Contracting for safety and communication
- Peer support
- Safe spaces
- Assurance that you will talk with them tomorrow

**Skill Building/Stabilization**

- Safety
- Tools to avoid and deal with triggers
- Understanding what's happening when it's happening
- Affect regulation
- Relational skills
- Dealing with self-harm and inner self-deprecating voices
- Education re: dealing with shame

## **Education on Threat Defenses**

- Fight/Flight/Freeze/Collapse

### **Trauma survivors who are successful in moving through stuck points in their recovery tend to follow this process:**

1. Recognizing the abuse as the cause of their symptoms and bad feelings.
2. Honoring their chronic defenses by understanding them as coping mechanisms used in childhood to survive.
3. Reassigning responsibility for the abuse to their perpetrator and others who failed to believe, protect, or rescue them.
4. Recognizing brainwashing (negative messages) instilled in them as a way to protect the abuser and secure continuation of the abuse.
5. Debriefing their brainwashing by listening for it and replacing it with positive, self-affirming statements.
6. Taking baby steps in their sexual abuse recovery instead of giant steps before mastering less complex ones.
7. Trusting their process of recovery by learning from others who are further along in recovery.

**Regression** – If you have a client whom you’re not sure about their ego strength (see “Assessing Ego Strength”), watch their affect! If they look like they’re starting to daydream, or get a “far-away” look in their eyes, intervene and begin contact immediately. If the client should abreact (physically/emotionally act as if the trauma were actually occurring), you should make sure they are safe and try and get their focus and attention onto you and the present situation. If they cannot focus on you or be calmed, move the other clients to safety and call 911 because they may have decompensated rather than regressed. Regression is a dissociative state in which the client reverts emotionally to the approximate age of the time of the abuse. While they can still engage with you in the present, they are experiencing feelings/emotions from the earlier age. This may happen spontaneously or may be triggered by intense emotions.

- Speak softly but firmly, directly to them, and have them answer directly to you.
- Establish eye contact and gently insist that they look at you in the eyes. Maintain eye contact with them at all times. Keep them engaged with you at all times. Position yourself in front of them so they can see you.
- Ask them what they need to feel safe and if it is within your power, grant it. You want to be able to provide safety, comfort and support.
- Have them focus on regular, steady breathing.
- If you are unsure about whether or not they have regressed and/or if they seem to be answering your questions in a vague manner, or seem to be dissociated, ask them how old they feel. If their answer is an age other than what is their actual age, then you can be pretty sure they’ve regressed.
- Take all the time you need, even if the time runs over for the group. You cannot let them walk out of group in a regressed state.
- Use a guided imagery of moving up (stairs, a path, a ladder, climbing, etc. You may want to have them choose the imagery)
- Have them visualize that they are climbing upwards

- Stop every so often and ask their age and feelings (if they are stuck at an age, ask them what's going on there and follow the above steps)
- Once they reach their present age (ask them if they're certain they feel their current age), have them get grounded with the group by:
  - Slowly look at every person in the group (this may take some time because they may be embarrassed)
  - Ask the client to describe what they see in each group member's expression
  - Then, have each group member give the client feedback
- Once they are back with the group, debrief the experience with them and the rest of the group (they will need the group's feedback and support). Ask them about feelings and if they had any insights. They typically feel very tired physically and fragile emotionally.
- Reassure the client that they are going to be alright and that they are safe. Remind them that they didn't die or disintegrate.
- Contract with the client for safety. They may not have any suicidal ideation at the time, but that may come up later.
- Predict the rest of the day for them. Tell them what to focus on and help them plan the rest of their day. If they live in the recovery residence, ask someone to help by being their buddy for the rest of the day. Explain that this is not a punishment, but a safety precaution.
- Give them tools to help stabilize for the rest of the day
  - If they start to feel anxious, they are to immediately talk to their peer
  - Focus on breathing slowly and regularly
  - Focus on the present (e.g. what's beautiful around them, who is around them, listen to the speaker at the meeting, etc)
  - They may use the on-call counselor
  - You will touch base with them tomorrow
- By the way, you will be tired too, so debrief with a colleague and do some things that nourish and strengthen you.

**Assessing Ego Strength** – Ego strength refers to how stable the client is emotionally and whether or not they are able to deal with some of the intense emotional content of group without dissociating, regressing or decompensating. Determining each client's ability to handle group will guide you in knowing how to structure your group.

- Be familiar with client diagnosis, history and possible problems with decompensation or regression (e.g. sexual abuse survivors have a tendency to regress in groups when intense feelings are being expressed).
- If there was abuse in the client's history, how severe was it? In general, the more intense the abuse, the more gently you want to proceed.
- What are the client's current issues? What are their current stressors and resources?
- Are they working with another therapist? What is their support system?
- What are the client's boundaries regarding touch? Do they sexualize touch or interpret touch as a threat?
- How does the client present?
- Is their affect flat or animated?
- Is their body language open or closed? (e.g. fetal position or open)
- Do they get upset easily?

- Do they dissociate easily?
- Listen to your own feelings and experience with past clients. Do you feel comfortable or uncomfortable, anxious or confident regarding the client when the group process becomes more intense?

**Have we done all we can?**

Personality Disordered clients will push staff clinically further than they have gone before. The temptation and tendency is to think we have done everything for them, structured them too many times or that they have reached “maximum benefit” for our structure (it is true that there are some clients who are not appropriate for our structure and vice versa, but the question is whether or not we do that out of frustration and a subjective decision). In this exercise we examine the behaviors/attitudes, possible causes and then brainstorm interventions. This helps us to respond to what the real problem is, rather than react to the behavior.

Example:

Behavior/Attitude	Possible Causes	Intervention Ideas
Client appears very resistant to treatment and is argumentative with staff and peers	Fear of: Shame exposure Abandonment Emptiness  Reenacting abusive relationships	Help the client in group to talk out the feelings rather than act them out.  Explore family role and system and how client continues

Note: While all clients can teach us something about how to improve our skills, Personality Disordered clients will teach us more than any other type of client (if we are willing to learn).