

**The Critical Importance of**  
**Personality Disorders**  
**for All Types of**  
**Injury, Impairment, and Disability Claims**

*American Academy of Disability Evaluating  
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Robert J. Barth, Ph.D.  
Parkridge Hospital Plaza Two  
Suite 202  
2339 McCallie Av.  
Chattanooga, TN 37404  
USA

Telephone: 423/624-2000  
Fax: 423/629-0230

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## **A. Key Points**

Personality disorders are pervasive forms of mental illness.

Personality disorders always lead to distress or impairment (by definition), regardless of whether the individual experiences injury, any other general medical issue, or any other mental illness.

*(Note: the phrase “general medical” refers to issues that are usually addressed by clinicians who do not have specialized expertise in mental illness. Examples include internal medicine issues, pulmonary issues, orthopedic issues, cardiology issues, neurology issues, etc.)*

When a personality disorder is relevant for a claimant/plaintiff, it will be a pre-existing condition (by definition).

Consequently, a personality disorder, when present, can provide a comprehensive non-injury-related, non-general medical, explanation for a medical-legal claim of injury, impairment, or disability.

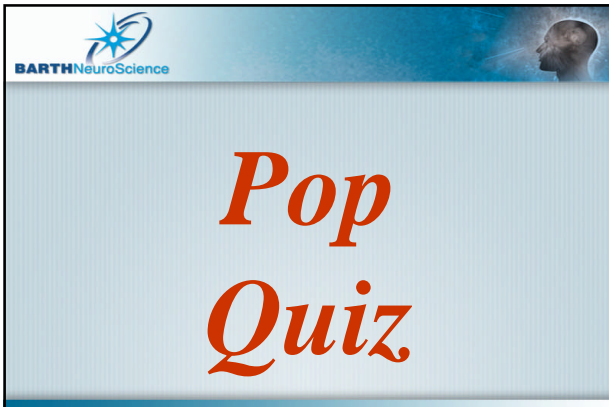
Personality disorders are common in the general population, and especially common among claimants/plaintiffs.

The possibility of a personality disorder is almost never actually investigated during the course of a medical-legal claim, even when a mental health specialist is involved.

Given the common nature and importance of personality disorders, the investigation of this possibility is probably justifiable in every claim of injury, impairment, or disability. Such investigation is **definitely warranted** in every claim which involves claims of unusually severe or unusually extensive impairment or disability.

## **B. Examples of the Significance of Personality Disorders for All Types of Claims**

B. 1. Dersh research – see the following slide presentation



•Your back hurts.  
 •You decide to go to the doctor to have your back pain investigated.  
 •You tell your doctor that you would like him or her to start by doing whatever would be *most likely* to identify an explanation for your back pain, and whatever would *most likely* lead to a helpful treatment plan.

**In order to grant your wish, what should the doctor investigate for first?**

What should your doctors investigate for first, in order to have the *best chance* of identifying a probable cause for your back pain, and in order to *most likely* help you with that pain?

a. Spine abnormalities via MRI	f. Job dissatisfaction
b. Indications of injury	g. Cumulative trauma/repetitive motion
c. Depression	h. Work conditions
d. Discogenic pain via discography	i. Personality disorder
e. MMPI scale 3 elevation	j. Tumor
	k. Eligibility for litigation-compensation

In order to have the *best chance* of identifying a probable cause for your back pain, and in order to *most likely* help you with that pain, what should the doctor investigate for first?

## Depression

Jarvik JG, Hollingworth W, Heagerty PJ, Haynor DR, Boyko EJ, Deyo RA. Three-year incidence of low back pain in an initially asymptomatic cohort: clinical and imaging risk factors. Spine. 2005 Jul 1;30(13):1541-8.

•You tell your doctor that *you are filing a workers comp claim* for “back injury”.

•You tell your doctor that you would like him or her to start by doing whatever would be *most likely* to identify an explanation for your back pain, and whatever would *most likely* lead to a helpful treatment plan.

**In order to grant your wish, what *two* things should the doctor investigate for now?**

What *two things* should your doctors investigate for first, in order to have the *best chance* of identifying a probable cause for your back pain, and in order to *most likely* help you with that pain?

a. Spine abnormalities via MRI	f. Job dissatisfaction
b. Indications of injury	g. Cumulative trauma/repetitive motion
c. Depression	h. Work conditions
d. Discogenic pain via discography	i. Personality disorder
e. MMPI scale 3 elevation	j. Tumor
	k. Eligibility for litigation-compensation

Now that you have filed a workers comp claim for back “injury”, what two things should your doctors investigate for first, in order to have the best chance of identifying a probable cause for your back pain, and in order to most likely help you with that pain?

- **Job dissatisfaction**
- **Elevations of Scale 3 of the MMPI**

Bigos SJ, et al. A prospective study of work perceptions and psychological factors affecting the report of back injury. Spine, 1991, 16, 1-6.

•You tell your doctor that your back pain is chronic and disabling.

•You tell your doctor that you would like him or her to start by doing whatever would be most likely to identify an explanation for your back pain, and whatever would most likely lead to a helpful treatment plan.

**In order to grant your wish, what should the doctor investigate for now?**

What should your doctors investigate for first, in order to have the best chance of identifying a probable cause for your back pain, and in order to most likely help you with that pain?

- |                                    |                                            |
|------------------------------------|--------------------------------------------|
| a. Spine abnormalities via MRI     | f. Job dissatisfaction                     |
| b. Indications of injury           | g. Cumulative trauma/repetitive motion     |
| c. Depression                      | h. Work conditions                         |
| d. Discogenic pain via discography | i. Personality disorder                    |
| e. MMPI scale 3 elevation          | j. Tumor                                   |
|                                    | k. Eligibility for litigation-compensation |

Now that you have filed a workers comp claim, and your back pain is chronic and disabling, what should your doctors investigate for first, in order to have the best chance of identifying a probable cause for your back pain, and in order to most likely help you?

**Personality Disorders  
(70% rate among claimants/plaintiffs with chronic disabling back pain)**

Dersh J, et al. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. Spine. 2006 May 1;31(10):1156-62.

**In the only relevant, well-designed, large scale, long-term scientific study ever conducted, what was the one thing that separated accident survivors who developed serious low back pain, from those who did not develop serious low back pain, with 100% reliability?**

In the only relevant scientific study ever conducted, what was the one thing that all chronic neck and back pain patients had in common?

- |                                    |                                            |
|------------------------------------|--------------------------------------------|
| a. Spine abnormalities via MRI     | f. Job dissatisfaction                     |
| b. Indications of injury           | g. Cumulative trauma/repetitive motion     |
| c. Depression                      | h. Work conditions                         |
| d. Discogenic pain via discography | i. Personality disorder                    |
| e. MMPI scale 3 elevation          | j. Tumor                                   |
|                                    | k. Eligibility for litigation-compensation |

In the only relevant research project ever conducted, the only people who complained of persistent neck or back pain after an accident, were those who were eligible for compensation.

Carragee E, et al. Spine. 2006.

What are the primary risk factors for chronic disabling back pain?



## #2. Personality Disorders

Personality disorders as the #2 risk factor for chronic back pain



Definition (American Psychiatric Association diagnostic manual for mental illness):  
 “A personality disorder 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.”

Personality disorders as the #2 risk factor for chronic back pain



In other words...  
 Personality disorders are a pervasive form of mental illness that, by definition,...

- is pre-existing, and
- would lead to distress or impairment regardless of whether an injury occurs.

### Personality Disorders



- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Personality Disorder Not Otherwise Specified (e.g. Passive Aggressive; Depressive)

What is the rate of personality disorders in the general population?



**10% - 13%**

Hales, R. E., Yudofsky, S. C., (2002). The American Psychiatric Publishing Textbook of Clinical Psychiatry, Fourth Edition. American Psychiatric Publishing.

How many  
**chronic pain patients**  
have a personality  
disorder?  
**31% - 64%**

Gatchel and Weisberg (2000). Personality Characteristics of Patients With Pain. American Psychological Association.



**Chronic disabling  
back pain  
in workers comp**

When actually investigated, how many  
chronic disabling back or neck pain  
patients in workers' comp  
are discovered to have a personality  
disorder?



How many *chronic disabling spine  
pain patients in workers' comp*  
have a personality disorder?

**70%**

Dersh J, et al.  
Prevalence of psychiatric disorders in patients with  
chronic disabling occupational spinal disorders.  
Spine. 2006 May 1;31(10):1156-62.



Personality disorders as the #2  
risk factor for chronic  
back pain

1. **General medical investigation of low back pain claims will almost never produce truly significant findings, but...**
2. **Investigating for a personality disorder will produce significant results 70% of the time for medical-legal claims of chronic low back pain...**



Personality disorders as the #2 risk  
factor for chronic  
back pain

**Rhetorical question:**

Why are we always doing MRIs and  
other general medical investigations,  
while we almost never respond to  
back claims by evaluating for  
personality disorders?



**B. Examples of the Significance of Personality Disorders for All Types of Claims (continued from prior to the slide presentation)**

- B. 2. The unique, and uniquely strong, association between disability and personality disorders

In a research project which investigated for the possibility of only one personality disorder (Borderline) in an *internal medicine* disability sample, 72% of the claimants were found to have that personality disorder.

Sansone RA, Hruschka J, Vasudevan A, Miller SN. Disability and borderline personality symptoms. *Psychosomatics*. 2003 Sep-Oct;44(5):442.

Research findings focused on just one personality disorder (Borderline) have indicated that 20 to 45 percent have obtained disability benefits, and half demonstrate long-term unemployment.

Sansone RA, Sansone LA. Employment in borderline personality disorder. *Innov Clin Neurosci*. 2012 Sep;9(9):25-9.

Readers should note that the role of personality disorders in claims of impairment is *not simply confounded* with other diagnostic issues. Instead, research findings have indicated that *even when the effects of general medical conditions are controlled for, and even when the effects of other mental illnesses are controlled for, a unique and specific association is still demonstrated between personality disorders and claims of disability.*

Reference: Jackson HJ, Burgess PM. Personality disorders in the community: results from the Australian National Survey of Mental Health and Wellbeing Part II. Relationships between personality disorder, Axis I mental disorders and physical conditions with disability and health consultations. *Soc Psychiatry Psychiatr Epidemiol* (2002 Jun) 37(6):251-60.

In fact, on general measures of *quality of life*, research findings have indicated that *personality disorders are more important predictors than are other types of mental illness, and are more important than general medical health.*

Reference: Cramer V, Torgersen S, Kringlen E. Personality disorders and quality of life. A population study. *Compr Psychiatry*. 2006 May-Jun;47(3):178-84.

- “Personality disorders appeared to be more important statistical predictors of quality of life than sociodemographic variables, somatic health, and axis I disorder.”

Findings from the same research project (Cramer) have even indicated that *personality disorders have a stronger association with quality of life than sociodemographic / socio-economic variables* which have traditionally been singled out as the most significant factor in predicting disability.

Example of a reference which discusses the massive effect of socio-economic variables on health outcomes: Smith GD. *Poverty, Inequality and Health in Britain: 1800-2000*. Policy Press, 2002.

Almost all personality disorders “were found to have a significant relationship with validity indicators in the direction of faking bad. These results suggest that the presence of characterological factors (i.e., a personality disorder)...contributes to exaggerated results in a forensic setting.”

Grillo J, Brown RS, Hilsabeck R, Price JR, Lees-Haley PR. Raising doubts about claims of malingering: implications of relationships between MCMI-II and MMPI-2 performances. *J Clin Psychol.* 1994 Jul;50(4):651-5.

The importance of personality disorders is further highlighted by scientific findings which indicate that the association between personality disorders and “functional impairment” is surprisingly strong, to an extent that is actually unique in the scientific study of personality. This issue is informative for the overall scientific study of personality, as well as being informative for the evaluation of impairment. In order to understand the surprising and unique nature of this relationship, it should first be noted that the scientific study of personality has demonstrated a trend away from the categorical concept of personality types/disorders, and toward a more dimensional concept of personality traits that apply to all people to some measurable degree (Hales RE, et al. *The American Psychiatric Publishing Textbook of Clinical Psychiatry.* Fifth Edition. Washington, DC: American Psychiatric Publishing; 2008). This movement toward a dimensional approach is supported by numerous findings which have illustrated that such an approach may have greater scientific validity in most circumstances. However, “functional impairment” is a surprising exception to that trend, in that research findings have indicated that the categorical approach (the personality disorders that were listed earlier in the slides of section B. 1.) is actually a better predictor of “functional impairment” than is the dimensional approach (reference: Skodol AE et al. Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *Am J Psychiatry.* 2002 Feb;159(2):276-83). Such findings provide further evidence of the unique value of the personality disorder constructs for claims of impairment and disability.

### **C. Introduction**

#### **C. 1. Generic Definition of Personality Disorders, and Ramifications of that Definition**

The American Psychiatric Association defines personality disorder as "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."

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision. Washington, D.C., American Psychiatric Association, 2000.

Readers should note the implications for Guides-based evaluations that are inherent in this definition. First, the fact that a personality disorder definitionally “leads to distress or impairment” indicates that the development of impairment at some point in life is normal for such individuals. Therefore, when such individuals attribute claimed impairment to some other condition, evaluators will be faced with the task of determining whether there is actually some



basis for that attribution, rather the claim of impairment simply being a natural, predictable, and expected manifestation of the personality disorder.

*Secondly, the onset in adolescence or early adulthood means that the personality disorder will be a pre-existing condition for any adult examinee.* As such, a personality disorder will be a pre-existing cause of impairment, when compared to any other conditions to which impairment is ostensibly being attributed. There is no opportunity to consider a personality disorder to be a consequence of some other form of impairment, because such a scenario is definitionally impossible. As a result, evaluators must consider personality disorders in order to credibly address issues which commonly arise during impairment evaluations, such as the injury-relatedness of any claimed impairment, the work-relatedness of any claimed impairment, and the legal construct commonly called apportionment.

### **C. 2. Specific Types of Personality Disorders**

The American Psychiatric Association's diagnostic manual identifies ten specific types of personality disorder.

REFERENCE: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision. Washington, D.C., American Psychiatric Association, 2000.

The following list of disorders and their succinct definitions is offered as an introductory discussion. Readers should note that this brief discussion is not intended to provide an adequate understanding of each disorder. Readers are referred to the American Psychiatric Association's diagnostic manual (referenced immediately above) for a more comprehensive review.

- Paranoid Personality Disorder involves pervasive suspiciousness and distrust. (Perhaps more than any of the other personality disorders, these people are prone to unjustifiably blaming their problems on someone else.)
- Schizoid Personality Disorder is characterized by detachment from social relationships and a restricted range of emotional expression.
- Schizotypal Personality Disorder is manifested in discomfort in close relationships, cognitive and perceptual distortions, and eccentricities of behavior. (This disorder is similar to, and genetically related to, Schizophrenia).
- Antisocial Personality Disorder involves disregard for the rights of others. (These people are commonly said to lack a conscience – to have no regard for what is morally right or wrong.)
- Borderline Personality Disorder is characterized by instability in interpersonal relationships, self-image, and affects; and marked impulsivity. (Many scholars have commented on the “hot rage” that additionally characterizes these individuals.)

- Histrionic Personality Disorder is manifested in excessive emotionality and attention seeking. (Such individuals have also been characterized as always “dramatic” – always acting as if they are in a play – never being genuine.)
- Narcissistic Personality Disorder involves grandiosity, a need for admiration, and a lack of empathy.
- Avoidant Personality Disorder is characterized by social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. (“painfully shy”)
- Dependent Personality Disorder is manifested in submissive and clinging behavior related to an excessive need to be taken care of. (inability to make decisions for oneself is another commonly noted characteristic)
- Obsessive Compulsive Personality Disorder involves a preoccupation with orderliness, perfectionism, and control. (the perfectionist)

The diagnostic manual also allows for the possibility of a Personality Disorder Not Otherwise Specified, for presentations that meet the general description of a personality disorder, but fail to fully satisfy criteria for any of the specific disorders that are listed above.

This “not otherwise specified” diagnosis is also the diagnostic label to be used for two specific syndromes which are currently designated as being in need of further study before it can be determined whether they represent a discrete disorder, and whether that disorder has been adequately defined:

- Passive Aggressive Personality Disorder involves negativistic attitudes and passive resistance to social and occupational expectations. This concept was listed as a discrete diagnosis in previous editions of the American Psychiatric Association’s diagnostic manual, and its relegation to a concept that requires further study in the current edition has been publicly acknowledged as a mistake by the person who chaired the creation of the current edition of the diagnostic manual.

Reference: Institute for Behavioral Healthcare: "A Practitioner's Guide to DSM-IV." Allen J. Frances, M.D. Chattanooga, TN. Dec., 1994.

- Depressive Personality Disorder involves depressive thoughts and behaviors which, as is the case with all personality disorder attributes, play a pervasive role in the individual’s life.

### **C. 3. The Common Nature of Personality Disorders, and Their Overriding Importance for Impairment Claims**

Personality disorders are prevalent in the general population.

See the referencing in the slides from section B. 1. Above, as well as the following references:

- Grant BF, Hasin DS, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering RP. Prevalence, correlates, and disability of personality disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions. *J Clin Psychiatry*. 2004 Jul;65(7):948-58.
  - “*CONCLUSION: Personality disorders are prevalent in the general population and are generally highly associated with disability.*”

Personality disorders are especially prevalent in forensic contexts (e.g. cases where Guides-based evaluations are required).

Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006 May 1;31(10):1156-62.

- 73% rate among workers compensation claimants claiming disability due to back pain

Personality disorders are “highly associated” (Reference: Grant 2004, full referencing slightly above this line) with “a tremendous amount of disability”.

- Reference for “tremendous”: Oldham JM Diagnosis and treatment of personality disorders. *Psychiatr Q* (1992 Winter) 63(4):413-24.
  - “There is a tremendous amount of disability, personal distress, and public health expense as a result of the personality disorders.”

Personality disorders are a category of mental illness. As such, they have obvious relevance for the evaluation of claims of impairment that are overtly attributed to mental illness. Scientific findings have revealed that personality disorders also play a dominant role in claims of impairment subsequent to chronic pain.

- Examples of relevant references:
  - Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006 May 1;31(10):1156-62.
  - Gatchel RJ, and Weisberg JN: *Personality Characteristics of Patients With Pain*. Washington, DC: American Psychological Association, 2000.

Further, research findings have indicated that personality disorders also play a role in claims of impairment that is being attributed to maladies that are inarguably of a general medical nature (examples provided in a later section of this article).

Examples of scientific findings which illustrate the significance of personality disorders for all types of claims are provided throughout the remainder of this article.

Readers should note that the role of personality disorders in claims of impairment is not simply confounded with other diagnostic issues. Instead, research findings have indicated that even when the effects of general medical conditions are controlled for, and even when the effects of other mental illnesses are controlled for, personality disorders remain additionally predictive of disability.

Reference: Jackson HJ, Burgess PM. Personality disorders in the community: results from the Australian National Survey of Mental Health and Wellbeing Part II. Relationships between personality disorder, Axis I mental disorders and physical conditions with disability and health consultations. *Soc Psychiatry Psychiatr Epidemiol* (2002 Jun) 37(6):251-60.

In fact, on general measures of quality of life, research findings have indicated that personality disorders are more important predictors than are other types of mental illness, and are more important than general medical health.

Reference: Cramer V, Torgersen S, Kringlen E. Personality disorders and quality of life. A population study. *Compr Psychiatry*. 2006 May-Jun;47(3):178-84.

- “Personality disorders appeared to be more important statistical predictors of quality of life than sociodemographic variables, somatic health, and axis I disorder.”

Research findings from the same project (Cramer) have even indicated that personality disorders are more strongly correlated with quality of life than are sociodemographic /socio-economic variables (which have traditionally been singled out as the most significant correlate/predictor of disability).

Example of a reference which discusses the massive effect of socio-economic variables on health outcomes: Smith GD. *Poverty, Inequality and Health in Britain: 1800-2000*. Policy Press, 2002.

#### **C. 4. Aspects of Personality Disorders Which Contribute to Claims of Impairment**

Other sections of this article provide reviews of scientific findings which have revealed associations between personality disorders and specific types of impairment claims (e.g., pain, overt claims of mental illness, general medical claims). In order to provide a richer context that will hopefully facilitate comprehension of that science, this section will provide some examples of how personality disorders contribute to claims of impairment in general.

The importance of personality disorders in regard to claims of impairment takes two basic forms. First, there is the scientific finding that people who have a personality disorder are more likely to file legal claims of all types. Relevant references include:

- Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006 May 1;31(10):1156-62.
  - 73% rate of personality disorders among workers compensation claimants who are claiming to be disabled due to back pain

- Simon, RI (editor): *Posttraumatic Stress Disorder in Litigation-Guidelines for Forensic Assessment. Second Edition.* Washington D.C. American Psychiatric Publishing, 2003.
  - Personality disorders are an “often overlooked” factor in the genesis of medical-legal claims.
  - Borderline personality disorder is “especially common in all types of litigation”.
  
- McDonald JJ. Personality Disorders in Employment Litigation. *Psychiatric Times.* Vol. 19 No. 4. April 1, 2002.
  - “Personality disorders often cause conflicts between a plaintiff and their co-workers that lead to claims of victimization by the plaintiff.”
  
- Yudofsky SC. *Fatal Flaws.* American Psychiatric Publishing, 2005.
  - Personality disorders are associated with a tendency to be litigious. Example of a relevant quote from a patient with a personality disorder: "This doctor’s advice has made me feel much worse. His terrible advice caused most of my problems. Not only won't I pay his outrageous bills, but I'm going to sue him for malpractice."
  
- Hales, R. E., Yudofsky, S. C., (2002). *The American Psychiatric Publishing Textbook of Clinical Psychiatry, Fourth Edition.* American Psychiatric Publishing.
  - “they are oblivious that their personality causes problems so they blame others. Personality disorders often cause problems for others and are costly to society. Areas of difficulty include family, academic, occupational, and other roles. They have elevated rates of separation, divorce, child custody proceedings, unemployment, homelessness, perpetuation of child abuse, accidents, police contacts, emergency department visits, medical hospitalization, violence, self-injurious behavior, attempted and completed suicide (lots of references after each). A high percentage of criminals, 60-70% of alcoholic individuals, and 70-90% of persons who abuse drugs have a personality disorder.
  
- Block AR et al. *The Psychology of Spine Surgery,* American Psychological Association, 2003.
  - “***Passive-aggressive personality disorder***, in 14.9% of chronic pain population (Fishbain et al, 1988), involves resistance to demand for adequate social and occupational performance through dawdling or enlisting others to resist or criticize authority figures. Significantly, 24.7% of the male workers’ compensation patients fit this personality disorder “... “Spine pain patients with this disorder may fail to establish trust with their health care team and may have diminished motivation for improvement. *Histrionic personality disorder*, in 12% of pain patients (Fishbain et al, 1986), involves dramatic, attention

*seeking behavior, impaired functioning, and a tendency to experience vague physical symptoms”.*

- Gordon RE, et al. Predicting prognosis by means of the DSM-III multi-axial diagnoses. *Can J Psychiatry*. 1991 Apr;36(3):218-21.
  - Personality disorders are more prevalent among claimants than among patients/examinees who have not filed any type of legal/disability claim.

In regard to the tendency for people who have personality disorders to file legal claims, it appears that the insidious nature of personality disorders is fundamental for understanding this phenomenon. Personality disorders are insidious in that the person with the disorder is often not aware that she or he has any problem. Because the disorder is inherent to the individual's personality, it is part of who he or she is, and therefore often does not come to the individual's attention. As a result, the role that personality disorders play in the genesis of the individual's problems is often hidden from the disordered individual. Since such individuals do not realize that their personality creates problems, they tend to blame others for those problems (see the Hales reference and quote slightly above this passage).

As a consequence, personality disordered individuals file legal claims at an elevated rate, thereby causing personality disorders to be especially common in all types of litigation and disability claims, and consequently causing presentations that involve personality disorders to be a frequent focus of Guides-related evaluations.

The insidious nature of personality disorders also helps to explain why personality disorders are regularly overlooked during evaluations. It is difficult to identify these disorders, and to do anything about them, because of the personality disordered individual's lack of awareness of a problem. Because the disorder is inherent to the individual's personality, it is part of who he or she is, and therefore often does not come to the individual's attention as a health issue (or as any kind of problem). The afflicted individual typically will not have any concerns about their personality, and typically will not ask for help (clinical or otherwise). In other words, the role that personality disorders play in the generation of impairment claims is often hidden from the disordered individual, and consequently hidden from evaluators (until the evaluator undertakes a focused effort to specifically and thoroughly assess for it).

A second means by which personality disorders contribute to impairment claims involves the fact that personality disorders actually create a health risk (for both mental health and general medical health). The health consequences of personality disorders additionally contribute to the tendency for such individuals to file medical-legal claims. In other words, because personality disorders lead to more frequent and more severe health problems, such individuals are more likely to file medical-legal claims. Detailed examples of the health correlates of personality disorders are discussed in other sections of this article.

It is difficult to separate personality disorder factors that contribute to poor health from those that simply contribute to the filing of legal claims. Subsequently, the following list provides an overview of both types of mechanisms.

In summary, the relevant science explains that people with personality dysfunction:

- have elevated rates of smoking and inadequate physical exercise

Charles ST, Gatz M, Kato K, et al. Physical health 25 years later: The predictive ability of neuroticism. *Health Psychology*, 2008, 27 (3), 369-378.

- have elevated rates of other forms of substance abuse; lack resilience under stress because they have difficulty responding flexibly and adaptively to changes and demands of life; have elevated difficulty living up to the demands of occupational roles; have elevated rates of unemployment; are at elevated risk of being involved in an accident; are more likely to seek emergency medical services; are more likely to be hospitalized; are more likely to be involved in interpersonal violence; are more likely to engage in self-injurious behavior; are more likely to attempt suicide

Hales, R. E., Yudofsky, S. C., (2002). *The American Psychiatric Publishing Textbook of Clinical Psychiatry, Fourth Edition*. American Psychiatric Publishing.

-Are more likely to seek general medical care; are more likely to undergo surgery; are more likely to be noncompliant with healthcare

*Oldham JM et al. Textbook of Personality Disorders. American Psychiatric Publishing, 2005.*

-Are more likely to have dysfunctional interactions with clinicians; more likely to demonstrate inflexibility when health concerns indicate that behavioral changes are needed; are more likely to be noncompliant with their healthcare

*Wesley AL, et al. Psychosocial Psychiatric and Socioeconomic Factors in Chronic Occupational Musculoskeletal Disorders. In: Occupational Musculoskeletal Disorders: Function, Outcomes and Evidence. LW&W, 2000.*

-are more likely to attempt to bully clinicians through the use of rage, blame, and threats, in order to secure medications and other interventions, thereby sabotaging their own well-being through the procurement of excessive treatment

- Dworkin RH et al. *Psychosocial Factors in Pain: Critical Perspectives*. IASP Press, 2004.
- Loeser JD, et al. *Bonica's Management of Pain*, 3rd ed. LW&W, 2001.

-are more likely to be resistant to meeting occupational and other social responsibilities, to have difficulty establishing trust with clinicians, to demonstrate a lack of motivation for improvement of health complaints, and to demonstrate a tendency to experience somatoform complaints

*Block AR et al. The Psychology of Spine Surgery*, American Psychological Association, 2003

**C. 5. The Guides to the Evaluation of Permanent Impairment 6<sup>th</sup> Edition Specifies that Impairment From a Personality Disorder is to Be Excluded From An Impairment Rating**

The Mental and Behavioral Disorders chapter in the 6<sup>th</sup> Edition of the *Guides* involves a new focus on work-relatedness (for example, see section 14.1c Diagnostic Categories, page 349; section 14.3a Physician Alliance, page 351; Table 14-4, Suggestions for the M&BD IME, page 352; section 14.5d Further Considerations, page 356, etc.). This emphasis on work-relatedness was absent from previous editions. As a consequence of this new emphasis, the 6<sup>th</sup> Edition

excludes most mental illnesses from eligibility for impairment ratings (while all mental illnesses were eligible for impairment rating in previous editions).

One category of mental illness which the 6<sup>th</sup> Edition excludes from eligibility for impairment ratings is personality disorders (this is specified on page 349, section 14.1c Diagnostic Categories). The chapter explains that impairment from a personality disorder would be, by definition, among the “pre-existing conditions which are not ratable” (Page 355, section 14.5d). Because personality disorders are to be excluded from any final rating, the chapter instructs evaluators to assess what portion of impairment is due to any issues which are eligible for impairment rating, versus what portion is due to personality disorders. *Impairment due to personality disorders is then excluded/subtracted from the final impairment rating.*

The directive to separate out impairment that is due to personality disorders only appears in the Mental and Behavioral Disorders chapter. This is unfortunate because, as is detailed in the remainder of this article, the influence of personality disorders is not limited to claims of mental illness. In fact, *research findings have actually indicated that personality disorders are a more important consideration for claims of chronic pain and claims of general medical disability, than for overt claims of mental illness.*

### **C. 6. Relevance to all three of the major Guides**

The three primary AMA *Guides* (Impairment, Causation, and Work Ability), provide a multi-level organizational structure for the discussion of the relevance of personality disorders for all types of claims.

The fundamental nature of personality disorders is key to understanding the relevance for all three *Guides*. By definition (as was discussed in the slides from section B. 1. above), these disorders eventually lead to distress or impairment. Consequently, whenever a personality disorder is present in a claim (any type of claim), it will be clinically important to assess the role that the personality disorder is playing in that presentation.

This consideration is of direct relevance to the AMA *Guides to the Evaluation of Work Ability and Return to Work*, but the relevance actually goes beyond any *Guides*-related considerations. If a personality disorder is present, but an evaluation process fails to investigate for it, then rehabilitation plans will fail to incorporate relevant interventions, which means that rehabilitation efforts will be less likely to succeed, and the end result will be that the examinee will be less likely to overcome the claimed impairment.

In regard to impairment evaluation: personality disorders can have a huge influence on impairment ratings for cases which are actually focused on other health issues. This unfortunate and inappropriate influence was enabled when the 6<sup>th</sup> Edition of the *Guides to the Evaluation of Permanent Impairment* adopted a focus on the functional manifestations of impairment (SEE 1.2b Five Axioms of the Sixth Edition, Axiom number 4, page 2). That focus is operationalized through the use of subjective self-reports from examinees (see section 1.7c Choice of Functional Assessment Tools, pages 10-11). Because the personality of the examinee will have an inherent influence on such self-reports, the 6<sup>th</sup> Edition’s focus on functional manifestations creates an unusually direct mechanism for personality disorders to influence the final impairment rating (for all types of claims). Because of this vulnerability to impairment ratings being contaminated by personality disorders, and because personality disorders are extremely common among claimants,



evaluators should be prepared to evaluate for the possibility of a personality disorder in any one case, and to apportion out the effects of that personality disorder from the impairment rating.

Personality disorders will also frequently have relevance for the causation analysis protocol that has been detailed in the Guides to the Evaluation of Disease and Injury Causation.

NOTE: In 2012, the AMA published a concise discussion of that protocol, which involved a concerted effort to bring all of the details from the various sections of the Causation Guides into a single document: Barth RJ. Determining Injury-Relatedness, Work-Relatedness, and Claim-Relatedness. *AMA Guides Newsletter*, May/June 2012. American Medical Association.

Personality disorders will be present in many cases, if evaluators make the effort to investigate for it. Personality disorders are common in the general population, even more common among patients who present to general medical clinicians, and even more common among claimants (details and references discussed elsewhere in this article). As such, if evaluators fail to consider the possibility of a personality disorder in their causation evaluations, they will frequently be overlooking a critically important factor in the genesis of many impairment claims.

In fact, it is likely that the evaluator who investigates for personality disorders will discover that some impairment claims are completely explained by personality disorders, rather than by the overt issue that is superficially associated with the claim. In common types of supposedly general medical disability claims (e.g. back pain claims; claims of CRPS; claims of fibromyalgia; other chronic pain claims; claims of persistent postconcussion syndrome; claims of persistent PTSD; claims of disabling mental illness), the overtly claimed issue and the associated clinical findings typically do not provide an explanation for the claim, but personality disorders often will provide a comprehensive explanation (given the prevalence of personality disorders among such claimants, given the reliable trend for personality disorders to eventually lead to presentations of impairment, and given the pervasive influence that personality disorders have on the life of an afflicted individual).

Therefore, evaluators would be wise to address the possibility of a personality disorder for almost all claimants, for almost all types of claims, and for all types of Guides-relevant evaluations. Mental health specialists should know how to do this thoroughly, but as is discussed later in this article, research findings have indicated that they usually fail to do so (relevant findings documented in the Mental Illness chapter of the *Guides to the Evaluation of Disease and Injury Causation*). Some of the reasons for this trend are discussed later in this article. For non-mental health specialists, some initial steps toward screening for the possibility of a personality disorder can be easily adopted, so that potentially relevant examinees can be identified and referred for comprehensive mental health evaluations. Options in this regard will also be discussed later in this article (see the discussions of the SCID and the MCMI-3). Hopefully, the information presented in this article will help evaluators to understand why screening for personality disorders would be a justifiable component of all impairment evaluations.

In the hope of encouraging impairment evaluators, and clinicians in general, to consider this important issue, this article provides descriptions of personality disorders, provides a review of some of the science which has highlighted the relevance of these disorders to all types of impairment claims, discusses the reasons why evaluators typically avoid this issue, and provides examples of how this pervasive shortcoming can be remedied.

Additionally, this information is offered for consideration as an aid for developing future *Guides* publications. The GEPI 6<sup>th</sup> Edition's new directive for evaluators to exclude impairment that is due to a personality disorders should be highlighted, and expanded if necessary, so that the *Guides* text makes it clear that this issue is of relevance to the entirety of the *Guides* (rather than being limited to the Mental and Behavioral Disorders claims). Such clarification is warranted because of the greater role that personality disorders play in pain complaints and general medical claims, relative to claims of mental illness. Such expansion would also be in keeping with the axiom calling for internal consistency (Axiom 5, page 2, section 1.2b Five New Axioms of the Sixth Edition), because it is not internally consistent for the *Guides* to call for impairment from personality disorders to be excluded from only the Mental and Behavioral Disorders chapter (given the fact that scientific findings have indicated that personality disorders play a greater role in other types of claims). Additionally, such expansion would be consistent with the *Guides* axiom which calls for a more diagnosis-specific focus (Axiom 2, page 2, section 1.2b Five New Axioms of the Sixth Edition), because functional impairment which is actually attributable to personality disorders (rather than being directly attributable to the overtly claimed condition) is not diagnosis-specific.

#### **D. Pain claims: Examples of relevant scientific findings**

##### **D. 1. Excerpt from AMA and AAOS Chronic Pain Summaries**

- Barth RJ. Chronic Pain: How to Make Sense of It Within Orthopaedic Claims. In: Melhorn JM and Carragee E. 14th Annual American Academy of Orthopaedic Surgeons Occupational Orthopaedics and Workers Compensation: A Multidisciplinary Perspective. 2012. American Academy of Orthopaedic Surgeons.
- Barth RJ. Chronic Pain: Fundamental Scientific Considerations, Specifically For Legal Claims. AMA Guides Newsletter, Jan/Feb, 2013 (In press).

Note: The outline for the AMA version of this publication is provided (with only the personality disorder section being provided in full), in order to provide a context for the significance of personality disorders as a risk factor for chronic pain.

*I. Introduction: Chronic pain is normal.*

*II. The Dominant Role of Financial Compensation*

*III. Personality Disorders*

*The information that was discussed above indicates that compensation contingencies are the primary risk factor for chronic pain within a legal claim context. Of course, compensation contingencies are not a health issue.*

*Among health issues, the most important risk factor for the development of the types of chronic pain presentations which become the focus of medical-legal claims appears to be personality disorders.*

*Personality disorders are a pervasive form of mental illness. By definition, they are pre-existing for the purposes of any adult legal claim (because they are defined as first manifesting in adolescence or, at the latest, early adulthood).*

*Also by definition, they lead to distress or impairment regardless of whether the individual has experienced an injury.*

*When chronic pain populations have been credibly studied for purposes of determining the extent to which personality disorders are risk factors for the development of chronic pain, the findings have dwarfed all other risk factors, with the exception of compensation contingencies. For example:*

- *When Dersh et al. evaluated a population of workers compensation claimants who were claiming to be disabled by chronic back pain, they found a 73% rate of personality disorders (compared to reports of 10-13% for the general population; Hales).*
  - Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006 May 1;31(10):1156-62.
  - Hales RE, et al. *The American Psychiatric Publishing Textbook of Clinical Psychiatry. Fifth Edition.* Washington, DC: American Psychiatric Publishing; 2008.
- *When Monti et al. evaluated a population of people who had been given a diagnosis of complex regional pain syndrome type I, they found a 60% rate of personality disorders (in the same project, they found a 64% rate among “patients with chronic low back pain from disc pathology”).*
  - Monti DA, et al. Personality assessment of patients with complex regional pain syndrome type I. *The Clin JI of Pain*. 1998;14:295-302.
- *For fibromyalgia, Martinez et al. reported a 63.8% rate of personality disorders, and Rose et al. reported a 46.7% rate.*
  - Martinez JE, Ferraz MB, Fontana AM, Atra E. Psychological aspects of Brazilian women with fibromyalgia. *J Psychosom Res*. 1995 Feb;39(2):167-74.
  - Rose S, Cottencin O, Chouraki V, Wattier JM, Houvenagel E, Vallet B, Goudemand M. Study on personality and psychiatric disorder in fibromyalgia. *Presse Med*. 2009 May;38(5):695-700.
- *For temporomandibular pain, Gatchel et al. (1996) reported a 42% rate of personality disorders.*
  - Gatchel RJ, Garofalo JP, Ellis E, Holt C. Major psychological disorders in acute and chronic TMD: an initial examination. *J Am Dent Assoc*. 1996 Sep;127(9):1365-70, 1372, 1374.
- *For 283 consecutive admissions to a chronic pain specialty clinic, Fishbain found a 58% rate of personality disorders.*

- Fishbain DA, Goldberg M, Meagher BR, Steele R, Rosomoff H. Male and female chronic pain patients categorized by DSM-III psychiatric diagnostic criteria. *Pain*. 1986 Aug;26(2):181-97.
- *A review of research regarding personality disorders among chronic pain patients of all types (published prior to some of the above information) reported rates of 31%-64% (Gatchel et al., 2000).*
  - Gatchel RJ, and Weisberg JN: *Personality Characteristics of Patients With Pain*. Washington, DC: American Psychological Association, 2000.
- *Based on a review of relevant scientific findings, First and Tasman reported that approximately 75% of cases which present for medical help with complaints of pain will not lead to any significant or explanatory general medical findings, and at least half of those cases will involve “major personality problems”. Of note, their review was not limited to chronic pain.*
  - First MB & Tasman A. *DSM-IV-TR Mental Disorders. Diagnosis, Etiology & Treatment*. Wiley. 2004.

*Given the prominence of personality disorders as a risk factor for chronic pain, it is noteworthy (and distressing) that scientific findings have indicated that workers compensation claimants are almost never evaluated for the possibility of a personality disorder, even when a mental health specialist provides a direct evaluation (details provided in the Mental Illness chapter of the AMA Guides to the Evaluation of Disease and Injury Causation).*

IV. Narcotics

V. Malingering

VI. A focus on one painful part of the body will usually be misdirected

VII. Other forms of mental illness

VIII. Detailed discussion of the psychodynamics of chronic pain

IX. Smoking

X. Obesity

XI. Childhood abuse and neglect

#### **D. 2. Text prepared specifically for this personality disorder project**

Chronic non-malignant pain cases are an appropriate starting point for reviewing scientific findings in regard to the role of personality disorders in medical-legal claims for at least two reasons:

- a. Personality disorders are especially prevalent among chronic pain claimants, even more prevalent than among chronic pain patients who are not claimants or plaintiffs, and even more prevalent than among psychiatric patients.

Referencing: In comparison to the rates reported above for chronic pain claimants and patients, findings regarding psychiatric patients have

indicated a rate of 45.5% (Zimmerman M, et al. The prevalence of DSM-IV personality disorders in psychiatric outpatients. *Am J Psychiatry*. 2005 Oct;162(10):1911-8).

and ...

b. Chronic pain claims bridge the gap between the mental illness and general medical discussions which follow this section, because the chronic pain presentations are primarily of a social or psychological nature (see the referencing for the chronic pain publications listed in section D. 1. Above), but they are all too often responded to as if they were exclusively of a general medical nature.

General population research has indicated personality disorder rates of 10%-13% (Hales RE, et al. *The American Psychiatric Publishing Textbook of Clinical Psychiatry*. Fifth Edition. Washington, DC: American Psychiatric Publishing; 2008). In contrast, research findings have indicated drastically higher rates in samples of chronic pain patients. For example, a review of relevant research reported rates of 31%-64% (Gatchel RJ, and Weisberg JN: *Personality Characteristics of Patients With Pain*. Washington, DC: American Psychological Association, 2000) and more recent research has revealed even higher rates among chronic pain patients in a workers compensation context (Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006 May 1;31(10):1156-62).

Because back pain is a relatively popular area of scientific research, studies of back pain patients have provided some of the most in-depth information regarding the relationship between claims of pain-related impairment and personality disorders. For example, research focused on workers' compensation claimants with complaints of chronic disabling back pain found a 73% rate of personality disorders (Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006 May 1;31(10):1156-62), thereby demonstrating the overwhelming significance of personality disorders for this population.

That significance has been additionally demonstrated by prospective research findings which have indicated that personality disorders are one of the best predictors of who will develop claims of vocational disability attributed to chronic back pain.

Gatchel RJ, et al. Predicting outcome of chronic back pain using clinical predictors of psychopathology: a prospective analysis. *Health Psychol*. 1995 Sep;14(5):415-20.

*“Analyses, conducted to differentiate between those patients who were back at work at 6 months versus those who were not because of the original back injury, revealed the importance of 3 measures: self-reported pain and disability, the presence of a personality disorder, and scores on Scale 3 of the Minnesota Multiphasic Personality Inventory. These results demonstrate the presence of a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems.”*

These replicated findings of extremely high rates of personality disorders among chronic back pain patients are illuminating for the associated claims of impairment. The professional literature

has been quite clear that there are no general medical correlates for the majority of such presentations. For example, in reviewing the relevant science, the GEPI 5<sup>th</sup> Edition (Pain chapter) reported that there are no general medical findings in 85% of low back pain cases. Therefore, on the one hand, claims of impairment from chronic back pain have a lack of correlation with general medical findings, while on the other hand, such claims have an extremely high correlation with personality disorders.

These findings of an elevated rate of personality disorders among chronic pain patients are also instructive for the often revisited discussions regarding whether mental illness causes chronic pain, or chronic pain causes mental illness. These findings are instructive because it is definitionally impossible for adult-onset complaints of pain to be the cause of a personality disorder. By definition (as has been discussed previously in this article), the personality disorder would have to be a pre-existing condition.

The association between personality disorders and chronic pain complaints is not limited to back claims. Other examples of this association include a majority of subjects being found to have a personality disorder among people who had been given a diagnosis of complex regional pain syndrome or fibromyalgia (referencing was provided in section D. 1. above).

Similarly, when a sample of chronic pelvic pain patients was evaluated for personality disorders, a 76% rate was discovered.

Gross RJ, Doerr H, Caldirola D, Guzinski GM, Ripley HS. Borderline syndrome and incest in chronic pelvic pain patients. *Int J Psychiatry Med.* 1980-1981;10(1):79-96.

Personality disorders have also been found to be associated with elevated rates of temporomandibular joint syndrome.

Frankenburg FR, Zanarini MC. The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization. *J Clin Psychiatry.* 2004 Dec;65(12):1660-5.

NOTE: this project also revealed an elevated association between personality disorders and fibromyalgia, and chronic fatigue.

The association between personality disorders and chronic pain claims is helpful not only for understanding the nature of chronic non-malignant pain, but also for understanding the nature of personality disorders. For example, as was mentioned above, Passive Aggressive Personality Disorder has been removed from the official listing of mental illnesses and relegated to a concept that requires further study before it can be specified as a discrete illness. The study of the association between personality disorders and pain complaints provides strong support for re-instituting Passive Aggressive Personality Disorder as a formal diagnosis. For example, in a sample of chronic pain patients within a workers' compensation context, 24.7% of the males were found to have this disorder (Block AR et al. *The Psychology of Spine Surgery*, American Psychological Association, 2003). Consequently, it is clear that Passive Aggressive Personality Disorder is a highly relevant clinical construct, and it would be clinically helpful to re-formalize this diagnostic entity, because of its significance in developing an understanding of, and its value in directing treatment planning for such a troubled population.

Research which has focused on a lifespan perspective has further illuminated the importance of personality disorders for chronic pain presentations. For example, the relationship between personality and chronic abdominal pain has been found to manifest in childhood (Reference: Walker LS, Smith CA, and Garber J. Appraisal and coping with daily stressors by pediatric patients with chronic abdominal pain. *Journal of Pediatric Psychology*, 32 (2), 206-216, 2007).

Additionally, characteristics of Borderline Personality Disorder have been found to be predictive of the development of chronic pain complaints, even within a prospective research design that involved the personality evaluation taking place 25 years before the pain evaluation (Reference: Charles ST, Gatz M, Kato K, et al. Physical health 25 years later: The predictive ability of neuroticism. *Health Psychology*, 2008, 27 (3), 369-378).

A single personality disorder (Borderline) was found to apply to 30% of patients in a review project of multiple relevant studies.

Sansone RA, Sansone LA. Chronic pain syndromes and borderline personality. *Innov Clin Neurosci*. 2012 Jan;9(1):10-4.

There is a tendency for people who are not mental health clinicians to react to the scientific findings that have been referenced above by asking questions such as: How does a personality disorder lead to physical pain? The succinct answer involves pointing out that physical pain is a normal manifestation of mental illness in general. For example, scientific findings have revealed that a vast majority of psychiatric patients endorse current physical pain when asked, and a majority of psychiatric patients endorse their current pain as having been of a chronic nature (King, et al. (1998). The problem of pain among psychiatric inpatients. Paper presented at the Annual Meeting of the American Pain Society. Published discussion available in: Hales RE, Yudofsky SC. *The American Psychiatric Publishing Textbook of Clinical Psychiatry*. Fourth Edition. Washington, DC: American Psychiatric Publishing; 2002). Given the prominence of physical pain as a manifestation of mental illness, the definition of mental illness actually emphasizes such reports of pain as a key element (reference: American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision. Washington, D.C., American Psychiatric Association, 2000). Consequently, a question of how personality disorders lead to physical pain is misdirected, because mental illness and pain should not be viewed as separate entities. Instead, physical pain is simply an inherent component of mental illness in general, and this is especially true for personality disorders.

The overwhelming prominence, and prospective significance, of personality disorders is one of several indications that evaluators and other clinicians would be wise to focus on the psychology of chronic pain patients (rather than limiting the focus to the examinee's general medical status).

### **E. Overt Claims of Mental Illness: Examples of Relevant Scientific Findings**

In order to emphasize the importance of personality disorders in claims of impairment attributed to mental illness, it is necessary to note the difference between personality disorders and other forms of mental illness. Because of their pervasive nature, the American Psychiatric Association's diagnostic system (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision. Washington, D.C., American Psychiatric Association, 2000) places personality disorders into a category with only mental retardation, completely separate from all other forms of mental illness. According to that system, personality disorders are listed as a second component, or "Axis", of an examinee's diagnostic formulation. Therefore, personality disorders are referred to as "Axis 2" diagnoses. In contrast, all other forms of mental illness (except for mental retardation) are listed as the first component, or "Axis", of a diagnostic formulation, and are therefore referred to as "Axis 1" diagnoses, in

order to distinguish them from personality disorders. NOTE: This multi-axial categorization is reportedly absent from the forthcoming new edition of the diagnostic system.

Mental health specialists demonstrate a strong trend toward overlooking personality disorders (relevant research findings documented in the Mental Illness chapter of the AMA's Guides to the Evaluation of Disease and Injury Causation). One general reason for this is the tendency for examinees to present Axis 1 issues as their primary concern (Reference: Zimmerman M, et al. The prevalence of DSM-IV personality disorders in psychiatric outpatients. *Am J Psychiatry*. 2005 Oct;162(10):1911-8). As was discussed earlier in this article, personality disordered individuals usually fail to realize that their personality is causing the problems in their lives. When the personality disordered individual is in a claims context, there are more apparent reasons for the tendency of mental health specialists to overlook personality disorders. Those reasons are discussed later in this article.

Scientific findings have provided indications that the typical focus on Axis 1 issues, to the exclusion of personality disorders, will cause evaluators to overlook some of the most significant aspects of the examinee's presentation. For example, personality disorders are especially prominent among people who have an Axis 1 mental illness. Readers are reminded of the general population personality disorder rates of 10%-13% (Hales, R. E., Yudofsky, S. C., (2002). *The American Psychiatric Publishing Textbook of Clinical Psychiatry, Fourth Edition*. American Psychiatric Publishing), in order to highlight the significance of the 45.5% rate of personality disorders that has been reported among patients with an Axis 1 mental illness (Zimmerman M, et al. The prevalence of DSM-IV personality disorders in psychiatric outpatients. *Am J Psychiatry*. 2005 Oct;162(10): 1911-8).

Given this high rate, a personality disorder is going to be one of the most common diagnostic findings among mentally ill people, regardless of the nature of their Axis 1 presentation. Personality disorders are even more prevalent among claimants (compared to patients/examinees who have not filed any type of legal/disability claim) (Gordon RE, et al. Predicting prognosis by means of the DSM-III multiaxial diagnoses. *Can J Psychiatry*. 1991 Apr;36(3):218-21), which further highlights the significance of this diagnostic issue for Guides-related evaluations.

Additionally, personality disorders influence the course and treatment planning for the Axis 1 disorders (Zimmerman M, et al. The prevalence of DSM-IV personality disorders in psychiatric outpatients. *Am J Psychiatry*. 2005 Oct;162(10): 1911-8), which means that clinicians are going to have a less than adequate understanding of the Axis 1 presentation if they overlook a personality disorder.

Further, given the definitional association between personality disorders and impairment (American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision*. Washington, D.C., American Psychiatric Association, 2000), personality disorders are also going to be one of the most frequent causes of impairment among mental illness claimants. Consistent with such definitional considerations, the results of empirical study have indicated that the presence of a personality disorder has an additive effect on disability, beyond the effects of any Axis 1 disorder (in other words, even when the effect of Axis 1 psychopathology is controlled for, personality disorders are still predictive of disability) (Reference: Jackson HJ, Burgess PM. Personality disorders in the community: results from the Australian National Survey of Mental Health and Wellbeing Part II. Relationships between personality disorder, Axis I mental disorders and physical conditions with disability and health consultations. *Soc Psychiatry Psychiatr Epidemiol* (2002 Jun) 37(6):251-60).



Scientific efforts have also addressed the question of which type of mental illness causes more impairment and disability, Axis I disorders or personality disorders. For example, such research has compared personality disorders with Major Depressive Disorder (one of the most commonly claimed mental illnesses within disability claims – reference: Barth, RJ. *Mental Illness*, in: Melhorn, JM, and Ackerman, WE. *Guides to the Evaluation of Disease and Injury Causation*. 2008. American Medical Association). The findings indicated that most personality disorders were found to be associated with greater impairment than Major Depressive Disorder, and none were found to be less impairing than Major Depressive Disorder (reference: Skodol AE et al. Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *Am J Psychiatry*. 2002 Feb;159(2):276-83).

The importance of personality disorders is further highlighted by scientific findings which indicate that the association between personality disorders and impairment is surprisingly strong, to an extent that is actually unique in the scientific study of personality. This issue is informative for the overall scientific study of personality, as well as being informative for the evaluation of impairment. In order to understand the surprising and unique nature of this relationship, it should first be noted that the scientific study of personality has demonstrated a trend away from the categorical concept of personality types/disorders, and toward a more dimensional concept of personality traits that apply to all people to some measurable degree (Hales RE, et al. *The American Psychiatric Publishing Textbook of Clinical Psychiatry*. Fifth Edition. Washington, DC: American Psychiatric Publishing; 2008). This movement toward a dimensional approach is supported by numerous findings which have illustrated that such an approach may have greater scientific validity in most circumstances. However, impairment is a surprising exception to that trend, in that research findings have indicated that the categorical approach (the personality disorders that were listed earlier in this article) is actually a better predictor of “functional impairment” than is the dimensional approach (reference: Skodol AE et al. Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *Am J Psychiatry*. 2002 Feb;159(2):276-83). Such findings indicate that the trend toward dimensional approaches for personality assessment may be misdirected for Guides-related issues. Such findings additionally highlight the importance of a focus on personality disorders within a Guides-related evaluation (beyond the importance that has been indicated by all of the issues previously discussed in this article), because the association between personality disorders and impairment is so surprisingly strong that it actually creates a unique (and therefore noteworthy) exception to the general scientific knowledge base regarding personality.

The means by which personality disorders contribute to a presentation of impairment from mental illness go beyond the direct effects of the disorder. Indirect effects which compound the clinical presentation and associated impairment include:

- the personality disorder leads to higher rates of noncompliance with mental health treatment plans
- the personality disorder leads to a less reliable presentation in regard to Axis I pathology (with that unreliability creating obstacles to effective treatment planning)
  - Reference: Oldham JM et al. *Textbook of Personality Disorders*. American Psychiatric Publishing, 2005.

Guides-related claims usually focus on Axis I disorders, rather than on personality disorders. This tendency was formalized in the GEPI 6<sup>th</sup> Edition, when personality disorders were formally excluded from the impairment ratings. However, the GEPI 6<sup>th</sup> Edition does not call for personality disorders to be ignored (in fact, evaluators must carefully evaluate for personality

disorders and associated impairment so that any such impairment can be subtracted from the overall rating of impairment). Unfortunately, there has been a strong tendency for the focus on Axis I disorders to lead mental health specialists to ignore personality disorders, in favor of an exclusive focus on Axis I of the diagnostic process (reference: Barth, RJ. *Mental Illness*, in: Melhorn, JM, and Ackerman, WE. *Guides to the Evaluation of Disease and Injury Causation*. 2008. American Medical Association). Some apparent reasons for this misdirected trend are discussed later in this article. For now, it should simply be noted that this trend causes evaluations to be far from complete.

#### F. General medical claims: Examples of Relevant Scientific Findings

The role of personality disorders in general medical claims appears to be even stronger than the role that such disorders play in mental illness claims. For example, in a direct comparison of general medical and mental illness disability claimants, the general medical sample was found to have a significantly higher rate of personality disorders.

Ekselius L, et al. Comorbidity of personality disorders and major depression in patients with somatoform pain disorders or medical illnesses with long-standing work disability. *Scand J Rehabil Med*. 1997 Jun;29(2):91-6.

This trend for personality disorders to be more prominent among general medical claimants might be partially attributable to an established trend among people with personality disorders to express their psychopathology through physical complaints, and to therefore seek general medical consultation (rather than psychiatric consultation).

Oldham JM. Personality disorders. Current perspectives. *JAMA* (1994 Dec 14) 272(22):1770-6.

Apparently because of this tendency, samples of patients in primary care practices have actually demonstrated a higher rate of personality disorders (20-30%) (*Oldham JM et al. Textbook of Personality Disorders. American Psychiatric Publishing, 2005*) than have general population samples (13%) (Hales, R. E., Yudofsky, S. C., (2002). *The American Psychiatric Publishing Textbook of Clinical Psychiatry, Fourth Edition*. American Psychiatric Publishing).

Such findings highlight the need for disability evaluation decisions to be based on scientific findings rather than on “logic” or “common sense”. Because personality disorders are a form of mental illness, “common sense” or “logic” might lead a clinician to conclude that the need for personality evaluation is greatest among mental illness claimants, and that there is not a need for such evaluation among general medical claimants. In contrast, scientific findings actually indicate that the need for personality assessment is greatest when the disability claim is based on a general medical diagnosis. This also highlights the need for the GEPI 6<sup>th</sup> Edition policy of excluding impairment which is due to personality disorders from the rating process to be applied to all types of claims.

The prominence of personality disorders among general medical patients additionally appears to be attributable to factors beyond the simple tendency for such individuals to seek general medical consultation. Even when the effects of the general medical conditions (and even the effects of other mental illnesses) are controlled for, personality disorders are additionally predictive of disability associated with general medical diagnoses (Jackson HJ, Burgess PM. Personality disorders in the community: results from the Australian National Survey of Mental Health and

Wellbeing Part II. Relationships between personality disorder, Axis I mental disorders and physical conditions with disability and health consultations. *Soc Psychiatry Psychiatr Epidemiol* (2002 Jun) 37(6):251-60). In response to such scientific findings, researchers have offered explanations that include: the tendency for people with personality disorders to resist normal social and occupational demands through whatever means might be available to them (and general medical complaints provide such means); the tendency for such individuals to demonstrate a lack of motivation for improvement in health, and for improvement in quality of life; and the tendency for such patients to use their health complaints as a means of securing attention from others, and their subsequent unwillingness to admit improvement in regard to such complaints (Block AR et al. *The Psychology of Spine Surgery*, American Psychological Association, 2003).

But there is also evidence which indicates that such patients are actually more impaired, from a general medical perspective, than are patients who do not have personality disorders (discussed below). In regard to general medical health (beyond the filing of disability claims), patients with personality disorders demonstrate a greater variety and severity of morbidity (a finding that has been replicated across a diverse list of general medical specialties).

Oldham JM et al. *Textbook of Personality Disorders*. American Psychiatric Publishing, 2005).

“All these studies can be summarized: Patients with personality disorders in (general) medical settings are more morbid and go to these settings more frequently than patients without personality disorders. ... This pattern is replicated across medicine. It needs to be widely known to practitioners that those with personality disorders carry greater morbidity. Economically speaking, those with personality disorders need to be recognized because care for these patients carries a greater economic cost.”

Characteristics of Borderline Personality Disorder have been found to be predictive of general medical status, including the results of a prospective research design in which the personality assessment took place 25 years before the general medical assessment. General medical conditions that have been predicted by such personality characteristics included ulcers, coronary heart disease, arthritis, peptic ulcer disease, and irritable bowel syndrome.

Charles ST, Gatz M, Kato K, et al. Physical health 25 years later: The predictive ability of neuroticism. *Health Psychology*, 2008, 27 (3), 369-378.

The predictive effect of personality on general medical health is so powerful that it has been demonstrated to extend across the lifespan, in that childhood personality traits having been found to predict adult health outcomes, including mortality.

Hampson SE, Goldberg LR, Vogt TM, and Dubanoski JP. Mechanisms by which childhood personality traits influence adult health status: educational attainment and health behaviors. *Health Psychology*, 2007, 26, 121-125.

Some research findings indicate that personality-related mechanisms of influence on general medical health include:

- unhealthy behavioral patterns

Hampson SE, Goldberg LR, Vogt TM, and Dubanoski JP. Mechanisms by which childhood personality traits influence adult health status: educational attainment and health behaviors. *Health Psychology*, 2007, 26, 121-125.

- failing to adhere to treatment plans  
Oldham JM et al. *Textbook of Personality Disorders*. American Psychiatric Publishing, 2005).
- Elevated tendencies toward smoking, daily consumption of alcohol, daily use of sleep medications, and sustained use of pain medications  
Frankenburg FR, Zanarini MC. The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization. *J Clin Psychiatry*. 2004 Dec;65(12):1660-5.

However, such mechanisms have not been reliably demonstrated for all of the general medical conditions that are associated with personality disorders, thereby leading to conclusions that there is a more direct correlation between personality disorders and some general medical health issues (such as cardiovascular disease).

Moran P, et al. Personality disorder and cardiovascular disease: results from a national household survey. *J Clin Psychiatry*. 2007 Jan;68(1):69-74.

“People at risk for personality disorder are also at increased risk for cardiovascular disease. This increased risk is not explained by differences in socioeconomic status or lifestyle. Dysfunctional personality traits may have a direct role in the etiology of cardiovascular disease.”

Personality disorders lead to more extensive and more expensive general medical care, thereby raising the risk of iatrogenesis.

Oldham JM et al. *Textbook of Personality Disorders*. American Psychiatric Publishing, 2005).

In a group of patients who presented to a neurology clinic with complaints which appeared to be of a neurological nature, but for whom no general medical explanation could be established, 83% were found to have a personality disorder.

Rechlin T, Loew TH, Joraschky P. Pseudoseizure "status". *J Psychosom Res*. 1997 May;42(5):495-8.

Large scale scientific reviews, including meta-analyses, have indicated an association between avoidant / dependent personality disorders and breast cancer.

Boll TJ, et al. *Handbook of Clinical Health Psychology: (1) Medical Disorders and Behavioral Applications*. American Psychological Association, 2002.

Borderline personality disorder is has been found to be associated with reduced bone mass. Kahl KG, Greggersen W, Rudolf S, Stoeckelhuber BM, Bergmann-Koester CU, Dibbelt L, Schweiger U. Bone mineral density, bone turnover, and osteoprotegerin in depressed women with and without borderline personality disorder. *Psychosom Med.* 2006 Sep-Oct;68(5):669-74.

Personality disorders are associated with a higher rate of surgeries.

Oldham JM et al. *Textbook of Personality Disorders.* American Psychiatric Publishing, 2005.

Borderline personality disorder is associated with chronic fatigue, fibromyalgia, temporomandibular joint syndrome, obesity, osteoarthritis, diabetes, hypertension, back pain, urinary incontinence, smoking, daily consumption of alcohol, lack of regular exercise, daily use of sleep medications, sustained use of pain medications, an elevated rate of emergency room visits for general medical concerns, and an elevated rate of general medical hospitalization.

(NOTE: this paragraph has been formatted with a primary goal of simplicity – it is not intended to claim that all of the issues listed above are actually of a general medical nature.)

“CONCLUSIONS: ... borderline personality disorder seems to be associated with a heightened risk of suffering from chronic physical conditions, making poor health-related lifestyle choices, and using costly forms of medical services.”

Frankenburg FR, Zanarini MC. The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization. *J Clin Psychiatry.* 2004 Dec;65(12):1660-5. Links

Characteristics of Dependent Personality Disorder have been identified as a risk factor for a relapse of duodenal ulcer.

Magni G, Di Mario F, Conlon P, et al. Personality patterns and duodenal ulcer relapse under antisecretory treatment. *Can J Psychiatry.* 1987 Dec; 32 (9): 777-8.

Chronic fatigue:

- Frankenburg FR, Zanarini MC. The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization. *J Clin Psychiatry.* 2004 Dec;65(12):1660-5.
  - Findings included an association between personality disorders and chronic fatigue.
- Charles ST, Gatz M, Kato K, et al. Physical health 25 years later: The predictive ability of neuroticism. *Health Psychology,* 2008, 27 (3), 369-378.
  - In the results of a prospective research design in which the personality assessment took place 25 years before the general medical assessment, Borderline Personality Disorder was predictive of the development of somatoform complaints, including chronic fatigue. (NOTE: This article is not making a claim that chronic fatigue is a general medical condition.)

Claims of vocational disability after myocardial infarction was predicted by avoidant/dependent/schizoid (introverted) personality styles. Claims of disability were not predicted by indices of infarction size of disease severity.

Soejima Y, et al. Psychosocial and clinical factors predicting resumption of work following acute myocardial infarction in Japanese men. *Int J Cardiol.* 1999 Dec 15;72(1):39-47.

Psoriasis: Claims of disability that are attributed to psoriasis do not correlate with general medical factors (such as disease severity, location of lesions, or duration of lesions). Such claims are instead predicted by psychological variables, including perceived well-being, perceptions of stigmatization, and depression. The best predictor of disability was the individual's idiosyncratic anticipation of other people's reactions to the psoriasis. The primacy of psychological factors in determining who will claim disability subsequent to psoriasis reflects the established correlation between psoriasis and personality disorders, anxiety, and depression; as well as the established tendency for psychological interventions to reduce psoriasis activity.

Levenson JL. *Textbook of Psychosomatic Medicine.* Washington, DC: American Psychiatric Publishing; 2005.

Barth, RJ, and Brigham, CR. Chapter 14 or 18 for pain complaints? Guidance from Chapter 14 and other mental health resources. *The Guides Newsletter.* March/April 2005: 4-5, 8-9.

Rohling ML, Binder LM, Langhinrichsen-Rohling J. Money matters: A meta-analytic review of the association between financial compensation and the experience and treatment of chronic pain. *Health Psychol* (1995 Nov) 14(6):537-47.

Barth, RJ, and Roth, VS. (2003). Health Benefits of Returning to Work. *Occupational and Environmental Medicine Report*, 17, 3, March, 2003, p13-17.

Impaired wound healing: In scientific investigation, 1/25 patients reported deliberately interfering with the healing of their wounds. This behavior was significantly correlated with Borderline Personality Disorder.

Randy A. Sansone, MD, Joy Chang, BS, and Bryan Jewell, MD. Preventing Wounds From Healing and Borderline Personality Symptomatology. *Prim Care Companion CNS Disord.* 2012; 14(4).

### **G. Example of a Diagnostic Protocol for a Personality Disorder**

#### 301.4 Obsessive-Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost

- (2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
- (3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- (4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- (5) is unable to discard worn-out or worthless objects even when they have no sentimental value
- (6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
- (7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
- (8) shows rigidity and stubbornness

#### 301.82 Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
- (2) is unwilling to get involved with people unless certain of being liked
- (3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- (4) is preoccupied with being criticized or rejected in social situations
- (5) is inhibited in new interpersonal situations because of feelings of inadequacy
- (6) views self as socially inept, personally unappealing, or inferior to others
- (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

#### **H. Ways to Make the Evaluation Process More Efficient and More Credible**

##### **H. 1. Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)**

##### **H. 2. Testing Option: Millon Clinical Multi-Axial Inventory (Currently in a third edition) (MCMI-3)**

# SCID-II

## PERSONALITY QUESTIONNAIRE

(To be used with SCID-II Interview)

Your initials: \_\_\_\_\_

Today's date: \_\_\_\_\_ PQ1  
Month Day Year

Study No.: \_\_\_\_\_ PQ2

ID No.: \_\_\_\_\_ PQ3

(to be completed by study staff)



## Instructions

These questions are about the kind of person you generally are—that is, how you have usually felt or behaved over the past several years. Circle “YES” if the question completely or mostly applies to you, or circle “NO” if it does not apply to you. If you do not understand a question or are not sure of your answer, leave it blank.

- |                                                                                                                                                      |    |     |      |
|------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|------|
| 1. Have you avoided jobs or tasks that involved having to deal with a lot of people?                                                                 | NO | YES | PQ4  |
| 2. Do you avoid getting involved with people unless you are certain they will like you?                                                              | NO | YES | PQ5  |
| 3. Do you find it hard to be “open” even with people you are close to?                                                                               | NO | YES | PQ6  |
| 4. Do you often worry about being criticized or rejected in social situations?                                                                       | NO | YES | PQ7  |
| 5. Are you usually quiet when you meet new people?                                                                                                   | NO | YES | PQ8  |
| 6. Do you believe that you’re not as good, as smart, or as attractive as most other people?                                                          | NO | YES | PQ9  |
| 7. Are you afraid to try new things?                                                                                                                 | NO | YES | PQ10 |
| 8. Do you need a lot of advice or reassurance from others before you can make everyday decisions—like what to wear or what to order in a restaurant? | NO | YES | PQ11 |
| 9. Do you depend on other people to handle important areas in your life such as finances, child care, or living arrangements?                        | NO | YES | PQ12 |
| 10. Do you find it hard to disagree with people even when you think they are wrong?                                                                  | NO | YES | PQ13 |
| 11. Do you find it hard to start or work on tasks when there is no one to help you?                                                                  | NO | YES | PQ14 |
| 12. Have you often volunteered to do things that are unpleasant?                                                                                     | NO | YES | PQ15 |
| 13. Do you usually feel uncomfortable when you are by yourself?                                                                                      | NO | YES | PQ16 |

14.	When a close relationship ends, do you feel you immediately have to find someone else to take care of you?	NO	YES	PQ17
15.	Do you worry a lot about being left alone to take care of yourself?	NO	YES	PQ18
16.	Are you the kind of person who focuses on details, order, and organization or likes to make lists and schedules?	NO	YES	PQ19
17.	Do you have trouble finishing jobs because you spend so much time trying to get things exactly right?	NO	YES	PQ20
18.	Do you or other people feel that you are so devoted to work (or school) that you have no time left for anyone else or for just having fun?	NO	YES	PQ21
19.	Do you have very high standards about what is right and what is wrong?	NO	YES	PQ22
20.	Do you have trouble throwing things out because they might come in handy some day?	NO	YES	PQ23
21.	Is it hard for you to let other people help you unless they agree to do things exactly the way you want?	NO	YES	PQ24
22.	Is it hard for you to spend money on yourself and other people even when you have enough?	NO	YES	PQ25
23.	Are you often so sure you are right that it doesn't matter what other people say?	NO	YES	PQ26
24.	Have other people told you that you are stubborn or rigid?	NO	YES	PQ27
25.	When someone asks you to do something that you don't want to do, do you say "yes" but then work slowly or do a bad job?	NO	YES	PQ28
26.	If you don't want to do something, do you often just "forget" to do it?	NO	YES	PQ29
27.	Do you often feel that other people don't understand you, or don't appreciate how much you do?	NO	YES	PQ30
28.	Are you often grumpy and likely to get into arguments?	NO	YES	PQ31

**STRUCTURED  
CLINICAL  
INTERVIEW  
FOR  
DSM-IV AXIS II  
PERSONALITY DISORDERS**

**SCID-II**

Michael B. First, M.D.  
Miriam Gibbon, M.S.W.  
Robert L. Spitzer, M.D.  
Janet B. W. Williams, D.S.W.  
Lorna Smith Benjamin, Ph.D.

**AVOIDANT PERSONALITY DISORDER**

**AVOIDANT PERSONALITY DISORDER CRITERIA**

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- |                                                                                                                                |                                                                                                                                                   |                |           |
|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------|
| <p>1. You've said that you have [<i>Have you</i>] avoided jobs or tasks that involved having to deal with a lot of people.</p> | <p>(1) avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection</p> | <p>? 1 2 3</p> | <p>25</p> |
|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------|

Give me some examples. What was the reason that you avoided these [LIST JOBS OR TASKS]?

3 = at least two examples

(Have you ever refused a promotion because it would involve dealing with more people than you would be comfortable with?)

- |                                                                                                                          |                                                                                   |                |           |
|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------|-----------|
| <p>2. You've said that [<i>Do</i>] you avoid getting involved with people unless you are certain they will like you.</p> | <p>(2) is unwilling to get involved with people unless certain of being liked</p> | <p>? 1 2 3</p> | <p>26</p> |
|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------|-----------|

If you don't know whether someone likes you, would you ever make the first move?

3 = almost never takes the initiative in becoming involved in a social relationship

- |                                                                                                         |                                                                                                           |                |           |
|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------|-----------|
| <p>3. You've said that [<i>Do</i>] you find it hard to be "open" even with people you are close to.</p> | <p>(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed</p> | <p>? 1 2 3</p> | <p>27</p> |
|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------|-----------|

Why is this? (Are you afraid of being made fun of or embarrassed?)

3 = true for almost all relationships

4. You've said that *[Do]* you often worry about being criticized or rejected in social situations. (4) is preoccupied with being criticized or rejected in social situations ? 1 2 3 28

Give me some examples. 3 = a lot of time spent worrying about social situations

Do you spend a lot of time worrying about this?

5. You've said that you're *[Are you]* usually quiet when you meet new people. (5) is inhibited in new interpersonal situations because of feelings of inadequacy ? 1 2 3 29

Why is that? 3 = acknowledges trait and many examples

(Is it because you feel in some way inadequate, or not good enough?)

6. You've said that *[Do]* you believe that you're not as good, as smart, or as attractive as most other people. (6) views self as socially inept, personally unappealing, or inferior to others ? 1 2 3 30

Tell me about that. 3 = acknowledges belief

7. You've said that you're *[Are you]* afraid to try new things. (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing ? 1 2 3 31

Is that because you are afraid of being embarrassed?

Give me some examples. 3 = several examples of avoiding activities because of fear of embarrassment

AT LEAST FOUR ITEMS ARE CODED "3"

1 3  
↓

32

**AVOIDANT  
PERSONALITY  
DISORDER**

**DEPENDENT  
PERSONALITY DISORDER**

**DEPENDENT  
PERSONALITY DISORDER  
CRITERIA**

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- |                                                                                                                                                                                       |                                                                                                                       |                |           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------|-----------|
| <p>8. You've said that <i>[Do]</i> you need a lot of advice or reassurance from others before you can make everyday decisions—like what to wear or what to order in a restaurant.</p> | <p>(1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others</p> | <p>? 1 2 3</p> | <p>33</p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------|-----------|

3 = several examples

Can you give me some examples of the kinds of decisions you would ask for advice or reassurance about?

(Does this happen most of the time?)

- |                                                                                                                                                                    |                                                                                          |                |           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------|-----------|
| <p>9. You've said that you <i>[Do you]</i> depend on other people to handle important areas in your life such as finances, child care, or living arrangements.</p> | <p>(2) needs others to assume responsibility for most major areas of his or her life</p> | <p>? 1 2 3</p> | <p>34</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------|-----------|

[Note: Do not include merely getting advice from others or subculturally expected behavior.]

3 = several examples

Give me some examples. (Is this more than just getting advice from people?)

(Has this happened with MOST important areas of your life?)

- |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                           |                |           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------|
| <p>10. You've said that [<i>Do</i>] you find it hard to disagree with people even when you think they are wrong.</p> <p>Give me some examples of when you've found it hard to disagree.</p> <p>What are you afraid will happen if you disagree?</p> | <p>(3) has difficulty expressing disagreement with others because of fear of loss of support or approval (Note: Do not include realistic fears of retribution.)</p> <p>3 = acknowledges trait or several examples</p>                                                                                                     | <p>? 1 2 3</p> | <p>35</p> |
| <p>11. You've said [<i>Do</i>] you find it hard to start or work on tasks when there is no one to help you.</p> <p>Give me some examples.</p> <p>Why is that? (Is this because you are not sure you can do it right?)</p>                           | <p>(4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)</p> <p>3 = acknowledges trait</p>                                                                                                  | <p>? 1 2 3</p> | <p>36</p> |
| <p>12. You've said that you have [<i>Have you</i>] often volunteered to do things that are unpleasant.</p> <p>Give me some examples of these kinds of things.</p> <p>Why is that?</p>                                                               | <p>(5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant</p> <p>[Note: Do not include behavior intended to achieve goals other than being liked, such as job advancement.]</p> <p>3 = acknowledges trait and at least one example</p> | <p>? 1 2 3</p> | <p>37</p> |
| <p>13. You've said that [<i>Do</i>] you usually feel uncomfortable when you are by yourself. Why is that? (Is it because you need someone to take care of you?)</p>                                                                                 | <p>(6) feels uncomfortable or helpless when alone, because of exaggerated fears of being unable to care for himself or herself</p> <p>3 = acknowledges trait</p>                                                                                                                                                          | <p>? 1 2 3</p> | <p>38</p> |

? = inadequate information

1 = absent or false

2 = subthreshold

3 = threshold or true

14. You've said that when a close relationship ends you *[When a close relationship ends, do you]* feel you immediately have to find someone else to take care of you. (7) urgently seeks another relationship as a source of care and support when a close relationship ends ? 1 2 3 39  
 3 = happens when most close relationships end

Tell me about that.

(Have you reacted this way almost always when close relationships have ended?)

15. You've said that *[Do]* you worry a lot about being left alone to take care of yourself. (8) is unrealistically preoccupied with fears of being left to take care of himself or herself ? 1 2 3 40

Are there often times when you keep worrying about this? 3 = persistent unrealistic worry

Do you have periods when you worry about this all the time?

AT LEAST FIVE ITEMS ARE CODED "3"

1 3  
 ↓  
**DEPENDENT PERSONALITY DISORDER**



OBSESSIVE-COMPULSIVE  
PERSONALITY DISORDEROBSESSIVE-COMPULSIVE  
PERSONALITY DISORDER  
CRITERIA

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- |                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                             |                |           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------|
| <p>16. You've said that you are [<i>Are you</i>] the kind of person who focuses on details, order, and organization or likes to make lists and schedules.</p> <p>Give me some examples.</p> <p>Do you sometimes get so caught up with [EXAMPLES] that you lose sight of what you are trying to accomplish? (. . . Like you can't see the forest for the trees?)</p> <p>(Does this happen often?)</p> | <p>(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost</p> <p>3 = acknowledges trait and at least one example</p>                                                                   | <p>? 1 2 3</p> | <p>42</p> |
| <p>17. You've said that [<i>Do</i>] you have trouble finishing jobs because you spend so much time trying to get things exactly right.</p> <p>Give me some examples.</p> <p>(How often does this happen?)</p>                                                                                                                                                                                        | <p>(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)</p> <p>3 = several examples of tasks not completed or significantly delayed because of perfectionism</p> | <p>? 1 2 3</p> | <p>43</p> |

? = inadequate information

1 = absent or false

2 = subthreshold

3 = threshold or true

<p>18. You've said that you or other people feel that you <i>[Do you or other people feel that you]</i> are so devoted to work (or school) that you have no time left for anyone else or for just having fun.</p> <p>Tell me about it.</p>	<p>(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)</p> <p>[Note: Also not accounted for by temporary job requirements.]</p> <p>3 = acknowledges trait or has been told by other people</p>	<p>? 1 2 3</p>	<p>44</p>
<p>19. You've said that <i>[Do]</i> you have very high standards about what is right and what is wrong.</p> <p>Give me some examples of your high standards.</p> <p>(Do you follow rules to the letter of the law, no matter what?)</p> <p>IF GIVES RELIGIOUS EXAMPLE: Do even people who share your religious views say you're too strict about right and wrong?</p>	<p>(4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)</p> <p>3 = several examples of holding self or others to rigidly high moral standards</p>	<p>? 1 2 3</p>	<p>45</p>
<p>20. You've said that <i>[Do]</i> you have trouble throwing things out because they might come in handy some day.</p> <p>Give me some examples of things that you're unable to throw out.</p> <p>(How cluttered does your place get because you don't throw things out?)</p>	<p>(5) is unable to discard worn-out or worthless objects even when they have no sentimental value</p> <p>3 = results in a cluttered environment</p>	<p>? 1 2 3</p>	<p>46</p>

? = inadequate information    1 = absent or false    2 = subthreshold    3 = threshold or true

21. You've said that it is *[Is it]* hard for you to let other people help you unless they agree to do things exactly the way you want. (6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things ? 1 2 3 47

Tell me about that. (Does this happen often?)

3 = acknowledges trait and at least one example

(Do you often end up doing things yourself to make sure they are done right?)

22. You've said that it is *[Is it]* hard for you to spend money on yourself and other people even when you have enough. (7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes ? 1 2 3 48

Why? (Is this because you're worried about not having enough in the future when you really need it?)

3 = acknowledges trait and at least one example

Tell me about some things you haven't spent money on because you have to save for the future.

23. You've said that you are *[Are you]* often so sure you are right that it doesn't matter what other people say. (8) shows rigidity and stubbornness ? 1 2 3 49

Tell me about it.

3 = acknowledges trait or has been told by other people

24. You've said that other people have told you *[Have other people told you]* that you are stubborn or rigid.

Tell me about that.

**AT LEAST FOUR ITEMS ARE CODED "3"**

1 3 50

**OBSESSIVE-COMPULSIVE PERSONALITY DISORDER**



**MCMII-III™**  
MILLON™ CLINICAL  
MULTIAXIAL INVENTORY-III

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**MCMII-III™**  
**Millon™ Clinical Multiaxial Inventory-III**  
**Interpretive Report with Grossman Facet Scales**  
*Theodore Millon, PhD, DSc*

---

Name: Joan Sample  
ID Number: 12566  
Age: 44  
Gender: Female  
Setting: Outpatient Never Hospitalized  
Race: White  
Marital Status: Divorced  
Date Assessed: 02/12/2011

**PEARSON**

 **PsychCorp**

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**TRADE SECRET INFORMATION**

Not for release under HIPAA or other data disclosure laws that exempt trade secrets from disclosure.

## CAPSULE SUMMARY

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to patients or their relatives.

### Interpretive Considerations

The client is a 44-year-old divorced white female with 15 years of education. She is currently being seen as an outpatient, and she did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

This patient's response style may indicate a tendency to magnify illness, an inclination to complain, or feelings of extreme vulnerability associated with a current episode of acute turmoil. The patient's scale scores may be somewhat exaggerated, and the interpretations should be read with this in mind.

### Profile Severity

On the basis of the test data, it may be assumed that the patient is experiencing a severe mental disorder; further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity.

### Possible Diagnoses

She appears to fit the following Axis II classifications best: Borderline Personality Disorder, and Negativistic (Passive-Aggressive) Personality Disorder, with Dependent Personality Traits, and Depressive Personality Traits.

Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Major Depression (recurrent, severe, without psychotic features), Generalized Anxiety Disorder, and Posttraumatic Stress Disorder.

### Therapeutic Considerations

Inconsistent and pessimistic, this patient may expect to be mishandled, if not harmed, even by well-intentioned therapists. Sensitive to messages of disapproval and lack of interest, she may complain excessively and be irritable and erratic in her relations with therapists. Straightforward and consistent communication may moderate her dependent/negativistic attitude. Focused, brief treatment approaches are likely to overcome her initial oppositional outlook.

*This section summarizes the patient's demographics, reported complaints, duration of disorder, severity of difficulties, possible DSM-IV diagnoses, and likely course of treatment.*

*Scale W works in a complementary fashion with the existing "V" scale to better detect random responding.*

MILLON CLINICAL MULTIAXIAL INVENTORY - III

*These indices measure validity.*

CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

INVALIDITY (SCALE V) = 0 INCONSISTENCY (SCALE W) = 4  
 PERSONALITY CODE: 8A 3 2B \*\* 2A \* 8B 1 6A + 6B 5 " 7 4 ' ' // C \*\* - \* //  
 SYNDROME CODE: A D \*\* T R \* // CC \*\* - \* //  
 DEMOGRAPHIC CODE: 12566/ON/F/44/W/D/15/--/--/-----/4/-----/

CATEGORY	SCORE	PROFILE OF BR SCORES					DIAGNOSTIC SCALES		
		RAW	BR	0	60	75		85	115
MODIFYING INDICES	X	166	94	[Bar chart showing score 94]					DISCLOSURE
	Y	4	20	[Bar chart showing score 20]					DESIRABILITY
	Z	28	90	[Bar chart showing score 90]					DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	15	68	[Bar chart showing score 68]					SCHIZOID
	2A	20	82	[Bar chart showing score 82]					AVOIDANT
	2B	21	85	[Bar chart showing score 85]					DEPRESSIVE
	3	20	86	[Bar chart showing score 86]					DEPENDENT
	4	7	11	[Bar chart showing score 11]					HISTRIONIC
	5	12	39	[Bar chart showing score 39]					NARCISSISTIC
	6A	14	65	[Bar chart showing score 65]					ANTISOCIAL
	6B	14	56	[Bar chart showing score 56]					SADISTIC
	7	8	15	[Bar chart showing score 15]					COMPULSIVE
	8A	24	93	[Bar chart showing score 93]					NEGATIVISTIC
8B	15	70	[Bar chart showing score 70]					MASOCHISTIC	
SEVERE PERSONALITY PATHOLOGY	S	16	65	[Bar chart showing score 65]					SCHIZOTYPAL
	C	23	93	[Bar chart showing score 93]					BORDERLINE
	P	15	68	[Bar chart showing score 68]					PARANOID
CLINICAL SYNDROMES	A	17	97	[Bar chart showing score 97]					ANXIETY
	H	13	66	[Bar chart showing score 66]					SOMATOFORM
	N	11	71	[Bar chart showing score 71]					BIPOLAR: MANIC
	D	17	88	[Bar chart showing score 88]					DYSTHYMIA
	B	8	68	[Bar chart showing score 68]					ALCOHOL DEPENDENCE
	T	14	76	[Bar chart showing score 76]					DRUG DEPENDENCE
	R	18	76	[Bar chart showing score 76]					POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	17	70	[Bar chart showing score 70]					THOUGHT DISORDER
	CC	21	100	[Bar chart showing score 100]					MAJOR DEPRESSION
	PP	7	63	[Bar chart showing score 63]					DELUSIONAL DISORDER

*A score of 75 and above is considered clinically elevated.*

## I. The pervasive avoidance of personality assessment within medical-legal claims

Excerpt from the working draft of the Mental Illness chapter of the forthcoming *Second Edition* of the *AMA Guides to the Evaluation of Disease and Injury Causation* (note – these scientific findings were also discussed in the first edition):

### *The pervasive violation of diagnostic standards within legal claims*

*Relevant scientific investigation was conducted specifically for the first edition of this book. A review of files from workers compensation claims that were in the primary author's (RJB) possession at the time of the creation of the first edition of the causation Guides was undertaken, in order to investigate the actual nature of diagnostic assertions that occur within legal claims. The review included 632 claims of occupational mental illness which involved the diagnostic evaluation having been conducted by a mental health specialist.*

*Analysis of the clinical documentation from those files revealed that approximately 43% involved a diagnostic claim that did not involve a DSM-IV-TR mental illness construct. Frequent examples included diagnostic claims that were similar to the invented labels that were discussed above, as well as "anxiety", "occupational stress", "anxiety disorder due to work-related injury", "depression due to work related injury", "personality change due to occupational trauma", "alcohol abuse due to occupational stress", "work-related drug abuse", "chronic pain due to work-related injury", and "substance abuse due to work-related pain".*

*Consequently, based on this review of files, and based on the aggregate reports from the various agencies, it is clear that occupational mental illness claims are afflicted by a trend toward invented "diagnoses".*

*That review of actual files also provided systematic verification of another trend that had been informally witnessed previously: a pervasive lack of utilization of diagnostic evaluation standards, even when a recognized mental illness was claimed. In explanation:*

- *The DSM-IV-TR provides a diagnostic protocol for every recognized mental illness. Those protocols are the gold standard for determining whether an individual has a mental illness, and which mental illness is involved.*
- *In order to justify a diagnosis of mental illness, the diagnostician must (at a minimum) document utilization of the relevant protocol, and a description of how the examinee's presentation satisfies the requirements of that protocol.*
- *In the files that were reviewed, when a recognized mental illness construct was being claimed, documentation of the protocol that would be necessary in order to justify that diagnosis was absent 91% of the time. In other words, even when a recognized mental illness construct is being claimed, the claim is almost never justified at even a minimal level.*

*The results were even more profound in regard to diagnostic standards for personality disorder constructs. This issue is of primary importance for legal claims, given findings such as a 73% rate of personality disorders among people who claim disabling back pain*

*in a claims context (when the possibility of a personality disorder is actually assessed) (Dersh). Despite the critical importance of assessing for personality disorder constructs, the review process revealed that this standard part of the diagnostic process is reliably avoided when a legal claim is involved. In almost every file that was reviewed (>99%), this portion of the diagnostic process was either "deferred" without explanation and without documented follow-up, concluded with a claim of that there was no personality disorder without any documentation of utilization of the diagnostic protocols that would have been necessary in order to justify this conclusion, or simply not mentioned.*

*Many of the involved files have been part of utilization review programs that afforded the primary author (RJB) an opportunity to directly speak to the clinicians who created the documentation, and ask why this critical portion of the evaluation process had been avoided. Most responses fell into one of the following four categories:*

- *The first category involved clinicians who did not understand the question, and offered responses which revealed that they had little to no understanding of diagnostic standards (it is again emphasized that every one of these clinicians claimed to be a licensed mental health specialist). As was the case in regard to the findings for Pain Disorder as discussed above, this finding revealed that widespread incompetence among mental health specialists is one explanation for the manner in which claims of mental illness have inappropriately become commonplace in legal systems.*
- *The second category involved a report that the clinician realized that any personality disorder would, by definition, not be a claim-related issue, and they subsequently avoided that standard portion of the diagnostic process in order to avoid mixing claim-related issues with non-claim-related issues. The obvious problem with this response is that such an approach could lead to misdirected conclusions of claim-related causation (due to a personality disorder being the dominant causative factor, but being overlooked), and to unnecessary exposure of the claimant to the reliably detrimental health effects of involvement in legal claims (Binder & Rohling; Harris et al.; Rohling et al.).*
- *The third category of responses involved reports that this standard portion of the evaluation process had been avoided because workers compensation payers do not reimburse for mental health evaluations in a manner that would be sufficient to justify the extensive time that is involved in a personality disorder evaluation. These clinicians typically acknowledged that their work had been less than complete, and less than adequate, but claimed that such substandard services were necessary because of the inadequate reimbursement that was available within the workers compensation system. This creates the same jeopardy for the claimant that was discussed in the previous bullet point.*
- *The fourth category of responses involved clinicians specifying that they avoided investigating the possibility of a personality disorder because if they had discovered a personality disorder, that discovery would have caused the clinical presentation to be identified as non-claim-related. The claimant would have consequently lost benefits, and the clinician would not be paid for the evaluation or the treatment that they wanted to provide for the claimant. The clinicians who offered such reports indicated that they believed that the financial benefits for themselves and the claimant somehow justified their violation of diagnostic standards. This set of circumstances creates the same jeopardy for the claimant that was discussed in the previous two bullet points.*



**J. The diagnostic constructs for personality disorders are about to change**

Moran M. APA Board Approves DSM-5; Release Scheduled for May 2013. *Psychiatric News*, December 21, 2012. Volume 47 Number 24 page 1-22. American Psychiatric Association

“One crucial overarching change is the elimination of the multiaxial system that had placed diagnoses such as depression, anxiety, bipolar, and schizophrenia on Axis I and personality disorders on Axis II.”

Grohol JM. Final DSM 5 Approved by American Psychiatric Association. PsychCentral: <http://psychcentral.com/blog/archives/2012/12/02/final-dsm-5-approved-by-american-psychiatric-association/>  
Accessed 01-14-2013

“Personality disorders: DSM-5 will maintain the categorical model and criteria for the 10 personality disorders included in DSM-IV and will include the new trait-specific methodology in a separate area of Section 3 to encourage further study of how this could be used to diagnose personality disorders in clinical practice.”

What about the SCID?

“Development efforts are underway for the SCID for DSM-5 and updated training materials, which are expected to be released in the fall/winter 2013.”

American Psychiatric Association website, accessed 01-14-2013: <http://www.scid4.org/>

**BARTHNeuroScience**

**Personality and the Occupational “Injury” Claimant**

**Robert J. Barth, Ph.D.**  
 Chattanooga, TN  
 Offices also maintained in Nashville, Birmingham, and Atlanta

**BARTHNeuroScience**

**Overview**

**Dr. Tonn asked:**  
**“Is there a certain type of personality that is associated with filing claims?”**

*“Is there a certain type of personality that is associated with filing claims?”*

**Yes!**

**In fact, there are several.**

**Here’s an easy example...**


**BARTHNeuroScience**

***Histrionic Personality***

*Just one example of the personality styles that play a dominant role in claims*

**Histrionic Personality**

**BARTHNeuroScience**



**Histrionic Personality**

**BARTHNeuroScience**

- Dramatic, almost always putting on an act, almost never genuine
- **Wants to be the center of attention**
- Might claim to have millions of best friends, but relationships are actually superficial
- Tries to “pull people in” (sometimes referred to as seductive, provocative, devious)

**73% of chronic disabling neck or back pain claimants have a personality disorder, and 30% had one specific type of personality disorder...**



## **Paranoid Personality Disorder**

### Paranoid Personality Disorder



### Paranoid Personality Disorder



- Suspicious - sees imminent threats (everywhere), and insults, where there are none
- Non-trusting
- Holds grudges



### Complex Regional Pain Syndrome (CRPS / "RSD" claims)

Primarily a litigation/compensation-driven phenomenon  
**60% of CRPS patients have some form of personality disorder**  
**28% of CRPS ("RSD") patients were found to have one specific personality disorder...**

**28% of CRPS ("RSD") patients were found to have one specific personality disorder**



## **Obsessive Compulsive Personality Disorder**

**Note: We are NOT talking about Obsessive Compulsive Disorder**

### Obsessive Compulsive Personality Disorder



Obsessive Compulsive  
Personality Disorder

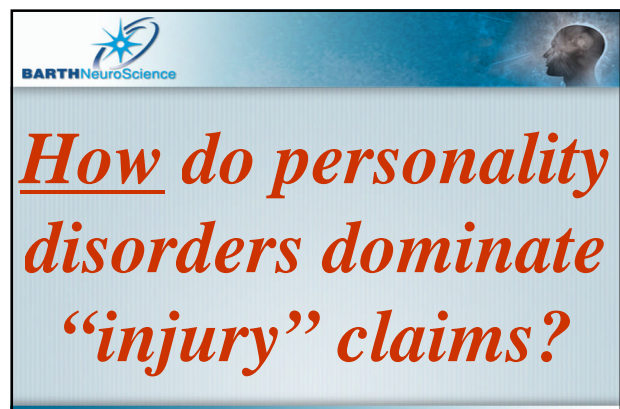


- Perfectionist
- Detail oriented
- Organized
- Extremely moral
- Devoted to work (workaholic?)
- “If you want something done right, you have got to do it yourself”
- Rigid, stubborn

Obsessive Compulsive  
Personality Disorder and Claims



For reasons that are not at all clear these people have an extremely high risk of developing physical complaints in the absence of general medical findings and even a high risk of claiming to be disabled by such complaints especially once they reach middle age.



How do personality disorders  
dominate “injury” claims?



Four basic mechanisms:

1. People with personality disorders are more likely to file legal claims of all kinds (not just “injury” claims).

How do personality disorders  
dominate “injury” claims?



1. More likely to file legal claims of all kinds

- They do not notice that their personality is problematic
- They do not see the role that they play in causing problems for themselves
- They place all of the blame for anything onto other people
- Consequently, they file lawsuits at a high rate.

How do personality disorders  
dominate "injury" claims?



Four basic mechanisms:

**2. People with personality disorders have more accidents and injuries.**

How do personality disorders  
dominate "injury" claims?



2. People with personality disorders  
have more accidents and injuries.

- Accidents and injuries are not randomly distributed throughout the population
- **A small fraction of the world's population accounts for the majority of accidents and injuries**
- Personality is one of the primary risk factors for the occurrence of accidents and injuries

How do personality disorders  
dominate "injury" claims?



Four basic mechanisms:

**3. People with personality disorders have worse health (all types of health).**

How do personality disorders  
dominate "injury" claims?



3. People with personality disorders  
have worse health (all types of health).

- **They have a higher frequency of health problems**
- Almost any health problem seems to have a more severe manifestation for people with personality disorders.
- **Apparent reasons include...**

Apparent reasons why personality  
disorders lead to worse health in general



Personality disorders are associated with  
elevated rates of:

- over-reacting to health problems
- Smoking
- Other forms of substance abuse
- Inadequate physical fitness

Continued...

Apparent reasons why personality  
disorders lead to worse health in general



Personality disorders are associated with  
elevated rates of:

- Treatment noncompliance
- Dysfunctional interactions with clinicians
- a lack of motivation for improvement of health complaints
- Etc.

How do personality disorders  
dominate “injury” claims?



Four basic mechanisms:

**4. Always looking  
(consciously or subconsciously)  
for some way to escape from  
responsibilities**



**Developing An Understanding  
of Claims that Cannot Be  
Credibly Explained Through  
General Medical Findings**

**Understanding of Claims that Cannot Be  
Credibly Explained Through General  
Medical Findings**



**1. Gather up, and present, the  
general scientific information  
evaluation results regarding the  
lack of explanatory general  
medical findings.**

**Understanding of Claims that Cannot Be  
Credibly Explained Through General  
Medical Findings**



**2. Arrange for competent  
general medical consultation  
in order to highlight the lack  
of significant general medical  
findings for this individual  
case.**

**Understanding of Claims that Cannot Be  
Credibly Explained Through General  
Medical Findings**



**3. Gather up, and present, the  
general scientific information  
regarding the overwhelming  
dominance of psychological (e.g.  
personality disorders) and social  
factors (eligibility for  
compensation) in such claims.**

**Understanding of Claims that Cannot Be  
Credibly Explained Through General  
Medical Findings**



**4. Arrange for competent  
psychology consultation in  
order to highlight the  
prominence of psychological  
risk factors for such claims in  
this individual case.**

## Key Strategies



For any claim that lacks crystal clear, inarguable, scientifically credible justification for claims of work-relatedness...

- Assume that non-work-related factors (such as a personality disorder) are playing a role.
- Investigate for such psychological and social factors
- In most cases, you will end up with a lack of general medical facts supporting the claim, and a wealth of non-injury-related facts that contradict the claim.



*Personality disorders  
that are most  
common in claims  
And how to deal with them*

## Histrionic Personality Disorder



## Histrionic Personality Disorder



- Dramatic, almost always putting on an act, almost never genuine
- Wants to be the center of attention
- Might claim to have millions of best friends, but relationships are actually superficial
- Tries to “pull people in” (sometimes referred to as seductive, provocative, devious)

## Histrionic Personality Disorder and “Injury” Claims



- Prone to feeling overwhelmed by normal life/work demands
- Can develop physical symptoms as a means of escaping responsibility when feeling overwhelmed (they might not otherwise admit to being overwhelmed)
- Also prone to developing physical symptoms in order to make sure they are the center of attention

## Personality disorders that are most common in claims



## Obsessive Compulsive Personality Disorder

Note: We are NOT talking about  
Obsessive Compulsive Disorder

Obsessive Compulsive  
Personality Disorder



Obsessive Compulsive  
Personality Disorder



- Perfectionist
- Detail oriented
- Organized
- Extremely moral
- Devoted to work (workaholic?)
- “If you want something done right, you have got to do it yourself”
- Rigid, stubborn

Obsessive Compulsive  
Personality Disorder and Claims



For reasons that are not at all clear these people have an extremely high risk of developing physical complaints in the absence of general medical findings and even a high risk of claiming to be disabled by such complaints especially once they reach middle age.

Personality disorders that  
are most common in claims



# Paranoid Personality Disorder

Paranoid Personality Disorder



Paranoid Personality Disorder



- Suspicious - sees imminent threats (everywhere), and insults, where there are none
- Non-trusting
- Holds grudges



Paranoid Personality Disorder  
and claims



In that project that found a 70%  
rate of personality disorders  
among claimants with disabling  
chronic back pain,  
30% (of the total) had Paranoid  
Personality Disorder.

Personality disorders that  
are most common in claims



**Borderline  
Personality  
Disorder**

Borderline Personality Disorder



Borderline Personality Disorder



- Some of the craziest people you will ever meet
- Incredibly unreliable in their presentation, emotions, beliefs, desires, etc.
- Prone to rage
- Attempts to cause friction between other people
- Tend to go from thinking someone is wonderful to thinking that the same person is terrible
- Becomes suspicious or spaced out under stress
- Spontaneous / reckless

Borderline Personality Disorder  
and Claims



Perhaps more than any  
other personality type,  
**Prone to filing lawsuits**  
(often motivated by rage  
that they cannot control)

Personality disorders that  
are most common in claims



**Schizotypal  
Personality  
Disorder**

### Schizotypal Personality Disorder



### Schizotypal Personality Disorder



- **Just plain weird** – odd beliefs, magical thinking, acts noticeably weird, looks weird, misunderstands many things (a breeze causes them to think someone just touched them).
- **Almost /sometimes psychotic** – actually genetically related to schizophrenia.
- **Socially very anxious**
- **Has difficulty making friends, not sure if they want any**
- **Emotionally off** (laughs at something that upsets everyone else in the work place)

### Schizotypal Personality Disorder and Claims



- Prone to developing physical complaints in the absence of medical findings (including bizarre complaints).
- Prone to misinterpreting normal or minor problems as an indication that he/she has serious health problems.
- Prone to making illogical decisions (e.g. filing claims inappropriately; hiring the worst lawyers; interacting with claims management, doctors, and everyone else in a dysfunctional way, etc.).

### Personality disorders that are most common in claims



## Dependent Personality Disorder

### Dependent Personality Disorder



### Dependent Personality Disorder



- **Unable to make decisions for him/herself.**
- **Needs lots of advice, direction, and reassurance from others.**
- **Non-assertive.**
- **Has difficulty handling tasks/projects alone (because of self-doubt).**
- **Cannot tolerate being alone.**
- **Lack of confidence.**

### Dependent Personality Disorder and Claims



- Often give in to their essential **helplessness**, by developing physical complaints, filing an occupational injury claim, claiming to be disabled, and withdrawing from the world.
- Dr. Tonn and I have both seen cases where the claimant's dependent personality caused them to pursue a bogus claim that was actually being driven by their spouse.
- **Extremely vulnerable to exploitation by corrupt doctors (e.g. doctors who promote claims).**

### Personality disorders that are most common in claims



## Antisocial Personality Disorder

### Antisocial Personality Disorder



### Antisocial Personality Disorder



- Just plain crooks (although often in a socially acceptable way – doctors, lawyers, business executives, politicians, etc.)
- No conscience (no concern about morality, right vs. wrong, responsibility, other people, etc.)
- “Laws and rules do not apply to me”
- Impulsive / reckless
- Manipulative
- Aggressive, cruel, bullying, etc.
- Prone to substance abuse
- Often have a criminal history

### Antisocial Personality Disorder and Claims



- These are the people who are consciously and deliberately filing fraudulent claims (and almost always getting rewarded for doing so – at least in normal workers comp systems)
- Often “new hires” who quickly file a claim
- Often have a spotty work history, and multiple occupational injury claims

### Personality disorders that are most common in claims



## Avoidant Personality Disorder

### Avoidant Personality Disorder



### Avoidant Personality Disorder



- Shy
- “Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection”
- Leads a restrained, inhibited life in general, again because of constant fear of being disliked, ridiculed, criticized, embarrassed, etc.
- “Views self as socially inept, personally unappealing, or inferior to others”
- Might accidentally create an impression of cold unfriendliness.

### Avoidant Personality Disorder and Claims



- “Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection”
- Often give in to their fears, by developing physical complaints, filing an occupational injury claim, claiming to be disabled, and withdrawing from the world.

### Personality disorders that are most common in claims



## Narcissistic Personality Disorder

### Narcissistic Personality Disorder



**Skipper:** Mr. Howell, You don't know what it's like out there in the ocean, you may be bitten by a shark!

**Thurston:** A shark bite a Howell, ha ha he wouldn't dare.

**Skipper:** Besides, we don't have room for your luggage.

**Thurston:** Well that's different. If I can't go first class, I won't go at all.

### Narcissitic Personality Disorder



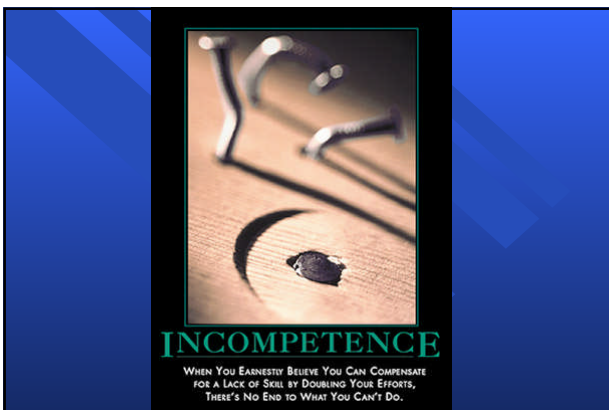
- Believes that he or she deserves special treatment, because he or she simply IS special (better than everybody else)
- Arrogant
- extreme preoccupation with himself or herself

**Narcissistic Personality Disorder and Claims**



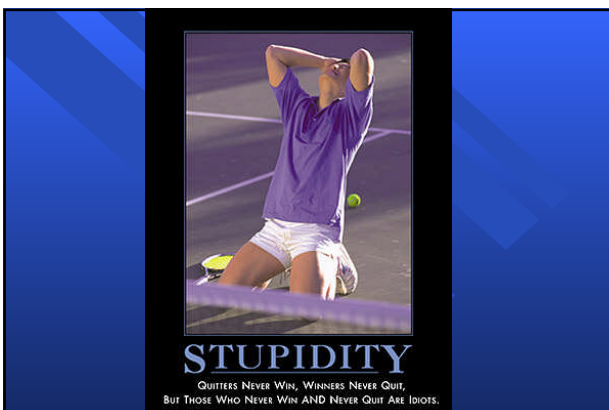
- Often preoccupied with health – with every tiny physical problem that comes to their attention
- Expects others to take every trivial physical complaint VERY seriously
- “Hypochondriacs”
- Hypochondriasis is common

# Case Study



## Case Study

- 60 yo female.
- History:
  - Claiming disability from low back pain of 20 years duration.
  - Six fusions.
  - For the second time in four years, a pain specialist anesthesiologist is recommending spinal cord stimulation.



## Case Study

- Mood disorder?
    - Treating doctor, citing his years of experience with the claimant, insists that her depression is nothing more than a normal reaction to her chronic pain and disability.
    - Records (and eventually interview) reveal pre-pain Major Depressive Disorder, Recurrent (with multiple episodes prior to the pain complaints).
- (continued)

## Case Study

### ■ Mood disorder?

- Testing reveals depression elevations beyond the typical effects of pain complaints and physical injury (despite minimizing response pattern).
- Diagnostic work-up never before attempted in 35 years of Major Depressive Disorder, Recurrent, or in 16 years of pain complaints.

## Case Study

### ■ Anxiety disorder?

- Treating doctor, citing his years of experience with the claimant, insists that all of her psychological problems are normal reactions to her chronic pain and disability.
- Records (and eventually interview) reveal pre-pain Panic Disorder, and treatment for non-pain-related anxiety.

## Case Study

### ■ Personality disorder?

- Treating doctor, citing his years of experience with the claimant, insists that all of her psychological problems are normal reactions to her chronic pain and disability.
- Testing reveals consistency with Dependent Personality Disorder and Obsessive Compulsive Personality Disorder (despite minimizing response patterns).



**LOSING**

IF AT FIRST YOU DON'T SUCCEED,  
FAILURE MAY BE YOUR STYLE.

## Case Study

### ■ Somatoform disorder?

- Consistency with Somatization Disorder (extremely wide variety of pain, stomach, sexual, and pseudo-neurological complaints; dating back to her 20's). (continued)

## Case Study

### ■ Somatoform disorder?

- Doctors have previously specified somatoform issues for claimant's chest pain, sweating, dizziness, fainting, hot flashes, blood pressure problems, blood sugar problems, and gastro-intestinal problems.

## Case Study

### ■ Somatoform disorder?

- Back pain presentation involved several of Waddell's indications of pain which is more likely due to psychological problems rather than physiological explanations.
- Back pain onset and exacerbation associated with family health crises.

## Case Study

### Recommendations:

Spinal cord stimulation is a bad idea for this claimant:

- Unlikely to benefit her.
- Inconsistent with her stated goals.
- Risk of worsening mood and somatoform disorder presentations.

## Case Study

### Recommendations:

Standard set of recommendations for chronic low back pain:

- preventing/avoiding dependence on medical treatment,
- emphasizing coping with symptoms rather than attempting to eliminate them,
- avoiding "as needed" medication regimens,

(continued)

## Case Study

### Recommendations:

Standard set of recommendations for chronic low back pain:

- avoiding long-term drug treatment,
- gradually increasing activities,
- exercise therapy that involves gradually increasing the intensity of the exercise at fixed periods independent of the presence of pain.

(continued)

## Case Study

### Recommendations:

Standard set of recommendations for chronic low back pain:

- **The risks associated with over-treatment are greater than the risks associated with under-treatment.**

- The American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines (Second Edition).

## Case Study

### Recommendations:

Mental health care (to take place outside of the workers' compensation system):

- Major Depressive Disorder, Recurrent;
- panic;
- additional anxiety problems;
- somatoform considerations;
- personality disorder considerations;

(continued)

## Case Study

### Recommendations:

Mental health care (to take place *outside* of the workers' compensation system):

- temporal correlations between life stress/concerns and her pain complaints;
- the consistency of her test results with individuals who attempt to control others by complaining of physical symptoms and who use their physical complaints as a means of gaining attention (especially in light of her report that her husband is otherwise a "workaholic");
- the tendency for individuals who experienced childhood abuse to adopt self-defeating disability behaviors.

## Case Study

### Recommendations:

**Maintaining/returning to work is reliably beneficial for a patient's health (both low back pain and mental health).**

## Note:

I have presented this in a manner that reveals it to be a complicated mess that will require extensive intervention to straighten out, but...

Through 20 years of medical care for low back pain, all treating doctors had perceived it to be an uncomplicated and typical case of low back pain.