

July 2008

# The Diagnosis Project

A Preliminary Analysis of Specific Mental Health  
Employment Barriers Present in Clients Enrolled in  
The HOPE Program between July 2006 and June 2007

*A. Jordan Wright, Ph.D., Debbie-Ann Chambers, The HOPE Staff*



The aim of The HOPE Diagnosis Project is to begin to understand in more depth what specific mental health barriers to work are present in the population of The HOPE Program, as well as to understand how well different types of people are being served by the program.

This preliminary report describes the breakdown of diagnosable mental disorders that are present in the population of 170 students who enrolled in The HOPE Program from July 2006 to June 2007.

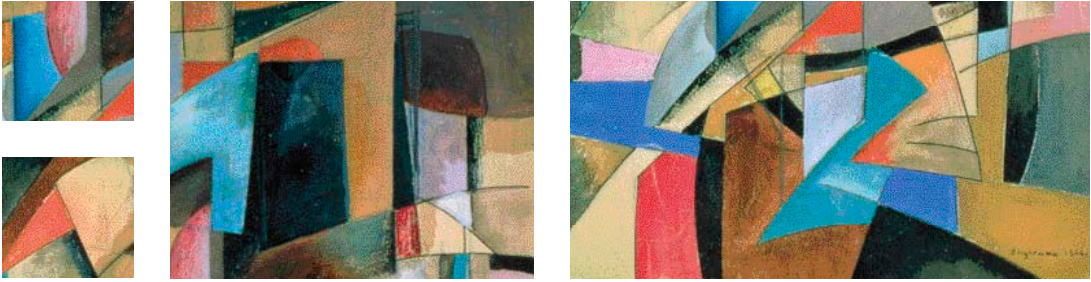
## Diagnosis

The aim of diagnosing an individual with any mental disorder is to better understand and communicate about clusters of symptoms that may impair his or her functioning. Diagnosable mental illness constitutes patterns of behaving that have developed in response to whatever obstacles an individual has had to endure throughout his or her lifetime. Whereas these patterns were at one time crucial to survival, they are currently not effective or adaptive and are impairing functioning. The driving question when diagnosing a mental disorder is "What is impairing this individual's functioning?" Specifically, at The HOPE Program, we are interested in what is getting in the way of each individual being able to find and/or sustain work and independent living.

Diagnosis consists of two major categories, referred to as Axes.

**Axis I** includes all disorders that are generally believed to be medically or biologically-based and situational or temporary; these disorders are referred to as Clinical Disorders. Included are Mood Disorders such as Depression and Bipolar Disorder, Anxiety Disorders, Psychotic Disorders, Eating and Sleep Disorders, and Adjustment Disorders. Also included on this axis are Substance Use Disorders which include substance abuse, dependence, withdrawal, intoxication, or other use disorders.

**Axis II** includes disorders that are generally believed to be much more pervasive and characterological; these disorders are referred to as Personality Disorders. Included are Cluster A Disorders (including Paranoid, Schizoid, and Schizotypal Personality Disorders). These disorders are generally odd or eccentric. Cluster B Disorders (including Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders) generally present as erratically emotional and dramatic. Cluster C Disorders (including Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders) usually present as anxious or fearful. Additionally, there is a diagnosis called Personality Disorder Not Otherwise Specified (PD NOS). This diagnosis includes Depressive Personality Disorder, which is characterized by a pervasive pessimism and bias toward negativity.



## Personality Functioning and Emotional Presentation

A useful way of conceptualizing personality and emotional functioning is an interactional model. Individuals create personality structures or styles based on the resources available to them and their developmental needs growing up. For example, an individual raised on the streets may need to present him- or herself in an overly narcissistic and grandiose way to survive that culture. This might constitute a Narcissistic Personality Style. However, in interaction with the current environment and stressors (e.g., the work world, which is very different from the street world), this personality style likely will not work. When the personality style impairs functioning in any way, it becomes a Personality Disorder (or Axis II Disorder). The interaction between that Personality Disorder and current stressors may lead to a presentation of Axis I Disorder symptoms. For example, this same individual with a Narcissistic Personality Disorder, in combination with the stress of being supervised on a job, may become anxious or depressed. Thus, Axis I Disorders can be seen as current manifestations of the interaction between personality and environmental stressors.

## Methodology

At The HOPE Program, great care is taken to incorporate a general understanding of each student's cultural, developmental, and personal background when attempting to understand what is currently impairing functioning. To that end, multiple methods of evaluation are employed when determining a diagnosis. Psychological assessment is utilized in order to gain insight into individuals' functioning that they themselves may not be able to report readily. Both objective and projective measures are used to evaluate students from different perspectives. Additionally, however, a strengths-based, structured clinical interview is used to gain context for the findings from the psychological assessment. Through analysis by the mental health team, diagnoses are decided upon.

## Preliminary Findings—Prevalence

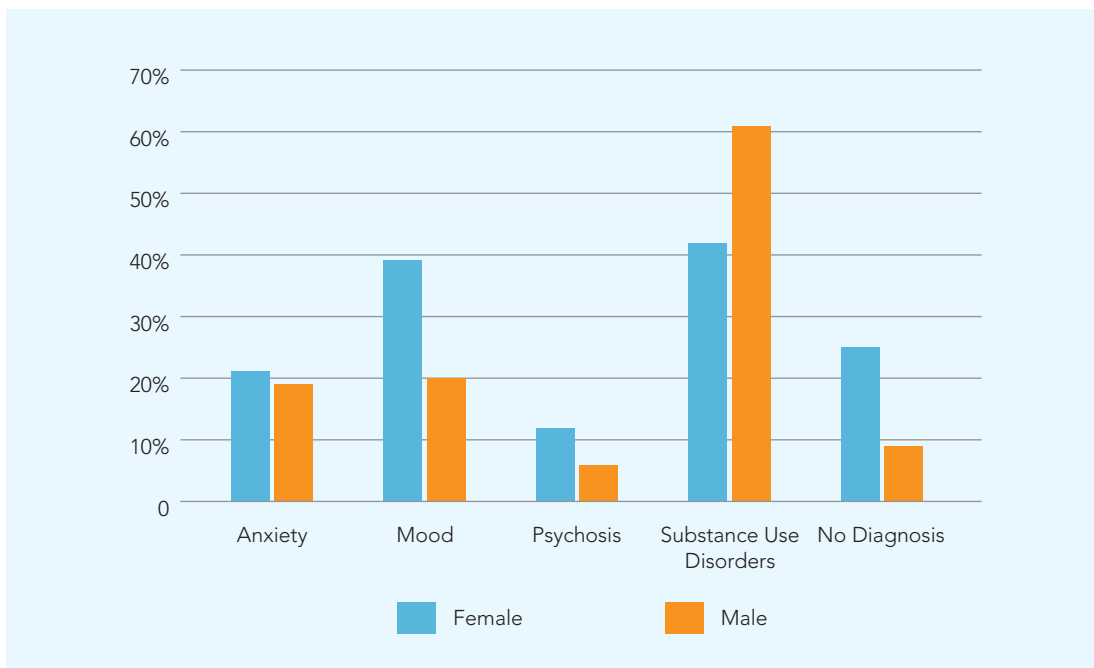
Based on a sample of 170 recent students enrolled in The HOPE Program, preliminary findings regarding rates and characteristics of mental disorders in our population are being presented.

# Axis I Disorders

80% meet criteria for an Axis I diagnosis.

- o 52% meet criteria for an Axis I diagnosis, not including Substance Use Disorders.
- 24% meet criteria for an **Anxiety Disorder** (including Posttraumatic Stress Disorder, Generalized Anxiety Disorder, and Social Phobia).
- 34% meet criteria for a **Mood Disorder** (including Depression and Bipolar Disorder).
- 11% meet criteria for a **Psychotic Disorder** (including Delusional Disorder and Schizophrenia).
- o 59% meet criteria for **Substance Use Disorders** on Axis I.
- o 39% meet criteria for more than one Axis I Disorder.

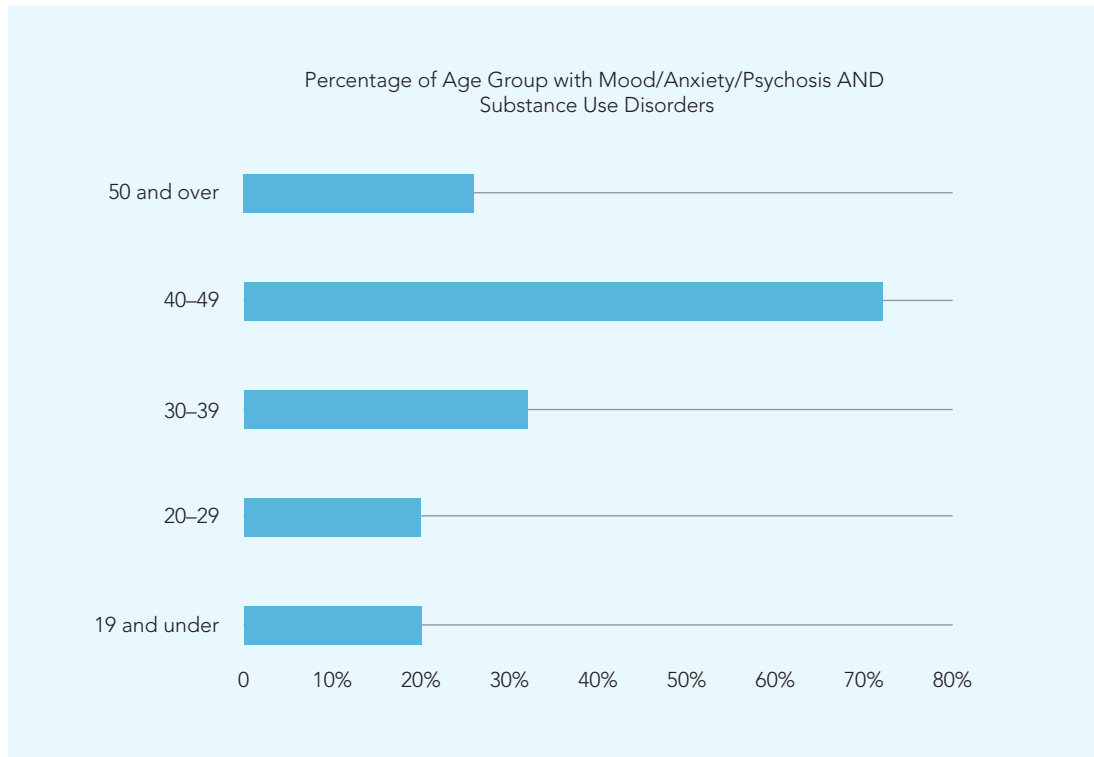
# Axis I and Gender



While students with Substance Use Disorders are more heavily male, Mood Disorders and Psychotic Disorders are more prevalent in females.

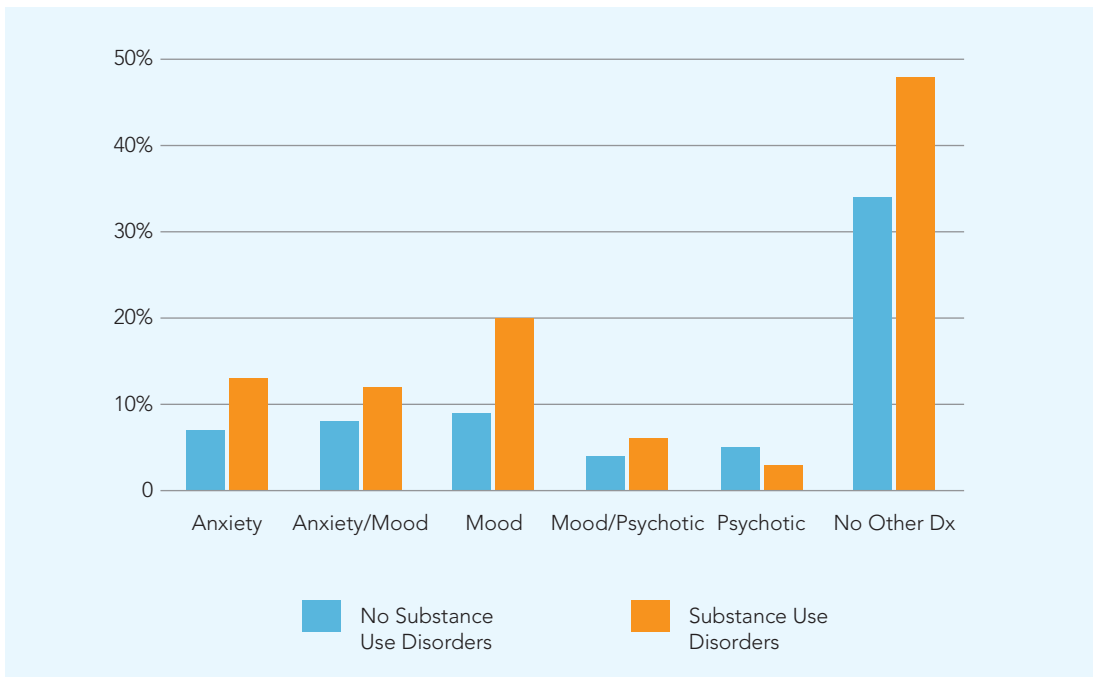
## Axis I and Age

For the dual diagnosis of a Substance Use Disorder and another Axis I Disorder, prevalence is much higher in the age range of 40–49 than any other age range.



For the age range of 40–49, a much higher percentage of students are diagnosed with BOTH a mental illness on Axis I (Mood, Anxiety, and Psychotic Disorders) AND a Substance Use Disorder. It seems that for this age cohort, substance abuse becomes a preferred method of self-medicating and coping with anxiety, depression, and psychosis. Other age groups, while there is some prevalence of this dual diagnosis, evidence other ways of coping as well.

# Axis I Dual Diagnosis with Substance Use Disorders



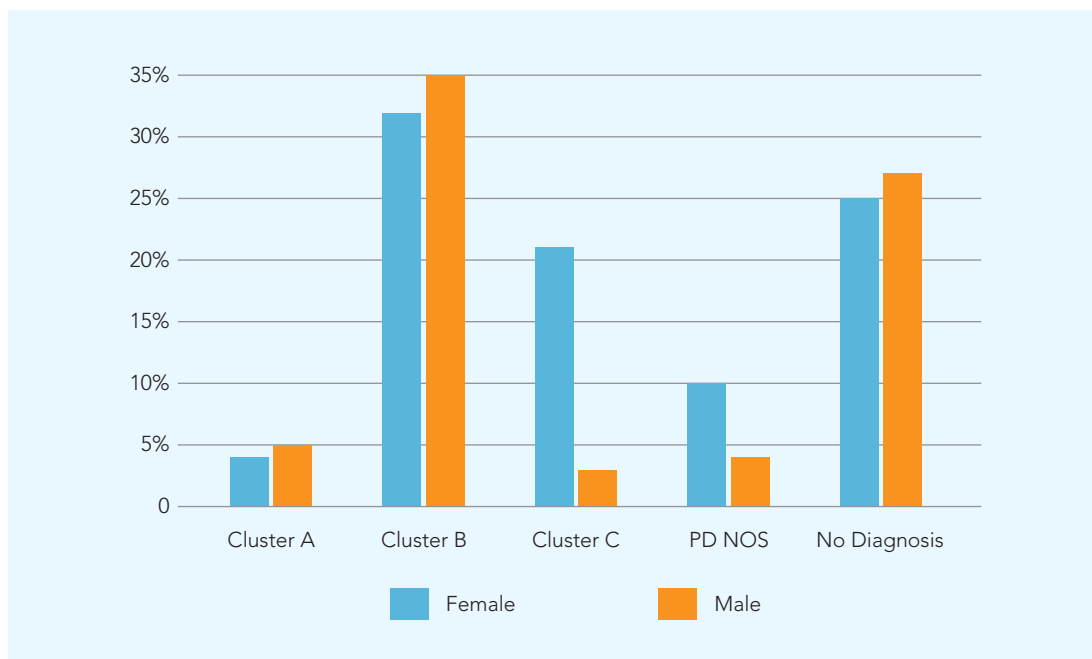
As would be expected, Substance Use Disorders are highly linked to Mood and Anxiety Disorders. Substance use is often a way to regulate emotions and cope with difficult experiences.

## Axis II Disorders

69% meet criteria for an Axis II diagnosis.

- 5% meet criteria for a **Cluster A Disorder** (bizarre or eccentric).
- 39% meet criteria for a **Cluster B Disorder** (erratically emotional).
  - 25% meet criteria for **Narcissistic Personality Disorder**.
- 14% meet criteria for a **Cluster C Disorder** (anxious or fearful).
- 8% meet criteria for a Personality Disorder Not Otherwise Specified (**Personality Disorder NOS**).

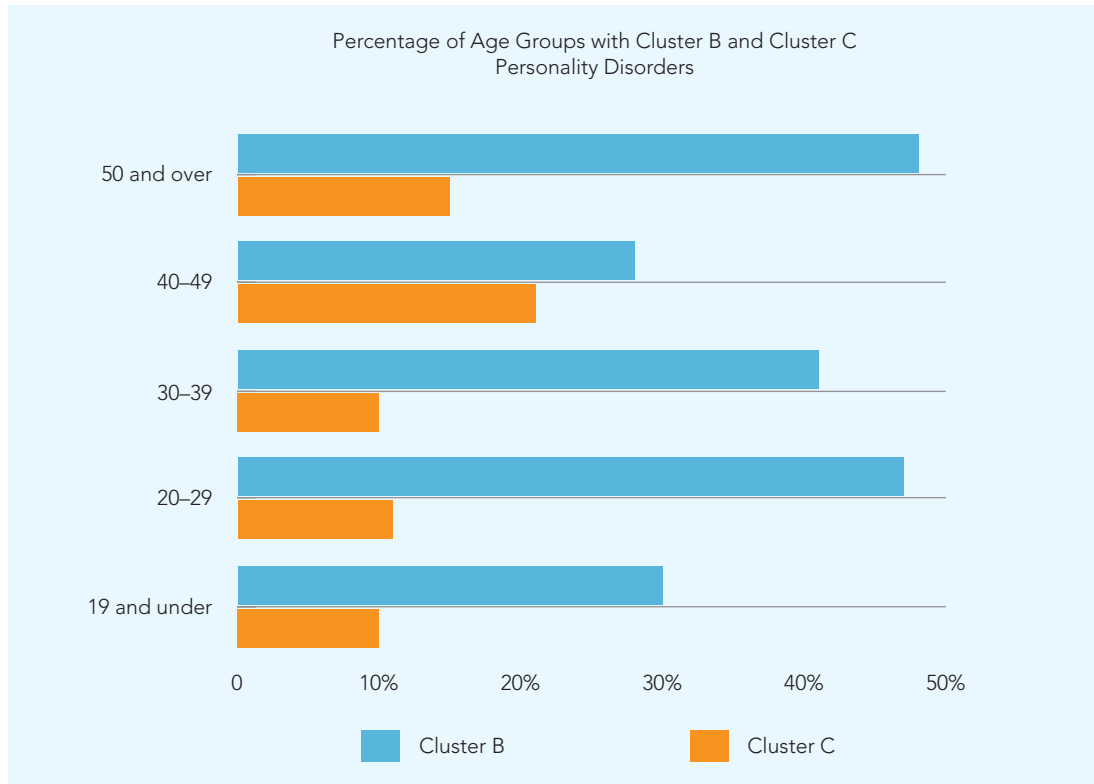
## Axis II and Gender



Whereas Clusters A and B are relatively equal by gender, both Cluster C and Personality Disorder NOS are heavily female. Included in Cluster C is Obsessive-Compulsive Personality Disorder, which is characterized by excessive perfectionism, conscientiousness, and respect for others, at the expense of one's own rights and genuine interpersonal relationships. Included in Personality Disorder NOS is the Depressive Personality Disorder, which is a pervasive pessimism and bias toward negativity. Both of these seem to be more heavily female personality traits in The HOPE Program's population.

## Axis II and Age

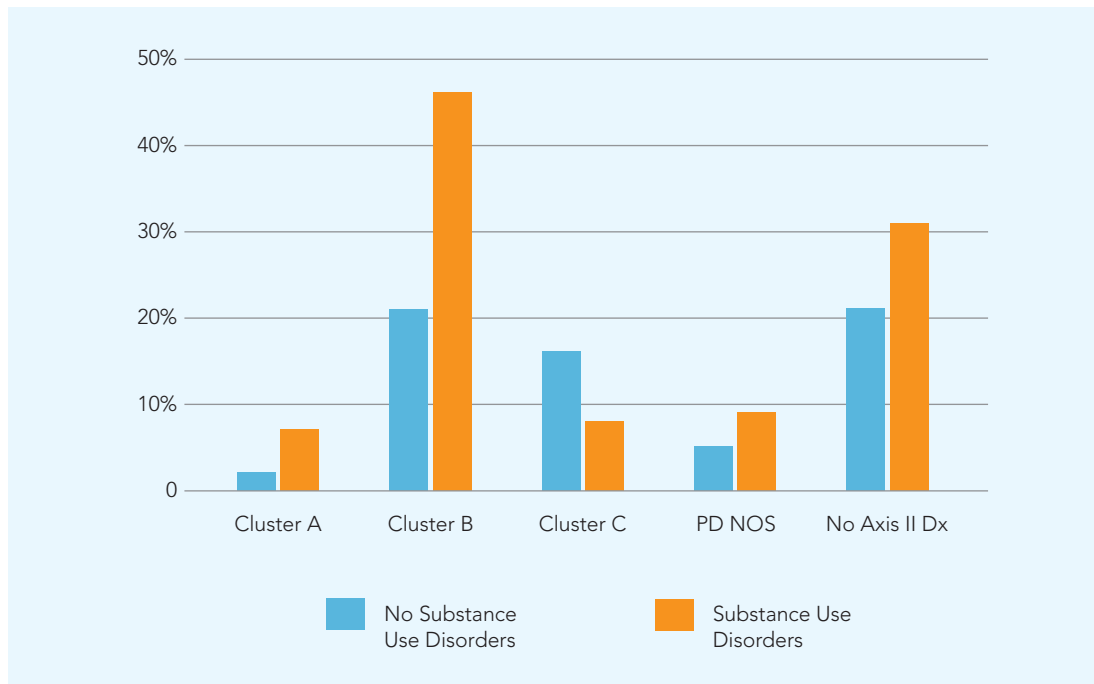
Based on age, Cluster A Personality Disorders and Personality Disorder NOS were generally evenly distributed. Cluster B and Cluster C Disorders, alternatively, were not.



For Cluster B Personality Disorders, which are characterized by erratic emotionality, those 19 and under and those between 40–49 present with fewer of these disorders. This may be related, respectively, to a lower proportion of Personality Disorders in general in individuals whose personalities are still developing (e.g., under 20 years old) and the fact that with higher prevalence of dual diagnosis of Axis I Disorders and a Substance Use Disorder, those individuals in the age 40–49 bracket have used illegal substances to dampen their emotionality.

For Cluster C, the opposite trend is present. Those in the age 40–49 bracket have a higher prevalence of Cluster C Personality Disorders. These disorders are characterized by perfectionism, respect, and hypervigilance to detail.

## Axis II Dual Diagnosis with Substance Use Disorders



Again, substance use seems to be related to regulating emotions, as the highest prevalence of Substance Use Disorders is with individuals who have Cluster B Personality Disorders, which are related to emotional dysregulation and erratic and dramatic emotionality.

## Axis I and Axis II Disorders

---

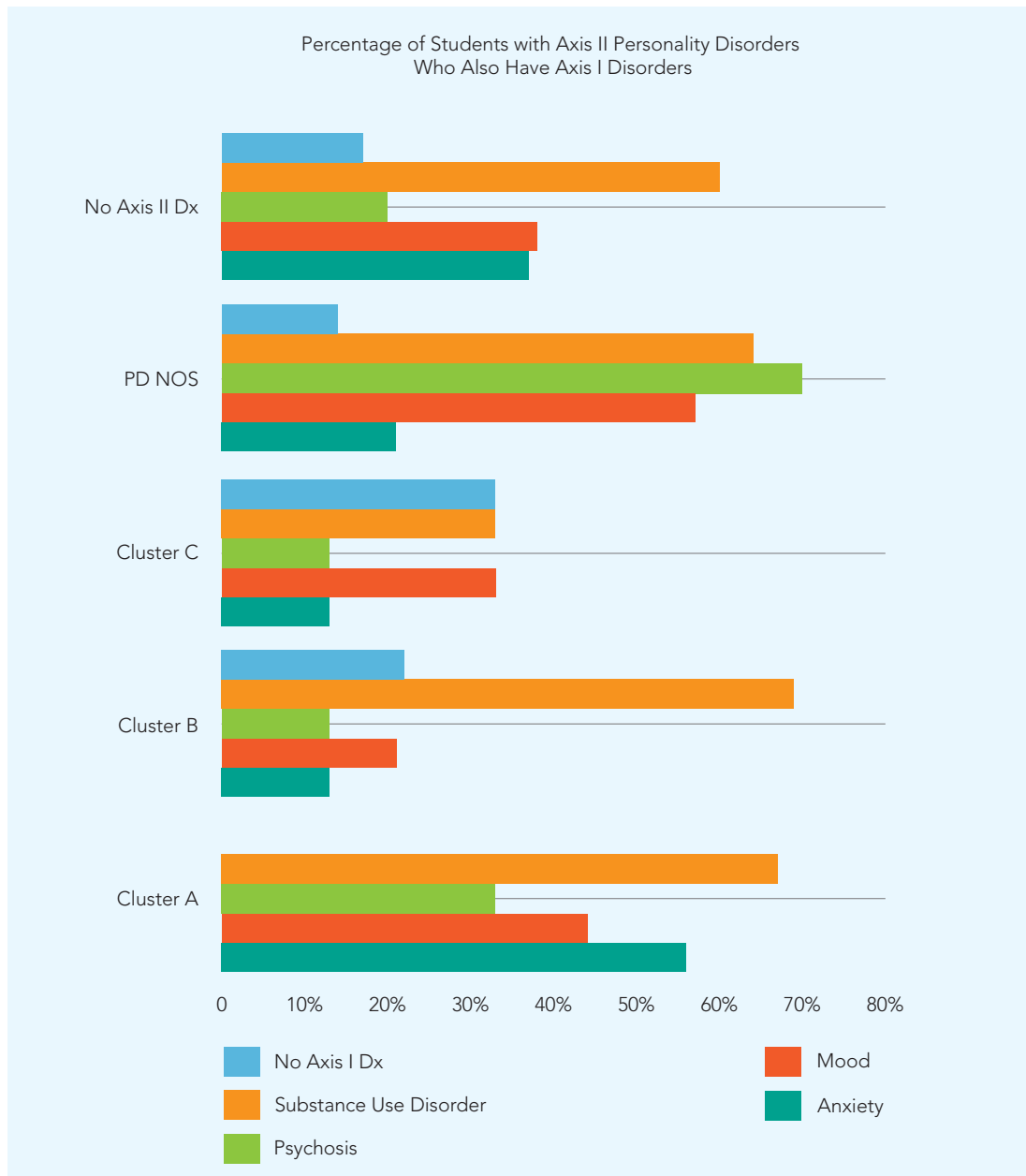
Most notable are the findings with regard to Substance Use Disorders. For Clusters A and B, Personality Disorder NOS, and No Axis II Diagnosis, the percentage of students who have Substance Use Disorders is between 60 and 69%. But for Cluster C, the percentage is only 33%. For those students with Cluster C Personality Disorders, who are overly concerned with correctness, rules, and respect, the choice to cope through illegal means seems to be less attractive.

Additionally, the prevalence of Mood Disorders is higher in the Personality Disorder NOS sample, which would be expected of the Depressive Personality type; those individuals who have an overly pessimistic and negative view of themselves and the world are much more likely to present as depressed than those who do not.

Finally, while the prevalence of Psychotic Disorders is low, it is lowest for those individuals who do not have an Axis II Disorder. Having a personality style that can effectively cope with the demands of everyday life seems to be protective against having a break from reality (which is the definition of a Psychotic Disorder). It should be noted that at intake, we refer applicants with clear psychoses, but when a Personality Disorder overshadows the psychosis (as it often can in a first meeting), the psychotic features are much less salient, and we may not refer them until a later point in the program when those features become apparent.

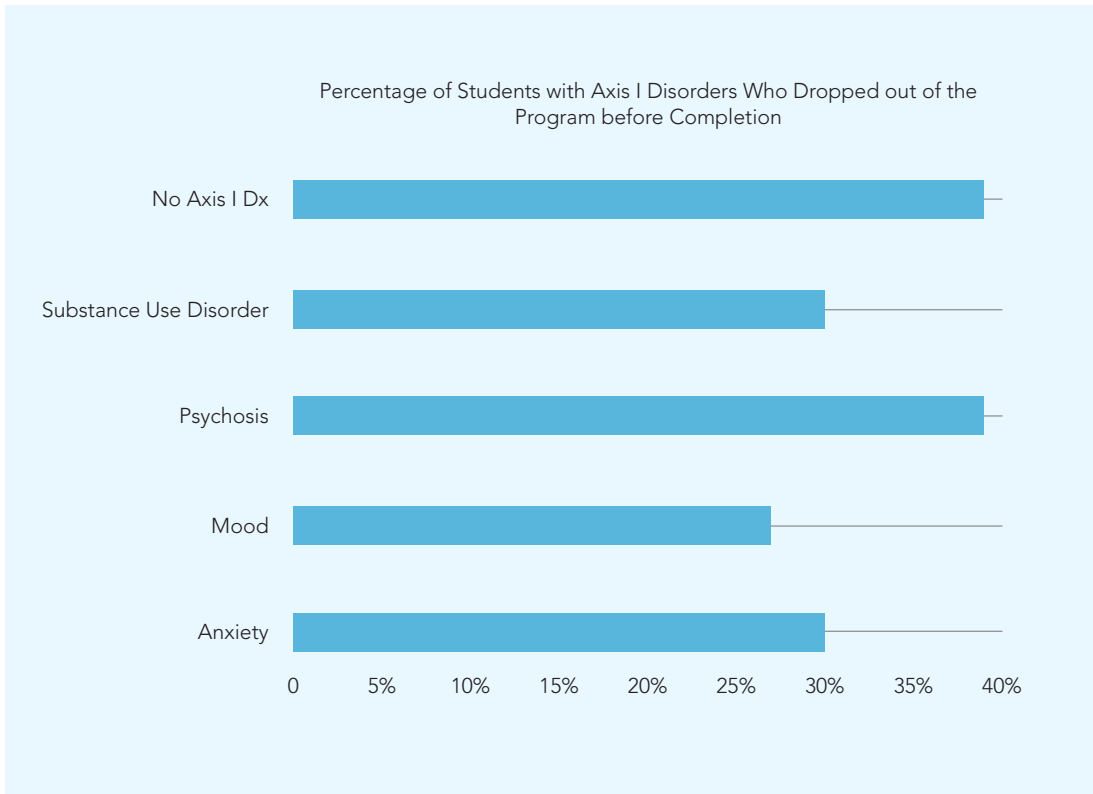
55% meet criteria for **BOTH** an Axis I Disorder AND an Axis II Disorder.

5% do **not** meet criteria for ANY Axis I or Axis II diagnosis.



# Completion Rates

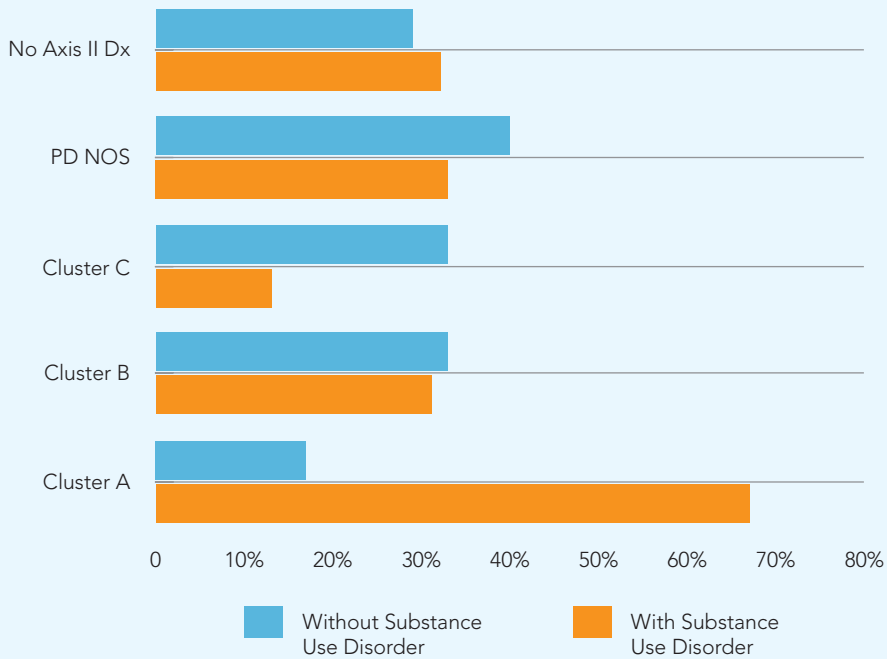
Based on preliminary findings, rates of individuals not completing the 12-week phase of the program are presented.



Based on Axis I Disorders, there is a slightly higher drop-out rate for those with Psychotic Disorders, which is understandable, given the presentation of psychotic disorders as indicating a separation from reality (based on hallucinations, paranoid delusions, or disordered thinking).

Additionally, those students with no Axis I Disorder had slightly higher drop-out rates than those with Axis I Disorders. This counterintuitive finding needs further examination.

Percentage of Students with Axis II Disorders, Both with and without Substance Use Disorders, Who Dropped out of the Program before Completion

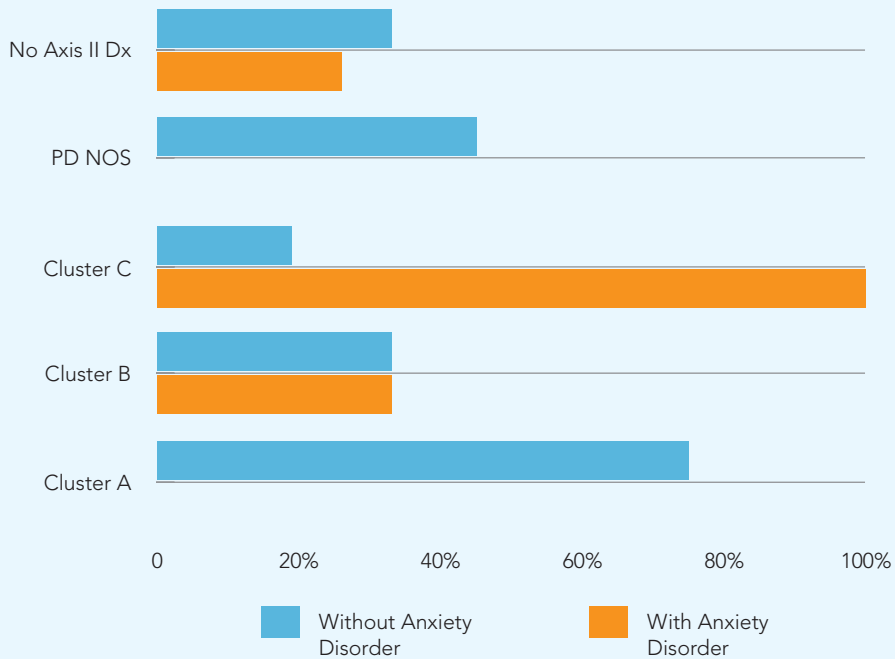


Based only on Axis II Disorders, there seems to be little difference in rates of drop-out by diagnosis.

Interestingly, however, when looking at Axis II Disorders along with Substance Use Disorders, it is striking how many more students who have both Cluster A Personality Disorders and Substance Use Disorders drop out of the program prematurely. Individuals with Cluster A Disorders, which are eccentric and odd, tend to exacerbate them with substances (rather than cope with them, as would be the case with other types of disorders). Thus, this subset are likely making their oddness even more eccentric and outside the norm of appropriate social behavior.

Also, there seems to be a slightly lower drop-out rate for those students with Cluster C Personality Disorders and Substance Use Disorders. Because it is unusual for an individual with a Cluster C Disorder, who is overly concerned with rules, appropriateness, and respect, to engage in illegal behavior, those who do engage in such behavior likely feel the need to normalize much more strongly than their peers. As such, they may remain engaged in the program in order to normalize themselves.

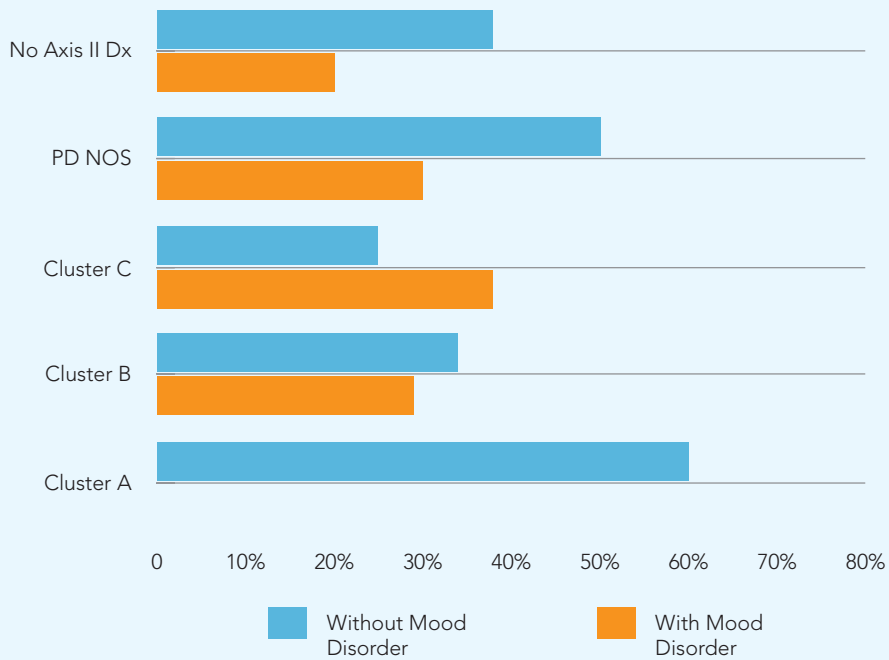
Percentage of Students with Axis II Disorders, Both with and without Anxiety Disorders, Who Dropped out of the Program before Completion



Interestingly, those individuals with both a Cluster C Personality Disorder (usually manifesting with an over-concern with propriety, rules, order, and perfectionism) and an Anxiety Disorder dropped out at a rate of 100%. This may be a population that needs aggressive interventions to keep them in the program.

Cluster A Personality Disorders, again, were interesting in terms of drop-out. Those with a Cluster A Disorder (bizarre, odd) and Anxiety had no drop-outs from the Program. This may be due to the fact that with insight about the bizarreness of behavior comes anxiety, as well as a desire to change. Those with Cluster A Personality Disorders but no Anxiety Disorder dropped out at a higher than average rate from the program.

Percentage of Students with Axis II Disorders, Both with and without Mood Disorders, Who Dropped out of the Program before Completion



Similar to the dual Personality and Anxiety Disorders, those individuals with both a Cluster A Personality Disorder and a Mood Disorder had a 0% drop-out rate. A similar explanation regarding the distress (Mood Disorder) related to their oddness (Cluster A Disorder) may explain why these individuals remain in a program aimed at helping them normalize their social interactions.

# Summary

## Axis I Disorders

**80% of the students meet the criteria for an Axis I diagnosis (Mood, Anxiety, Psychotic, and Substance Use Disorders)**

### **Axis I and Gender**

While Substance Use Disorders are more prevalent in males, Mood Disorders and Psychotic Disorders are more prevalent in females.

### **Axis I and Age**

For those who have an Axis I Disorder, dual diagnosis with a Substance Use Disorder is higher for those in the age range of 40–49 than any other age range.

### **Axis I Dual Diagnosis with Substance Use Disorders**

As would be expected, Substance Use Disorders are highly linked to Mood and Anxiety Disorders.

## Axis II Disorders

**69% of the students meet criteria for an Axis II diagnosis (Personality Disorders)**

### **Axis II and Gender**

Cluster C Axis II Disorders (including Obsessive-Compulsive Personality Disorder) and Personality Disorder NOS seem to be more heavily female personality traits in The HOPE Program's population.

### **Axis II and Age**

For Cluster B Personality Disorders (characterized by erratic emotionality), those 19 and under and those between 40–49 present with fewer of these disorders.

For Cluster C (generally anxious or fearful), the opposite trend is present. Those in the age 40–49 bracket have a higher prevalence of Cluster C Personality Disorders.

### **Axis II Dual Diagnosis with Substance Use Disorders**

The highest prevalence of Substance Use Disorders is with individuals who have Cluster B Personality Disorders, which are related to emotional dysregulation and erratic and dramatic emotionality.

## Axis I and Axis II Disorders

**55% of the students meet criteria for BOTH an Axis I Disorder AND an Axis II Disorder.**

**5%** do **not** meet criteria for ANY Axis I or Axis II diagnosis.

Additionally, the prevalence of Mood Disorders is higher in the Personality Disorder NOS sample, which would be expected of the Depressive Personality type; those individuals who have an overly pessimistic and negative view of themselves and the world are much more likely to present as depressed than those who do not.

Finally, while the prevalence of Psychotic Disorders is low, it is lowest for those individuals who do not have an Axis II Disorder.

### **Substance Use Disorders**

Most notable are the Substance Use Disorder findings. For Clusters A and B, Personality Disorder NOS, and No Axis II Diagnosis, the percentage of students who have Substance Abuse Disorders is between 60 and 69%. But for Cluster C, the percentage is only 33.

## Completion

Many more students who have both Cluster A Personality Disorders (characterized by bizarre and odd presentation, thinking, and behaviors) and Substance Use Disorders drop out of the program prematurely.

Students with both a Cluster C Personality Disorder (usually manifesting with an over-concern with propriety, rules, order, and perfectionism) and an Anxiety Disorder dropped out at a rate of 100%. This may be a population that needs aggressive interventions to help keep them in the program.

## Programmatic Implications

- While we will need to conduct further analysis over time and increase the sample size, the preliminary work indicates that a large percentage of HOPE students are functioning in the context of Clinical and/or Personality Disorders, which could impact their ability to be effective in the world of work.
- One implication for the program is to reinforce the importance of mental health assessments and therapeutic services, including group and individual counseling as well as classroom sessions on stress management.
- Given the high drop-out rates for students with anxiety disorders, changes in the intake protocol and other communication may be appropriate to clarify their expectations and ease their anxiety. While some clients with severe and persistent mental illness are identified early on and referred to more appropriate programs, for others, our findings can be used to better understand how to tailor services to them and, in doing so, prepare them for unsubsidized employment.
- The findings in this study may also serve to reinforce the program itself. For example, assuming additional study confirms the preliminary findings, appropriate modules to the curriculum (such as coping techniques or interpersonal skills classes, given that Personality Disorders are most often related to inappropriate interpersonal relations) could be introduced, which would benefit those populations of students with specific diagnoses.





One Smith Street, Brooklyn, New York 11201-5111 Telephone: 718-852-9307 Fax: 718-852-9681  
[www.thehopeprogram.org](http://www.thehopeprogram.org)