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10

**THE ATTITUDE OF DIFFERENT THERAPISTS TO
CLUSTER B PERSONALITY DISORDER**

by

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MRTANI001**

**A MINOR DISSERTATION
SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF
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IN CLINICAL SOCIAL WORK**

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

“a student asks him a question:

after the successful completion of a most intensive psychoanalytic treatment conducted by a most skillful psychoanalyst under the best circumstances, would an individual with severe character pathology become indistinguishable from a person who has always been psychologically well-adjusted and healthy?

Akhtar responds by comparing two flower vases made of fine china.

Both are intricately carved and of comparable value and elegance and beauty. Then a wind blows and one of them falls from its stand and is broken into pieces. An expert from a distant land is called. Painstakingly, step by step, the expert glues the pieces back together. Soon the broken vase is intact again, can hold water without leaking, is unblemished to all who see it. Yet this vase is now different from the other one. The lines along which it had broken, a subtle reminder of yesterday, will always remain discernible to an experienced eye. However, it will have a certain wisdom since it knows something that the vase that has never been broken does not: it knows what it is to break and what it is to come together.”

(Akhtar, in Whitely, 1994)

ABSTRACT

This study aims to explore therapists' attitudes, and therapeutic work with patients diagnosed with cluster B personality disorder, that is anti-social, narcissistic, borderline or histrionic personality disorder, in accordance with the diagnostic criteria as described in the Diagnostic Statistical Manual.

The study also aims to discuss treatment choices for patients diagnosed with anti-social, narcissistic, borderline or histrionic personality disorder as well as the value and use of the Diagnostic Statistical Manual as diagnostic tool.

The literature study reviews the concept of personality, the diagnosis and treatment of the anti-social, borderline, histrionic and narcissistic personality disorders and countertransference feelings of the therapist. Questions that the study aims to answer are whether therapists have preconceived ideas around treatment and outcome of treatment of anti-social, narcissistic, borderline and histrionic personality disorders and whether these ideas affect the therapists' willingness to accept these patients for treatment.

The Dominant-less-dominant model of combining qualitative and quantitative approaches was followed to obtain the data to test the research questions.

A sample of thirty therapists from the social work, psychology and psychiatry professions was randomly drawn from therapists in the Cape Peninsula. These therapists were interviewed through the use of an interview schedule consisting of statements and measured using the Likert scale. Some open ended questions were included to avoid leading the respondents in their responses. The data was quantified and presented with subgroup comparisons.

Analysis of the results confirmed that while the sample had some general negative attitudes in relation to cluster B personality disorder, the anti-social personality disorder is singled out by therapists as more difficult to work with. This was especially true for therapists following the medical model. Psychologists tended to respond less negatively to cluster B personality disorder, but more negatively towards cluster A personality disorders than social workers and psychiatrists. Responses within cluster B also proved that the anti-social personality disorder is singled out as not being able to respond to treatment, in relation to ability to form a therapeutic alliance, and in prognosis.

The Diagnostic Statistical Manual is found to be valuable when used as a guideline, but labelling as such affected attitudes and should therefore be limited and used with discretion. The clustering of personality disorders was found to be restrictive, not allowing for individual differences. It was found that assessment and treatment should focus on the individual rather than the diagnosis.

Supervision proved to be essential as a container for countertransference feelings, and is recommended as compulsory for clinicians treating patients with personality disorder. Along with this recommendation is the recommendation for clinicians' own therapy to facilitate the awareness of the boundary between patient problems and clinician problems.

The need for all Universities to focus more in training on the identification and management of personality disorder was identified.

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CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION TO THE STUDY

Within the helping professions, patients present with a varied spectrum of identified problems as well as specific expectations to receive relief from the identified problem. The therapist enters into the therapeutic alliance with the intention of rendering a service that would aim at meeting the expressed and sometimes even unexpressed needs of the patient.

The treatment of patients diagnosed with Personality Disorder has historically been controversial due to differences in the perceived treatability and prognosis of such patients.

This study will explore the attitudes of therapists towards patients diagnosed with anti-social, narcissistic, borderline and histrionic personality disorders and explore the literature to clarify and explain the findings of the research.

1.2 BACKGROUND TO THE STUDY

The researcher is a clinical social worker, who has been employed at Groote Schuur Hospital for many years. The unit in which she is based, provides a psychiatric emergency service, where patients receive services consisting of diagnostic assessment, crisis intervention and referral for further therapeutic interventions.

Referral of patients with a diagnosis of cluster B personality disorder, is often met with a reluctance or refusal to accept the patient for treatment, or reservations about the purpose of the referral on the grounds of an expectancy of poor prognosis.

The study was therefore initiated to identify treatment aspects that influence the attitudes of therapists when working with cluster B personality disorders.

1.3 THE MOTIVATION FOR THE STUDY

Patients suffering from personality disorder encounter difficulties in their everyday functioning and interaction with other significant people. As a result of these difficulties, they find themselves in crisis and may present to emergency units for treatment. As mentioned previously, it was at the emergency unit of a large teaching hospital, that the researcher became aware of the plight of these patients in need of psychiatric intervention.

Beard et al (1990) refer to the cluster B personality disorder (Borderline, Anti-social, Narcissistic and Histrionic) usually encountered by social workers in various settings such as accident and emergency departments, addiction treatment units, and in forensic units. They also refer to the unpopularity of such patients who are often unco-operative, destructive and regarded as difficult.

Tyrer et al (1991) refer to personality disorder as a term lacking respectability and being considered untreatable, whereas other psychiatric diagnoses such as depression and schizophrenia, are recognized as illnesses with no personal responsibility from the sufferer.

Psychodynamic thinking formulates personality difficulties as stemming from developmental deficits for which the patients carry no responsibility. Yet it seems difficult to relate to patients who present with inconsistency in their moods, undermine attempts to help, and have the tendency to harm themselves without insight into their own destructiveness. Beard et al

(1990:541) describe the “extreme reactions of both concern and rejection in staff” in reaction to patients suffering from personality disorder. This may serve to motivate the reluctance and sometimes even refusal of therapists, to accept patients diagnosed as suffering from personality disorder, for referral into their care.

1.4 RESEARCH OBJECTIVES

Given the obstacles in treatment of patients suffering from personality disorder as described above, it would be useful to consider the value of diagnosis or labeling of such patients. The use of the DSM IV will be discussed in terms of influence in the management plan of the patient.

Therapists’ own responses will be highlighted with the intention of formulating the need for supervision and awareness, which may serve as container for countertransference reactions to patients.

By exploring current treatment options and difficulties, it may be possible to redefine patients’ ability to benefit from treatment and place the therapists’ perception of prognosis in a healthy framework.

Social Workers who encounter personality problems in dysfunctional marriages or families without the benefit of a theoretical understanding of the behaviour patterns, may become overwhelmed by countertransference reactions or disillusioned by the attitudes of colleagues in the profession. In identifying the constructive approaches and available resources, the ability of patients to split professionals may be reduced by significant measures. The study will also aim

to explore avenues of containment of the therapists to the mutual benefit of therapists and their patients.

This study will further aim to explore:

- treatment choices for patients diagnosed with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders' classification of personality disorders that describes more destructive behaviour
- difficulties experienced in the treatment of such patients
- the value and use of the Diagnostic and Statistical Manual
- the experiences, theoretical approaches, countertransferences and beliefs of the therapists who engage in the therapeutic alliance with such patients.

The study will consist of a review of the literature on personality disorders as well as a survey using self-reporting responses to a structured interview of the treatment choices and reactions to patients of 30 therapists in the helping professions.

1.5 MAIN RESEARCH QUESTIONS

The study will address the attitudes of therapists regarding acceptance or refusal of referrals of patients, and whether these attitudes are influenced by a diagnoses of cluster B personality disorder. The study will further explore whether these attitudes are influenced by training or professional registration, by employment setting, and by the use of supervision. Lastly, the study will question the usefulness of the diagnostic classification and its implications for referrals and treatment.

1.6 RESEARCH ASSUMPTIONS

The researcher assumes:

- that clinicians will be more reluctant to accept for treatment, patients diagnosed with cluster B personality disorder
- that clinicians who are in an employment setting where patients can be refused for referral, will be more reluctant to accept referrals
- that professional registration has little impact on decisions to accept referrals
- that the DSM IV will be seen as useful, with acknowledgement of the limitations of the diagnostic tool

Research questions and assumptions are revisited in chapter four.

1.7 TERMINOLOGY AND DEFINITIONS

The patient referred to in the medical model, is referred to also as the client, the analysand or the individual. These terms are used interchangeably, but mostly considered from the medical perspective as dictated by the DSM IV.

The therapist, the analyst, or the clinician, are again different ways of referring to the same professional individual.

Personality disorders are always persons suffering from the disorder, but is often referred to as a disorder. This concept may contribute towards stigmatization of the patient.

The definitions of disorders are defined by the diagnostic criteria stipulated in the Diagnostic Statistical Manual of the American Psychiatric Association, mostly referred to as the DSM IV.

1.8 INTRODUCTION TO METHODOLOGY

The study introduces relevant literature with the acknowledgement that a review of literature is limited in relation to exploration of subjects focussing on attitudes of therapists, and to the management of cluster B personality disorders. While mention is made of models of treatment, transference, supervision, and burnout, the literature is focused on personality disorder in chapter two, and on countertransference in chapter three. These chapters were separated, as chapter two focusses on the patient while chapter three mainly focusses on the therapist.

In order to explore the attitudes of therapists, the researcher constructed an interview schedule to assist in the interviewing of thirty clinicians registered as social workers, psychologists or psychiatrists. The study surveys the awareness, treatment issues and countertransference reactions of therapists towards patients, combining the qualitative and quantitative research methods.

The results of these interviews were then processed in chapter five. Research questions are revisited with conclusions to inform recommendations in chapter six.

1.9 SUMMARY

This chapter provides an overview of the study that will be discussed in more detail in chapters to follow.

CHAPTER 2: PERSONALITY AND PERSONALITY DISORDER

2.1 INTRODUCTION

In this chapter, the writer explores the literature around the concept of personality and the assessment of personality. The use and value of the DSM as a diagnostic tool in the work with personality disorder, is explored in order to assess its role in patient management.

The anti-social, narcissistic, borderline and histrionic personality disorders, as clustered together in cluster B, are discussed in terms of characteristics, treatment and prognosis. The other clusters, cluster A and cluster C, will be examined more briefly, as the main focus of the study is on cluster B personality disorders.

Gender issues are visited briefly to emphasize the need for the awareness of possible differences in perceptions and attitudes towards male and female patients who are diagnosed with these specific personality disorders.

2.2 PERSONALITY

Kaplan et al (1994) define personality as “the totality of emotional and behavioural traits that characterize the person in day-to-day living under ordinary conditions; it is relatively stable and predictable” (1994: 731).

Burger (1993) defines personality as “consistent behaviour patterns originating within the individual” (1993:3). In his description of Allport’s trait approach to personality, he illustrates

the continuum of characteristics such as self-esteem, the need for achievement, and the presence of anxiety. These characteristics are relatively stable over time and across situations.

Meyer et al (1989) define personality as follows: “it is the constantly changing but nevertheless relatively stable organization of all physical, psychological and spiritual characteristics of the individual which determines his behaviour in interaction with the environment” (1989:8). They describe personology as the branch of psychology that studies the individual’s characteristics as well as the differences and similarities between people.

Extroversion, agreeability, conscientiousness, neuroticism and openness to experience are the components of personality that are described as the big five in Bernstein et al (1994).

Thus, according to these definitions, it is clear that personality is considered to be a fairly stable and consistent view of what someone is like, and how he is likely to behave in similar situations.

The development of personality is described differently by the many theories such as in the Psychoanalytic, Biological, Humanistic, Cognitive and Behavioural approaches. The theories differ in their beliefs around hereditary, learned and parental influences on personality. These theories are described and discussed at length in most references on mental health. Meyer et al (1989) suggest that there are so many theories due to the complexity of people. Each of these theories explores the structure and development of personality, a topic which is outside the purpose of this dissertation. The focus is rather on deviation from the concept of personality as described above.

2.3 ASSESSMENT OF PERSONALITY

Gelder et al (1991) stress that assessment of personality is necessary in order to be able to predict how a patient is capable of behaving when ill or stressed, but caution against hasty diagnosis that could be incorrect and therefore unhelpful in the treatment process. They suggest that personality should only be assessed with the support of reliable collateral on past behaviour over a significant period. Jaspers (in Gelder et al, 1991) warned in 1963 that assessment of personality is not the same as understanding the patient.

Horner (1984) sees diagnosis of personality in terms of object relations theory as a working hypothesis that is modified as treatment progresses. Blanck and Blanck (in Horner, 1984) prefer to start with a tentative diagnosis rather than obtain diagnostic information in the initial contact to the detriment of the therapeutic alliance.

Burger (1993) refers to the use of standardized tests to assess personality but warns that these tests have limitations and should be examined in terms of reliability and validity, with particular awareness of cultural differences.

Kaplan et al (1994) pay attention to the clinical interview in seven stages:

- warm up to set the patient at ease and observe for diagnostic cues
- screening of the problem to identify the main problem and explore mood, insight, judgment and memory
- follow-up of initial impression to verify or exclude diagnostic impressions
- taking a history to assess the course of the problem, its effect on life and social environment
- completing of the data base to fill in gaps and reconcile inconsistencies

- feedback and discussion of treatment options
- contracting to facilitate compliance

Bernstein et al (1994) question the place of diagnosis based on bias amongst diagnosticians stemming from stereotypes about certain groups of people. Should these biases colour judgement, the reliability and validity of labels are debatable.

Casey and Tyrer (1990) conducted a study of personality disordered patients who presented to the general practitioner with some evidence of psychiatric disturbance and who were then referred for psychiatric assessment. General practitioners diagnosed personality disorder in 5,3% of the cases presented and psychiatrists diagnosed the same in 5,6% of the cases. This percentage increased to 28% when the disorder was diagnosed with structured interviews rating 24 personality characteristics on a scale according to social dysfunction. They concluded that personality disorder is often unrecognized in both general and psychiatric practice. Thompson and Goldberg (1987) discovered diagnosis of personality disorder without any clinical evidence in reviewed process notes and felt that the problem was not related to the diagnostic criteria, but rather to the recognition of diagnostic criteria.

It appears from the literature that the use of the psychiatric interview over a period, which includes history taking and mental state examination, is preferred to psychometric testing alone as an assessment tool (Kaplan et al, 1994; Gelder et al, 1991; Burger, 1993).

2.4 HISTORICAL OVERVIEW OF PERSONALITY DISORDER

The development of the concept of abnormal personality is described in Gelder et al (1991) and Holmes (1991). The French Psychiatrist, Pinel, described patients prone to violent outbursts who were not diagnosed as suffering from delusions, the diagnostic criterion considered significant to the specific diagnosis of the mentally ill. The first diagnosis of these violent patients was *insanity without delirium*. The term *moral insanity* was later used by Prichard (Gelder et al, 1991) to describe patients who displayed different impulses, habits and affections without the presence of a psychiatric disorder or intellectual disability. Even when it later became clear that mental illness could exist without delusions, the concept of moral insanity continued. Maudsley (in Gelder et al, 1991) pointed out that the term could however lead to alienation and Koch introduced the term *psychopathic inferiority* to describe abnormal behaviour without evidence of a psychiatric disorder. Later still, the term *psychopathic inferiority* was replaced by *psychopathic personality* to move towards a less judgmental stance. Kraepelin described the different types of psychopathic personality as “excitable, unstable, eccentric, liars, swindlers, antisocial and quarrelsome” (Gelder et al 1991:127). Schneider also looked at a wider range of abnormal personalities to include people who created problems for themselves as well as for others. As early as 1939, Henderson referred to this group of personalities as displaying behaviours that have proved to be difficult to influence, prevent or cure through either medical, social or legal intervention.

2.5 DIAGNOSTIC STATISTICAL MANUAL (DSM IV)

The Diagnostic Statistical Manual provides criteria to enable the therapist to make a clear diagnosis on a multi-axial system, allowing for diagnoses of psychiatric disorders, personality disorders, developmental disorders, physical disorders important to the management of the

patient, and ratings for the severity of psychosocial stressors and level of functioning. The first edition of the DSM was published in 1952. The DSM-II followed in 1968, the DSM- III in 1980 and the DSM-III-R in 1987. The DSM-IV was published in 1994 and is the system currently in use in South Africa.

Clinicians using the DSM IV include psychiatrists, psychologists and social workers employed in a spectrum of employment settings (Kutchins & Kirk, 1988).

The Diagnostic Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994) provides three clusters of categories for personality disorders based on descriptive similarities.

- Cluster A personalities often appear odd and eccentric and include the paranoid, schizoid and schizotypal personality disorders.
- Cluster B personalities often appear dramatic, emotional and erratic and include the histrionic, narcissistic, anti-social and borderline personality disorders.
- Cluster C includes avoidant, dependent and obsessive-compulsive personality disorders who mostly appear anxious or fearful.

The writers of the DSM IV admit that this grouping has limitations as co-morbidity from different clusters can occur.

The writer understands that clustering is formed around developmental errors and that there are vague similarities in problem behaviour. The writer questions, however, the grouping together of the different disorders into one cluster. Each of these require different management strategies and could each elicit different responses from clinicians.

In this respect, Tyrer et al (1991) point out that there is an overlap in the descriptions of the different disorders in cluster B that can be referred to as flamboyant and dramatic.

However, Williams (1981) believes that the use of the DSM improves the efficacy of treatment based on the link between diagnosis and management and provides an accurate language for communication with colleagues. She also supports the recognition of psycho-social stressors in diagnosis, therefore assisting a more holistic management of mental disorders and creating an avenue to address, through diagnosis, those problems that are usually referred to social workers.

Kutchins and Kirk (1988), however, report on a survey amongst social workers who complained that the DSM:

- medicalizes mental disorders
- labels problems of childhood as pathological
- sometimes leads to inappropriate treatment
- inhibits understanding of clients or their problems by focusing too much on signs and symptoms
- does not serve the purpose of clinical social work

Cramer (1992) suggests that any psychiatric diagnostic system should provide information on the cause, course, prognosis and treatment of disorders. Since there is so much disagreement on these factors, the DSM IV and the International Classification of Diseases (ICD 10) developed by the World Health Organization, appear to be mostly descriptive tools to provide a common language.

It would therefore appear that the DSM IV is acknowledged as a valuable tool in diagnosis and formulation of management goals as long as the clinician remains aware of the limitations.

2.6 PERSONALITY DISORDER

Kaplan et al (1994) see personality disorder as consisting of those traits that are inflexible and significantly impair functioning. Schneider (in Gelder et al, 1991) points out that it would be impossible to classify personality disorders from a diagnostic classification into appropriate types without further qualification of the descriptions or combinations, since human beings cannot be measured precisely. This leaves the use of diagnostic criteria for personality disorder vulnerable to human interpretation.

For the purpose of this dissertation, personality disorder will be explored with the focus on the anti-social, narcissistic, borderline and histrionic personality disorders, which is the cluster B personality disorders.

2.6.1 ANTI-SOCIAL PERSONALITY DISORDER

According to the DSM IV, patterns of anti-social behaviour start in childhood or early adolescence and occur in 3% of males and 1% of females. It is also associated with low socioeconomic status and urban settings. Up to 30% of patients presenting for treatment in clinical settings fall into this diagnostic group.

Kisker (1964) reminds that the psychopathic personality was used as a dumping ground for conditions that did not fit anywhere else. It was only when the importance of social

maladjustment was emphasized, that the diagnosis became specific. He relates the anti-social personality as the charming person who cons people and still sometimes retains their loyalty.

Bernstein et al (1994) list the contributory stressors as broken homes, rejection by parents, lack of good parental models, lack of attachment to early caregivers, conflict-filled childhoods and living in poverty, but point out that the causal picture remains cloudy, as some people from similar backgrounds do not develop the same personality style.

Horner (1984) explains the development of the anti-social personality disorder as originating in the first stage described by object relations theorists when the child fails to attach to the caregiver.

Hare (1976) explored the aetiology of anti-social personalities and found a strong indicator in family history, for example a father who suffered from an anti-social personality disorder, could have children who present with the same diagnosis.

Cleckley (1964) describes the anti-social personality disorder as someone who is sane by the standards of psychiatry, is free from delusion and is as aware of facts as the next person, but still conducts himself in an unacceptable manner. He attributes characteristics to the patient that illustrate his interpersonal difficulties and socially unacceptable behaviour towards other individuals. He found these patients to have an inability to see themselves as others see them. He also experiences poverty of affect and a lack of remorse or shame in these patients.

Holmes (1991) describes the anti-social personality disorder's mood symptoms as avoidance of anxiety or guilt, lack of remorse, pleasure seeking, shallowness of feelings and a lack of attachment to others. Cognitively, they are intelligent, have good verbal and social skills and easily rationalize their inappropriate behaviour. They seem unable to benefit from punishment. Motor symptoms include impulsivity, sensation seeking behaviour and a small percentage even become aggressive in some situations. He cautions that sensational media cover may give the impression that aggressive behaviour is more common than it actually is.

Kaplan et al (1994) acknowledge that they may appear composed and credible but can give inconsistent histories capable of fooling experienced clinicians. They also mask their underlying hostility, irritation and rage.

Kaplan et al (1994) also suggest a neurological examination, as some anti-social personality disorders have presented with abnormal EEG results and soft neurological signs. They suggest that clinicians not qualified to do this may refer for such a neurological examination.

Svrakic and McCallum (1991) caution that anti-social behaviour should be explored and assessed according to the level of personality organization, before a diagnosis of personality disorder is made.

2.6.2 NARCISSISTIC PERSONALITY DISORDER

Morrison (1986) informs that a much greater emphasis has been placed on narcissism in terms of symptoms, character pathology and diagnosis since the 1980's. Narcissism was previously only seen as a protection mechanism in ego development. He believes that diagnosing

narcissistic personality disorder has pathologised people previously understood in terms of the psychoanalytical view of narcissism.

The DSM IV acknowledges that narcissistic traits are common in adolescence but less than 1% of the general population develop narcissistic personality disorder. More than half of diagnosed narcissistic personality disorders are male. Between 2% and 16% of patients presenting for treatment carry a diagnosis of narcissistic personality disorder.

Gottschalk (1988) states that the origins of narcissism can be traced to early infant and child development. Therapists do not always agree on the boundaries of healthy versus unhealthy narcissism. It is when the patient presents for treatment that the difference becomes very clear. According to Gottschalk, patients usually reveal some shame or embarrassment when presenting for treatment. The narcissistic personality disorder however suppresses these feelings in favour of obtaining reassurances.

Horner (1984) understands the development of the narcissistic personality disorder from an object relations perspective as failure to integrate and regression to the grandiose self.

Cooper (in Morrison, 1986) states clearly that narcissism is mainly about self-esteem regulation and self-representation and that all personalities will therefore have aspects of narcissism. He describes those people who are accurately diagnosed as suffering from a personality disorder as being unaware of their conscious grandiose fantasies. They rather report shyness, unworthiness, and fears of competition and exposure.

Garfield and Havens (1991) reviewed the schools of psychoanalysis and developments in the understanding of narcissism and the self and came to the conclusion that paranoid phenomena can arise from pathological narcissism. The roles of the ego-ideal, self-objects and deficits in the capacity for self-determination are seen as having a causal influence on the development of paranoid states. Kernberg (in Morrison, 1986) stresses the narcissistic inability to sustain relationships, and underlying rage and envy that could contribute to fragmentation and unexpected psychotic episodes during analytic therapy.

Goldstein (1985) refers to the work of Kernberg and describes ego strengths of the narcissist as intact reality testing, intact thought processes, superficially intact interpersonal relationships and relative intactness of adaptation to reality. The weaknesses are described as poor impulse control, poor frustration tolerance, use of primitive ego defenses, identity diffusion and affective instability.

Kaplan et al (1994) describe the narcissistic personality disorder as someone with an elaborate sense of importance and who as a result expects special treatment and has difficulty managing criticism. They have difficulty feeling empathy and consequently experience their relationships as more vulnerable. Holmes (1991) give a similar description with an awareness that criticism rather than praise could cause some disintegration through perceived injury. Bernstein et al (1994) add that the narcissist tends to arrogantly overestimate abilities and achievements.

Coderch (1991) refers to the need for an object and the self's dependency of that object to sustain the omnipotent role of the narcissistic self.

Siomopoulos (1988) describes similar clinical features of the narcissistic personality disorder but adds that this disorder is still an elusive and not adequately described clinical entity.

From the literature it seems as if the narcissistic personality disorder attempts to wear a mask to appear less vulnerable and thus avoids further narcissistic injury. The term “mask” is also referred to in the context of the patient diagnosed with anti-social personality disorder and the “false self” in patients diagnosed with borderline personality disorder.

2.6.3 BORDERLINE PERSONALITY DISORDER

The DSM IV quotes the prevalence of borderline personality disorder as 2% of the general population and about 10% - 20% of patients presenting for treatment in clinical settings. Of all patients diagnosed as suffering from borderline personality disorder, 75% are female. The clinical presentation of symptoms can usually be observed from early adulthood and should not be confused with identity problems of adolescence. The borderline personality disorder presents with a pattern of unstable relationships, impulsivity, labile affect and instability in self image. These patients usually make frantic efforts to avoid real or imagined abandonment and can react with rage at the perceived threat of rejection. They find it difficult to be alone and tend to use health and mental health services more often. They engage in self-destructive behaviour more often than other personality disorders.

Wastell (1992) disagrees slightly with the course of the diagnosis as described in the DSM IV by stating that borderline behaviour starts to feature in adolescence. Landecker (1992) noted the correlation between childhood sexual trauma and a diagnosis of borderline personality disorder in adulthood. This article refers to the stigmatization of such a diagnosis and suggests

a possible diagnosis of post traumatic stress disorder to expand the possibilities of treatment. Such a diagnosis would however not address personality style or the significance of symptoms and characteristics of the borderline personality disorder.

Goldstein (1989) points out that many writers have published on the borderline personality disorder to try to explain the dynamics and suggest treatment modalities. Horner (1984) understands the development of borderline personality disorder as failure of cohesion in the rapprochement phase. Fonagy (1991) quotes several child development studies which support object relations explanations of underlying feelings of emptiness and social isolation in borderline functioning.

The patient is described as someone with a specific structural configuration and impaired ego functioning (Goldstein, 1989). Bintzler (1978) comments on Kernberg who suggested that these patients function on the border between neurosis and psychosis. Further, there is a lack of integration of good and bad, which results in constant splitting. Kaplan et al (1994) support this description, and explain that patients suffering from borderline personality disorder bring the all good and all bad categories into their relationships, leading to unstable and volatile interactions. They also highlight the unpredictability of these patients. Chessick (1979) similarly refers to the unpredictable fluctuations in their ego state.

Johnson (1988) reports on the family systems perspective which suggests that borderline pathology is really a symptom of family dysfunction and not individual pathology on the grounds of unclear boundaries, inappropriate coalitions and inappropriate roles.

Kernberg (in Stone, 1986) explains the defensive operations at the level of borderline personality organization from the perspective of failure to integrate into a stable ego identity through introjections. “This defensive division of the ego (in which what was at first a simple defect in integration is then used actively for other purposes) is in essence the mechanism of splitting” (Stone, 1986:299) He suggests that the frustration created through denial of early oral needs is probably the main cause of the lack of differentiation between self and objects. He describes the blurring of boundaries between self and non-self as depending on failure to become autonomous, poor frustration tolerance and a consequent development of aggression. Kernberg, who is often quoted by other authors, lists the defense mechanisms, which are mostly, but not exclusively used by borderline personality disorders, as splitting, primitive idealization vs. omnipotence and devaluation, denial and projection, particularly projective identification.

2.6.4 HISTRIONIC PERSONALITY DISORDER

Gelder et al (1991) quote Schneider, who first identified the group of people presenting with histrionic traits and referred to them as *attention-seeking psychopaths*. These people were known to attempt to appear more than they were and made unreasonable demands on others. They consider histrionic traits in the normal personality to be an advantage on a social level due to their ability to entertain and access feelings with ease. When these traits are present in a more intense form, histrionic personality disorder can be diagnosed and interpersonal relationships are damaged through patients becoming too self-centered and shallow. Holmes (1991) describes relationships with histrionic personalities as stormy and short-lived.

The DSM IV reports that in clinical settings, this disorder is more commonly observed amongst females and lists the prevalence of histrionic personality disorder as 2% - 3% of the general population. Histrionic traits appear differently in different cultures and should therefore be assessed in terms of level of distress caused by the behaviour, rather than presentation of symptomatic behaviour. According to the DSM IV, histrionic personality disordered patients are indeed at greater risk of attempting suicide and even succeeding. Their manipulative threats should therefore be heard with caution even when it appears fairly clear that they are attempting to obtain attention from family or clinicians. Between 10% and 15% of patients in clinical settings have been diagnosed as having this disorder.

Tyrer et al (1991) list the descriptions of the histrionic personality disorder as excessively emotional, attention seeking, self dramatization, shallow mood, egocentricity, manipulative behaviour and craving for excitement. Gelder et al (1991) add the following: the angry and emotionally labile scenes, emotional blackmail and dramatic suicide attempts which are tolerable in childhood but unacceptable in adulthood. They describe the above behaviour in the most severe form as possibly developing into swindling and pathological lying.

Kaplan et al (1994) explain the seductive and flirtatious behaviour of both male and female persons diagnosed with histrionic personality disorder as stemming from a constant need for reassurance, and add that both male and female patients can suffer from sexual dysfunction disorders despite their attempts at displaying sexuality. They describe defenses of histrionic behaviour as repression and dissociation, which enable such patients to remain unaware of true feelings, and unable to make sense of the underlying reasons behind their behaviour. It is also

important to bear in mind that reality testing can become impaired when they find themselves in stressful situations.

2.7 TREATMENT ISSUES

The literature on psychotherapies is vast and relevant to the therapy of personality disorders. In this section, some general indicators relevant to the treatment of cluster B personality disorder, are discussed. The focus would move towards how these therapies are applied when working with personality disorders from the cluster B group. It would be assumed that the clinician is comfortable with the therapeutic process and skills applied for each of the therapies. Corey (1977) highlights, that although the different therapies have their philosophy and specific treatment goals, most approaches appreciate the importance of the therapeutic relationship.

Gelder et al (1991) believe that treatment of personality disorders should focus less on reframing past events and should closely explore patterns of relating, coping skills and management of feelings. They believe that it is important to be more direct than in classical forms of psychotherapy, but add that transference remains an important tool in therapy.

Giovacchini (in Lax, 1989) reports on cases where patients with fragmented egos were unable to tolerate an analytical relationship and required an adaptation of techniques to benefit from the therapeutic alliance. He believes that patients with fragile egos should be approached in a gentler and less intrusive way. He however cautions that the clinician should guard against a basic need to rescue the fragmented patient, as rescuing would bring a temporary and precarious comfort rather than a sense of integration within the patient. The treatability of the patient is assessed on the handling of transference and countertransference rather than the

patient's dynamics. The "wrong" therapist or therapeutic approach could therefore lead to the patient being considered unsuitable for therapy. Baudry (in Lax, 1989) supports the view on therapist contribution to treatment outcome and states that literature which suggests application of techniques totally ignores the effect of the clinician's subjectivity in applying techniques. She explains that the clinician has his or her own ethical and personal values, and stable characteristics such as optimism and impulsivity that could influence therapeutic stance. All clinicians have personalized styles, and an unconscious that cannot always be separate from what happens in the relationship. Corey (1977) supports this view point and adds, that unless the therapist becomes self-aware, the patient's therapy will be obstructed, and therapy will take place to meet the clinician's needs and not the needs of the patient.

Reich (in Lax, 1989) acknowledges that the fragile ego is often strengthened through supportive therapy. She expresses concern that the relationship may become so important to the patient who experiences a first reliable object relationship, that the patient may resist ever exploring the transference. She suggests a variation through which the clinician remains outside of the projective acting out for a while, until therapy moves to the point where there can be a working through of transference.

Milieu therapy, as a forum for treating acute ego damage, is described in Cumming and Cumming (1962) as providing enough activity to create a continuous and changing social situation, within which the patient has the task of regaining ego abilities related to functioning within a society. Whitely (1994) supports the concept of milieu therapy for personality disordered patients, by acknowledging that some patients may be too scared to enter therapy for fear of losing the therapist. The therapeutic community can become the potential space as

described by Winnicott (in Cumming & Cumming, 1962), where the patient will interact, explore these interactions through feedback and reality testing provided by the community members, and experiment with alternative roles and behaviours.

Truax and Carkhuff (in Corey, 1977) believe that patients need a high degree of inner disturbance and a low degree of behavioural disturbance to benefit from therapy. Considering that diagnostic criteria for cluster B personality disorders refer to problem behaviour, it would appear by definition, as though there are some therapists who would be less optimistic about the value of therapy for these patients.

Treatment and prognosis of specific Cluster B personality disorders can now be explored separately:

2.7.1 TREATMENT AND PROGNOSIS OF ANTI-SOCIAL PERSONALITY DISORDER

Hare (1976) discusses the modification of the behaviour of the anti-social personality disorder and says that traditional therapeutic procedures have not been effective. He sees a possible exception as some sort of therapeutic community, where the focus is on restructuring interpersonal relationships and social environment. He refers to evidence that behaviour can reduce in severity, in some cases, with age.

Cleckley (1964) also refers to the lack of response to any kind of psychiatric treatment. He proposes that some improvement in adjustment can be achieved through ongoing control, restriction, direction and support.

Kaplan et al (1994) suggest that anti-social personalities become more open to change when amongst a peer group or when admitted to hospital. This supports Hare's suggestion of milieu therapy as above. Gelder et al (1991) report on the use of milieu therapy for the anti-social personality disorder, where patients live and work together in a unit and meet several times a day for group discussions. In these discussions, patients are encouraged to consider the effect of their behaviour on others. In 1960, Rapoport (in Gelder et al, 1991) described the elements of the treatment as permission to act on feelings without the usual restraints, sharing of tasks and responsibilities, group decision on making and breaking rules, and lastly feedback on how each patient's behaviour affects the other patients. The aim of such treatment is to control acting out behaviour and finding more acceptable ways of expressing themselves.

Kaplan et al (1994) further suggest that the therapist takes a position of confronting self-harming behaviour and fears, and reformulates the patient's experience of punishment, retribution and isolation. Pharmacotherapy is recommended for co-morbid diagnoses such as anxiety, rage and depression. Since these patients often abuse substances, careful assessment is necessary. Kaplan et al (1994) support evidence that symptoms decrease in some patients as they grow older, but believe that the disorder mostly follows its course.

2.7.2 TREATMENT AND PROGNOSIS OF NARCISSISTIC PERSONALITY DISORDER

Kernberg (in Morrison, 1986) acknowledges that many experienced clinicians are sceptical about treatment for narcissistic personality disorders, but also agree that analysis seems to be the most likely treatment of choice. He quotes Abraham from 1919, who warned that narcissistic personalities are more likely to use therapists in the transference resistance as an

audience for their own analytic work. He believes that the prognosis of these patients remains guarded if they show an inability to tolerate depression and mourning. For those who have achieved some creative development in other areas, the prognosis is better.

Doroff (in Horner, 1984) comments on the transference when the narcissistic patient experiences the therapist as not psychologically separate from the self, and becomes entitled and even enraged that the therapist sees other patients. The therapist can also be perceived as having the same psychological make-up as the patient, and if the patient then fails to find a “twin”, emptiness is experienced. He also quotes Kohut who discussed a more “mature” transference when the therapist is acknowledged as being separate, but is expected to participate and confirm the narcissism. If the therapist is idealized as the caring mother, the therapeutic alliance begins and transference can be worked with. It is, however, very important to assess and remain aware of the ego resources of each patient. In the early stages of therapy, he suggests that therapy is structured so as not to repeat the earlier pathology. In ongoing work with the narcissistic patient, interpretation of the transference should only occur if the patient has the ego strength to receive the interpretation. Should this not be so, the therapist is advised to rather focus on the patient’s ability to observe own reactions and development. The therapist should take care not to form an alliance with the false self or to confront difficult behaviour, as it would hinder healing of the split self.

Kaplan et al (1994) consider treatment of the narcissistic personality as difficult since it requires patients renouncing their narcissism. They refer to the work of Kernberg and Kohut who guide clinicians in psychotherapy and rather suggest pharmacotherapy for mood swings and depression. They believe that the disorder is chronic as the patient is consistently

confronted with narcissistic injuries from life circumstances and also deals very poorly with the ageing process. They are therefore considered to be more vulnerable than other patients in the middle and later stages of the life cycle.

It is important to note that there is a difference between the concept of narcissism and a diagnosis of narcissistic personality disorder when deciding on management. The main factor to consider is the difference in ego strengths of patients without a diagnosis of personality disorder as compared with those with the diagnosis.

2.7.3 TREATMENT AND PROGNOSIS OF BORDERLINE PERSONALITY DISORDER

Gelder et al (1991) believe that borderline patients do not respond well to exploratory psychotherapy and may even act out more in therapy. They suggest supportive therapy and practical guidance to deal better with life. Kaplan et al (1994) agree that psychotherapy is difficult for patient and therapist, but believe that this is still the treatment of choice with greater focus on reality therapy rather than interpretation of the unconscious. Social skills training and behaviour modification help patients to become less sensitive to criticism and improve interpersonal behaviour. Pharmacotherapy is recommended for depression, rage and impulse control. They further suggest hospitalization where support structures are unable to contain the patient. Effective hospitalization is often for periods up to one year with regular follow up and even placement in a halfway house. This option is, however, only viable where resources are available.

Nurnberg (1982) claims that without supervision, therapeutic intervention between an untrained therapist and a borderline patient is a highly volatile situation. He stresses the need for limit-setting.

Graziano (1986) emphasizes the importance of understanding the characteristic behaviour and developmental issues of the borderline. She predicts that without this knowledge, the therapist might spend too much time feeling as helpless, bewildered and disorganized as the patient.

Woolcott (1985) suggests that making prognostic estimates is hazardous, although practically necessary for judgement of treatability of borderline personality disorder. Good prognostic indicators for the borderline patient include the capacity for developing a relationship with the therapist, a likeability, warmth, humour and interest in people as well as creativity and the capacity for sublimation. Kaplan et al (1994) are rather negative about prognosis. They believe that patients present mostly when making life choices, but that the condition is consistent and does not really change over time.

2.7.4 TREATMENT AND PROGNOSIS OF HISTRIONIC PERSONALITY DISORDER

Thompson and Goldberg (1989) studied the case notes of 52 patients diagnosed as suffering from histrionic personality disorder and found that in 27 cases, no core traits were recorded in the notes. They concluded that the diagnosis was often inaccurate. They found that non-compliant patients earned the diagnosis of histrionic personality disorder without any evidence of the disorder.

Nash et al (1990) see the aim of treatment as slowing down information-processing to facilitate logic and sequence. Kaplan et al (1994) support psychoanalytic treatment individually or in groups to clarify the feelings of this group of patients who are mostly unaware of their own feelings. They suggest the use of pharmacotherapy for depression, anxiety, derealization and illusions.

Murphy and Guze (1960, in Gelder et al, 1991) describe difficulties encountered in treatment as demands made by patients in a direct manner (i.e. unreasonable requests, unreasonable times) and an indirect manner (for example seductiveness, comparing therapists) to which the clinician should set early and clear limits.

The prognosis of histrionic personality disorder is discussed by Kaplan et al (1994) as presenting with fewer symptoms later in the life cycle. They caution that this could be due to decreasing energy rather than internalized growth.

2.8 GENDER ISSUES IN THE TREATMENT OF CLUSTER B PERSONALITY DISORDER

Erickson (1993) speculates about opinions that claim change to be difficult for males, because males are considered rigid, reluctant to give up powers and privileges previously enjoyed and are only interested in accumulating wealth. She prefers to see that change requires them to change their world view and not just learn new skills. She suggests that female therapists should respect this difficulty when working with men.

Even though this stance seems amusing rather than scientific, it is perhaps more important to focus on differences when dealing with personality disorder. It has already been mentioned that the DSM IV considers some disorders, for example anti-social personality disorder, more prevalent in males or, for example borderline personality disorder, in females. This statistic can complicate the diagnosis without the clinician being aware of prejudice. Ford & Widiger (1989) responded to a study by Warner in 1978, where characteristics of the anti-social and histrionic personality disorders were mixed in a case history. When presented as a female, the clinicians diagnosed histrionic personality disorder more readily and anti-social personality disorder was diagnosed by the majority of therapists who were informed that the patient was male. They could however not find gender bias in their own study.

2.9 SUMMARY

Theoretical understanding of personality and the assessment of personality evolved over many years. In an attempt to make sense of interpersonal or functional difficulties that some people experience, a system of diagnosis or labeling was established to guide clinicians in the treatment of patients. This system holds informative guidelines in the understanding and treatment of patients diagnosed with personality disorder, provided that the limitations are consciously considered and diagnostic labels attached with sensitivity in the interest of patient management.

The personality disorders in cluster B are described and understood in terms that appear to evoke responses different from those in the other clusters. The following chapter will therefore explore countertransference with specific reference to working with patients diagnosed with personality disorders.

CHAPTER 3: COUNTERTRANSFERENCE AND THE THERAPIST

3.1 INTRODUCTION

This chapter aims to provide an understanding of the concept of countertransference, its origins and its value in the therapeutic process. It will focus on the clinician, rather than the patient or the diagnosis, to explore contributing issues in therapy. The concept of burnout is well researched, but for the purpose of this dissertation, acknowledged rather than explored.

This chapter will refer to a study by Holmqvist and Armelius (2000), which deals with the notion that the patient's maladaptive interpersonal patterns are reflected in countertransference, but contribute less to the clinician's feelings than the clinician's own background and personality.

3.2 COUNTERTRANSFERENCE

Brammer and Shostrom (1977) point out that different writers view countertransference from different perspectives. They define countertransference as the conscious and unconscious attitudes of the clinician toward the real or imagined patient attitudes or overt behaviour. It could be a feeling of the moment, but could also be an emotional reaction or projection from the clinician. They identify three sources of countertransference feelings:

- the clinicians unresolved personal problems
- situational pressures which are tied up with the clinicians problems
- communication of the patient's feelings to the clinician

Corey (1977) sees countertransference as an inevitable part of the therapeutic relationship. He explains that even though all clinicians are human, it is important that the clinician remains as objective as possible when receiving anger, love, adulation, criticism or other intense feelings from the patient. He describes countertransference in two broad categories, namely clinicians developing either dislike of or overinvolvement with the patient, and adds that this could have disruptive effects on the therapy.

Miller (1990) believes that if the clinician has gained access to own childhood, s/he should be able to differentiate between countertransference and own transference. She experiences countertransference as quick signals through which the patient delegates split-off feelings or attitudes from the patient's primary objects.

Moylan (in Obholzer & Roberts, 1994) discusses working with a nurse who took care of a patient who was unable to communicate in English. She communicated her own feelings in terms of projective identification and expressed feelings of impotence, fear, anger and guilt - projecting these in turn on to the facilitator of the group for staff members. Mawson (in Obholzer & Roberts, 1994) confirms this by saying that when primitive anxieties are stirred up, there is a natural tendency to get rid of uncomfortable and unwanted thoughts and feelings by locating them in someone else, to seek a container for the painful feelings and the part of the self that experiences them.

According to Casement (1990) the clinician's feelings in the session may give important diagnostic clues about unspoken or unclear communications. Working with countertransference means finding a way to use these clues. He cautions that these feelings

cannot be interpreted indiscriminately as some patients might find it intrusive and persecutory while others will be pleased to indulge their passivity. In an earlier book (1985) he writes that interpreting countertransference should not make the patient feel responsible for the clinician's feelings and can only be used for the patient's understanding.

Fonagy (1991) believes that working with transference and countertransference enables the therapist to deal with resistance. Bollas (in Hedges, 1987) emphasizes that clinicians must sustain long periods of not knowing how to function while the patient manipulates through transference. Hedges (1987) adds that the clinician's countertransference is never totally independent of the clinician's personality or biased ways of experiencing the world, and can therefore never be interpreted as clear, clean-cut understanding of the transference. The clinician may not interpret countertransference to relieve own feelings but should develop a readiness through hunches, feeling states, passing images, fantasies and imagined interpretive interventions, before interpreting countertransference.

Horner (1984) views countertransference problems of working with patients suffering from character disorders as similar to the characterological problems of the patient. She lists negative countertransference as ranging from annihilation of the self to feelings of intrusion, impingement or narcissistic wounding when confronted with own limitations. Clinicians should be able to tolerate abandonment by the detached patient without losing own sense of presence in the situation, as well as maintain reality testing in the face of idealized transference.

Doroff (in Horner, 1984) also believes that the attributes of character structure should be considered when considering countertransference encountered in therapy with a narcissistic

personality disorder. He acknowledges that for the narcissistic personality, all others exist to meet his needs and he does not respond to people in their own right. This results in an onslaught on the clinician's own sense of self. Considering the narcissistic grandiosity and entitlement, he strongly advises a realistic assessment of the clinician's limitations. He believes that narcissistic personalities are difficult to work with, treatment is long-term and exhausting and progress is slow. He agrees with Kohut (1971, in Horner, 1984) and Kernberg (1975, in Horner, 1984) that clinicians should limit the number of narcissistic personality disorders in their case loads.

Searles (in Stone, 1986) sees countertransference as the most reliable approach to understanding patients and even more so with the borderline patient whose repressed emotions are very intense. Because so much of the borderline patient's functioning is at a symbiotic, pre-individuation level, the therapist is often the one to verbalize and make known which conflicts the patient is battling with. These conflicts could slowly be internalized by the patient through his/her identification with the therapist.

Considering the literature, it is clear that countertransference feelings are feelings belonging to the clinician. The literature describes the origin of these feelings as sometimes belonging primarily to the clinician on a background of the clinician's own frame of reference, or at other times, placed in the clinician, through defenses and transference, by a patient to whom the feelings belong.

3.3 THE THERAPIST'S ATTITUDES AND CHARACTER

Baudry (1982, in Lax, 1989) describes attitude as internal attributes that determine behaviour that are in turn interpreted, correctly or incorrectly as a character trait. The clinician's technique is influenced by own values and attitudes that he lists as:

- pessimism or optimism
- permissiveness
- tendency to gratify or frustrate wishes
- degree of warmth vs. distance
- passivity

The clinician's analytic style is influenced by tone, manner, verbosity, use of humour, authority and readiness to make interpretations or reconstructions. The clinician also has own reactions to the patient such as anger or criticism, and it becomes difficult to differentiate between character and professional behaviour. She continues to explain that a character trait in one person evokes either an opposite reaction in the other or acts as mirror to the other. The clinician's character response would either lead to understanding or acting out by the clinician. She believes that it is, therefore, possible that the clinician's character traits can either help or hinder the therapeutic process. Baudry believes that it is still impossible to measure the impact of the clinician's character on the therapy process, but that it shapes therapy more than we are willing to admit beyond the usually considered countertransference reactions.

Cooper (1986, in Lax 1989) also discusses the clinician's character and values as possible limitations to the therapeutic process. He suggests that it would be wise to remember how easy it is to become de-skilled and how important it is to maintain optimal balance as a clinician.

Corey (1977) sees therapy as a deeply intimate learning experience and demanding of a clinician who is prepared to shed stereotyped roles in favour of being a real person. He warns that the therapist who tries to be perfect will refrain from discussing problems, countertransference and mistakes with a supervisor to the detriment of the patient.

Allport (1935, in Fishbein & Ajzen, 1975) described attitude as the most distinctive and indispensable concept in contemporary social psychology, while Fishbein and Ajzen (1975) defined attitude as a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object. Edwards (1957) sees attitude in terms of likes and dislikes. From these descriptions, it seems reasonable to conclude that affect is an essential part of attitude.

Schuman and Presser (1981) conceptualized crystallized attitudes as those that exist before being measured and suggest the use of variations in attitude strength when offering closed questions so as to allow for a response closest to real attitude. They have also found that a combination of open and closed questions provided the most accurate results in attitude surveys.

Holmqvist and Armelius (2000) found that countertransference feelings are influenced by the habitual style of the clinician, and that the habitual style is influenced by personality factors such as self-image. They believe that the clinician's contribution to countertransference is greater than the contribution from the patient. The patient's personality organisation or DSM-diagnosis proved to be insubstantial in influencing the clinician's countertransference feelings. In a study of 163 subjects who completed a feelings checklist, they found that staff expressed

habitual feelings towards all their patients. These feelings could be placed on a continuum ranging from close, accepting, helpful and autonomous, to distant, rejecting, unhelpful and controlled. In this respect, the clinician's self-image and habitual style towards patients, were found to be related to: "a) the therapist's view of himself or herself (the introject), and his or her view of how b) mother and c) father acted towards him or her as a child." (Holmqvist & Armelius, 2000:477).

The clinician's use of sense of self, and personal life experiences are therefore significant in attitudes that unconsciously influence therapy.

3.4 BURNOUT

Cooper (1986, in Lax, 1989) quotes Freud who referred to psychoanalysis alongside teaching and government, as the impossible professions. An important factor that he discerns, is that of isolation of the clinician. The clinician's average day consists of contact with patients and thoughts about them when they are not physically present. This can lead to clinicians feeling isolated. Therapy is mostly terminated without any further opportunity to evaluate future outcome of therapy. The clinician is again isolated in terms of building confidence in skills or retrospective learning from the patient. Emotional investments in patients are large, and reward limited by ethical constraints. This lack of reward and isolation can easily lead to burnout. Cooper believes that we respond to burnout with masochistic and narcissistic defenses. Masochistic defenses appear as discouragement, boredom and lack of interest in the therapeutic process. Clinicians can unconsciously adopt a victim role toward their profession and patients. This could result in a loss of inventiveness and creativity in working with patients, to the detriment of the therapy. The narcissistic defense can manifest in behaviours to elicit

admiration from the patient. These clinicians are directive and paternalistic, give advice and guidance and attempt to maintain a childlike devotion from the patient. This clinician could also enliven his/her own deadness through the success of the patient. He admits that these defenses are used by most clinicians at some time and are effectively dealt with in own therapy. Mawson (in Obholzer & Roberts, 1994) referred briefly to burnout that could easily occur when countertransference is not dealt with. Moylan (in Obholzer & Roberts, 1994) agreed that staff who carry too many projections without developing an understanding and an ability to hold the feelings, cannot understand why their work is so difficult, and end up leaving their professional positions.

3.5 SUMMARY

This chapter has discussed attitudes, character, and countertransference and its significance in the outcome of diagnosis and treatment of patients. Exploring countertransference requires openness and honesty from the clinician. Countertransference feelings are as powerful as transference in the therapeutic relationship. It will probably continue to be partly conscious and partly unconscious. The clinician's responsibility towards the patient, and to herself, encourages her to strive towards greater awareness of countertransference feelings, and responsible use of supervision to prevent isolation and burnout.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

This chapter will focus on the methodology applied in the study. Decisions and choices are motivated and clarified with support from the literature. Limitations and attempts to minimize the impact of these limitations are reviewed.

The questions posed will be revisited in chapter six which contains conclusions and recommendations.

4.2 PURPOSE OF THE RESEARCH

The purpose of the research is:

- to explore attitudes of clinicians in the helping professions, towards referral and treatment of patients diagnosed with personality disorder, with special attention to the referral and treatment of cluster B personality disorders
- to explore possible related factors that could influence the attitudes of clinicians in the helping professions
- to explore the use and perceived value of the DSM IV as diagnostic tool

4.3 RESEARCH QUESTIONS

The study address the following questions:

- are clinicians *more* prepared to accept for treatment those patients who are diagnosed with disorders other than personality disorder?

- are clinicians negatively influenced in their decision making when accepting for treatment those patients who are diagnosed with cluster B personality disorder?
- are there differences in the attitudes of clinicians according to their training or professional registration?
- does the clinician's place of employment and/or duration of employment influence acceptance for treatment of those patients diagnosed as suffering from cluster B personality disorder?
- does the availability and constructive use of supervision influence countertransference issues and burnout?

4.4 RESEARCH ASSUMPTIONS

The researcher assumes the following:

- that clinicians are less prepared to accept for treatment, those patients diagnosed with cluster B personality disorder
- that there are insignificant differences in attitudes of clinicians in relation to their training and professional registration
- that clinicians in government employment settings and clinicians in young private practices are less likely to refuse for treatment, those patients diagnosed with cluster B personality disorder, than those clinicians in established private practices
- that supervision constructively assists with countertransference feelings and protects clinicians against burnout

4.5 RESEARCH DESIGN

The research design combines the quantitative and qualitative approaches following the Dominant-less-dominant model. This model is described by Creswell in De Vos (1998:360), despite his preference for the use of a single design. De Vos (1998:360) explains the model as predominantly following one design (quantitative in this study) with smaller components of another (qualitative). The design is described in greater detail in terms of general design, literature review, sampling, interview schedule, data collection and data analysis.

4.5.1 GENERAL DESIGN

The study consists of a survey conducted amongst clinicians of different professional registration, currently practicing in the Southern Suburbs and Metropolitan area of Cape Town. The study focuses on a description of therapist profile, and exploration of beliefs and preferences, with the intention of identifying attitudes and functioning of the sample group. The study also focuses on the use and usefulness of the DSM IV.

After reviewing the literature to identify pertinent issues, the researcher drew up an interview schedule to use as an instrument in a structured interviewing situation. The interview schedule was used in a pilot study and adapted in the areas that were clearly ambiguous. The interviews were finally conducted in different employment settings that will be discussed. The purposive sample was drawn from the population of therapists practicing in Cape Town between December 1999 and February 2000. Data was finally analyzed to arrive at conclusions to answer research questions and to highlight areas for future focus.

4.5.2 LITERATURE REVIEW

Review of the literature was assisted by the computerized information system at the University of Cape Town libraries. Information was gathered on psychiatric assessment, psychiatric disorders, personality theories, therapies and therapists. Some of the literature provided helpful references for further reading. This assisted the time-consuming search in journals for relevant articles.

The literature on theories and disorders tended to describe the same issues in different ways. This meant that even though the written works are extensive, the volume of information they offered was manageable. The literature review focussed on the diagnosis and treatment of the cluster B personality disorders. Other disorders and their treatment, as well as related subjects such as burnout and supervision, were considered relevant, but not the focus of the study.

4.5.3 SAMPLE

In order to select the sample, the method of purposive sampling was used as described by Grinell (1990). It is a form of nonprobability sampling that could be used because resource lists allow access to sufficient knowledge on educational qualifications and type of practice to assume that the population would be appropriate for the survey. Using two resource listings, namely the South African Association of Social Workers in Private Practice Resource list and the Med Pages Health Care Directory, clinicians were isolated as follows:

- social workers in private practice with MSocSc(Clin) or qualifications in mental health
- social workers employed in government psychiatric institutions
- clinical psychologists in private practice
- clinical psychologists employed in government psychiatric institutions

- psychiatrists in private practice
- psychiatrists employed in government psychiatric institutions

These names were stratified in terms of professional registration, which consisted of social workers, psychologists and psychiatrists. Within this frame, systematic sampling further reduced the sample to 30 clinicians.

A sample of 30 clinicians was selected to participate in the study, in the following manner. Using the resource directories, 27 clinical social workers were identified in private practice in the chosen catchment area and 11 in government psychiatric institutions. Using systematic sampling, every fourth name was selected to form the sample. The total number of 181 psychologists was made up of 173 listed as practicing in private practice and 9 employed in government setting. This meant that every 18th psychologist was selected for the sample. Psychiatrists practicing privately numbered 33 with 14 in government setting. This meant that every third psychiatrist was selected for the sample.

The choice of thirty as sample size has no theoretical foundation, other than “rule of thumb” as described by Neuman (2000:217).

A limitation can be that the sample is biased, as only clinicians from the Cape Central and Southern Suburbs were considered in order to facilitate accessibility for interviewing. In addition, there is a known difference in theoretical orientation of the teaching hospitals in the Western Cape which could influence the responses.

A further limitation of the sampling is the time period lapsing before resource lists are updated, although it is reasonable to accept that the numbers obtained from the resource lists were accurate for the time period compiled. However, the stratification of the groups ensured higher homogeneity in the sample. Grinell (1990) accepts that stratified sampling can be disproportional if the population is disproportional.

4.5.4 THE INTERVIEW SCHEDULE

The literature review guided the researcher to an understanding of which questions were relevant to be asked. The issues to be explored were ordered in a structured interview schedule to be used in the interviewing situation. Babbie (1992) points out that any interview schedule will consist of not only questions, but also of statements which are more helpful when measuring attitudes. Respondents could agree or disagree with such statements. The statements, which are measured on the Likert scale, were used with open ended questions in the interview. Babbie (1992) believes that the use of both statements and questions provides flexibility and can therefore make the interview schedule more interesting.

Questions posed were both closed and open-ended. Open ended questions were used where the writer deliberately chose not to lead the respondent. Questions were kept as short and clear as possible. The order of the questions may have lead respondents in their answers for example questions on supervision following questions on transference. The researcher, however attempted to order questions logically so that the clinician did not often have to change thought flow.

The interview schedule was pre-tested in interview settings at Groote Schuur Hospital with the assistance of two psychology interns and two psychiatric registrars who would not be part of the sample population. Subsequently, some adaptations were made where it was indicated that respondents needed to ask clarifying questions.

A limitation of the interview schedule is the use of clustering of personality disorders as described in the DSM IV. This did not allow respondents to differentiate between different personality disorders in the same cluster, when they would prefer to acknowledge differences in reactions within the same cluster. The interview schedule also did not contain elements of re-testing that would have enhanced reliability.

4.5.5 ETHICAL DIMENSIONS: INFORMED CONSENT AND CONFIDENTIALITY

Neuman (2000) formulates statements required for informed consent. In relation to Neuman's guidelines, the following was elaborated on. In the process of obtaining verbal consent from respondents, relevant information was presented in relation to the researcher, a description of the purpose and procedures of the study, a commitment to confidentiality, an offer of feedback on summarized findings, and the choice of voluntary participation. However, while anonymity is not possible with structured interviews, confidentiality does protect the privacy of respondents as far as possible. It should be noted that the population from which the sample was drawn, is a population with many potential close links and contacts, which could leave the study vulnerable to unintentional breach of anonymity.

4.5.6 DATA COLLECTION

Structured interviewing was used to collect data. Grinell (1990) sees interviewing as the most consistent and frequently used technique in social work. The advantages of interviewing are listed by Grinell as naturalness, spontaneity, flexibility and control of the environment as well as a high response rate. The disadvantages of this method are biases in self-reported data when respondents are uncomfortable admitting openly to attitudes and prejudices. They may even lie to cover up failure of memory or inadequate knowledge. This could be related to the loss of anonymity. The interviewer in turn listens to answers and in the attempt to record responses, could distort the meaning of responses if summarized. By using an interview schedule to conduct the interviews, the writer attempted to minimize interviewer bias. The questions were used without further clarification or questioning outside of the frame. When respondents were not sure what they were asked, the question was repeated with explanations limited to specific questions asked by respondents. It should, however, be considered a limitation that some respondents may have wanted to ask clarifying questions but were unsure whether they were allowed to do so.

Practical problems with this method of data collection are inaccessibility to respondents, time consumed with interviews and the intensity of the interview setting. The respondents were approached to find a suitable time to conduct the interviews. While it was difficult to find times as clinicians in private practice seemed to fill their diaries, they went out of their way to accommodate the researcher.

Neuman (2000) discusses the advantages and disadvantages of telephone and face-to-face interviews. Significant differences are absence of visual observation during telephone

interviews, higher social and interviewer bias during face-to-face interviews and administrative differences such as cost, time and response rate.

Nineteen interviews were conducted on the telephone and eleven interviews were conducted in the work setting. The high percentage of the interviews were conducted on the phone to accommodate the clinicians. Nineteen (63,3%) of the respondents found it easier to respond telephonically rather than find an appointment time in the diary.

This variation is considered a serious limitation in data collection as the interview questions were consistent but not the setting in which these interviews were conducted. It also excluded the opportunity for observation of non-verbal communication, but limited the opportunity for interviewer bias as described by Cozby (1981) and Neuman (2000).

4.5.7 DATA ANALYSIS

Data obtained from the structured interviews was processed from the questionnaires and was quantified using frequency distribution of numbers or percentiles. The data is presented with subgroup comparisons, interpretation of patterns and bivariate analysis as described by Neuman (2000). Qualitative analysis, by extracting themes or generalisations, was used with open ended questions. The analyzed data is presented and discussed in chapter five.

4.5.8 RELIABILITY AND VALIDITY

Neuman (2000) makes readers aware that reliability and validity in social research, where constructs are not directly observable, are salient, yet impossible to perfect. He also clarifies that reliability is necessary for validity and easier to achieve.

Reliability in this study was increased by the use of clearly conceptualized constructs through the use of diagnostic criteria for personality disorders as listed in the DSM IV. The use of the Likert scale facilitated a higher level of measurement of a construct as ambiguous as attitude. The use of the pilot study further contributed to reliability.

Distinguishing between the different professional registrations throughout, provided, to some extent, a measure of convergent validity (Neuman 2000). Neuman (2000) also states that qualitative researchers are more concerned with authenticity than validity and therefore focus more on the understanding of ideas and concepts. This study for example, relied strongly on respondents understanding of concepts such as countertransference.

4.6 LIMITATIONS OF THE STUDY

The limitations of the study has been addressed throughout the presentation in terms of sampling, population, and interviewing. It is maybe helpful to discuss limitations in more detail.

4.6.1 LIMITATIONS OF THE LITERATURE REVIEW

A closer examination of literature on cluster A and cluster C personality disorders would have been helpful in explaining the significance of findings, when comparing findings on cluster B personality disorder. However, the focus of this research was the cluster B personality disorder. Similarly, while the focus of the study was not on in-depth examination of supervision and burnout, a more intense literature review could have been helpful in relation to recommendations for supervision. This could be the focus of further research.

4.6.2 LIMITATIONS OF THE SAMPLE

The selection of social workers for the sample was made from a group with additional training in the area of mental health. It can, therefore, be assumed that they understand the terminology and the concepts used. There is, however, a much larger portion of the social work population, for example, those who work in family welfare organizations, who are unfamiliar with terms such as personality disorders, especially those trained at some Universities with a different theoretical focus. They are merely aware in their work that they encounter difficult people in their caseloads (PD vs. DP = Personality Disorder vs. Difficult Person). This study thus reflects the views of a specific selection of social workers, that is, those with recognized clinical qualifications and experience in the field of mental health.

Selecting ten respondents from each of the three identified fields of professional registration, may be too small a sample to represent the profession. The total number of thirty respondents is, however, adequate to formulate conclusions around the attitudes of clinicians towards the patients they treat.

4.6.3 LIMITATIONS OF THE INTERVIEW SCHEDULE

Existing attitude scales such as developed by Robinson et al. (1973) for measuring attitudes in terms of trust, acceptance, and similar characteristics, were not applied. While the researcher had considered using existing attitude scales, it was felt that adapting these scales to fit the needs of the study would threaten validity and reliability, removing the motivation for applying such scales. Thus the researcher formulated her own interview schedule tailored to measure the specifics of the study. The interview schedule tended to follow the medical model, which clinicians who work outside of this model, found difficult to accommodate.

The interview schedule explored the personality disorders in cluster B separately, but combined the personality disorders from other clusters in the formulation of some questions. Respondents may have responded differently to the different disorders in clusters A and C, similarly to differences in responses towards disorders in cluster B. However, this presented an opportunity to explore the concept of clustering of diagnoses.

4.6.4 LIMITATIONS OF DATA COLLECTION METHODS

Cozby (1981) alerts to the problems experienced with self-report measures such as interviewer bias and response set. In this respect, the interviewer could influence responses through showing approval or disapproval. The respondents interviewed telephonically could have been less affected by interviewer bias, but were not excluded from the possibility of choosing responses to project a desired image. The most common response set, called social desirability, (Cozby 1981:51) is of particular concern in the reporting of countertransference feelings and attitudes towards patients. Respondents were reassured of confidentiality but could not respond anonymously in the interview. Jourard (in Cozby 1981) reassures that respondents are more likely to be open and honest if promised feedback of results and the purpose of the study is explained clearly. This remains in keeping with suggestions by Neuman (2000) to obtain informed consent as an ethical standard in social research.

4.6.5 LIMITATIONS OF THE RESEARCHER

The researcher is a clinical social worker who has worked in a clinical setting where patients were assessed and mostly referred for further therapy. In the process of referring patients diagnosed as suffering from cluster B personality disorder, some resistance was found from other therapists. It was therefore important to have an awareness of the need for lack of bias

and objectivity in this research. In relation to the researcher's own experience of working with a variety of patients, including those with a diagnosis of personality disorder, she is aware of the need to maintain a professional attitude towards the patients themselves and in relation to therapists' dilemmas in working with the more difficult patient population.

The researcher practices as a colleague of some of the respondents from the sample of professionals, which raises the question of open and honest responses in the interviews. Despite these limitations, responses did not vary significantly, and it can be assumed that reliable and trustworthy information could be obtained.

Finally, the researcher was limited by conducting the research in her second language.

4.7 SUMMARY

This chapter covered the purpose of the research, posed research questions and described the research design.

Self-reporting measures in surveys with the aid of structured interviewing limits the size of the sample, but favours response rate. While there were limitations regarding self-reporting, it does not, however, exclude reaching helpful conclusions.

The following chapter will address the results of the study.

CHAPTER 5: RESULTS

5.1 INTRODUCTION

Chapter five is a record of all the results with reference to literature where appropriate. The results presented follow the format of the interview schedule.

5.2 RESPONDENTS

It should be noted that all the clinicians selected in the sample agreed to participate, although seven (23,3%) thought themselves an unsuitable choice and wanted to refer the writer to someone they considered more experienced or working in the medical model. After sampling was explained to them, however, they were more agreeable and proved suitable participants for the study.

Despite reassurance of confidentiality, one respondent asked whether the interview was to be recorded and commented that responses would be modified if that were the case. She accepted that the record on the interview schedule was the only record kept. One respondent was recovering from surgery but still insisted on participating as she found the subject interesting.

5.3 THE INTERVIEW SCHEDULE

The interview schedule seemed easy to follow for both the interviewer and the respondents. Some comments from respondents highlighted the difficulty they experienced with the use of the clustering of personality disorders as defined by the DSM IV. They felt that their responses would have been different without the use of the clusters. In this respect, the American Psychiatric Association acknowledged that the clustering system is useful in education and

research, but “has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-occurring Personality Disorders from different clusters.” (1994 : 630) This statement also applied to clinicians who suggested that their responses would be different if they were able to consider individual patients, rather than a diagnosis with many variables within the individual presentation.

5.4 CLINICIANS’ PROFILE

The first part of the interview schedule collected information on the clinicians, their training and experience. Identifying details were limited to that information which was relevant to the practice and excluded personal detail. The profiles of the clinicians are presented in table form with actual numbers and percentages. Percentages are rounded to the nearest decimal point. The sample consisted of mostly female respondents.

**TABLE 5.1
CLINICIAN GENDER AND PROFESSION**

	SOCIAL WORKERS	PSYCHOLOGISTS	PSYCHIATRISTS	TOTAL
MALE	1 (3,3%)	1 (3,3%)	5 (16,7%)	7 (23,3%)
FEMALE	9 (30%)	9 (30%)	5 (16,7%)	23 (76,7%)
TOTAL	10 (33,3%)	10 (33,3%)	10 (33,3%)	30 (100%)

Training details are as reflected in Table 5.2

**TABLE 5.2
SOCIAL WORK EDUCATOR**

	UNDERGRAD	POST-GRADUATE	TOTAL
UCT	3	5	8
UNISA	-	2	2
UPE	2	2	4
US	3	-	3
UWC	1	-	1
WITS	1	-	1
TOTAL	10	9	19

One Social Worker attended two different universities for post graduate studies.

Highest level of training for Social Workers:

BA/BSocSc	2
Honours	1
Masters	7
TOTAL	10

TABLE 5.3
PSYCHOLOGY EDUCATOR

	UNDERGRAD	POST-GRADUATE	TOTAL
NETHERLANDS	1	1	2
RHODES	2	2	4
UNIV. OF NATAL	-	1	1
UCT	3	3	6
US	1	1	2
UWC	-	1	1
WITS	3	2	5
TOTAL	10	11	21

Highest level of training for Psychologists:

Masters	8
Ph.D.	2
TOTAL	10

TABLE 5.4
PSYCHIATRY EDUCATOR

	UNDERGRAD	POST-GRADUATE	TOTAL
US	3	1	4
UCT	4	9	13
VIENNA	1	-	1
WITS	2	-	2
TOTAL	10	10	20

Highest level of training for Psychiatrists:

FF. PSYC/FC. PSYCH	10
TOTAL	10

Other specialist training for Social Workers included Honours in Psychology, Diploma in Psychotherapy and courses in Hypnosis, Narrative Therapy, Marital Counseling and Family Therapy. Specialist training for Psychologists included a Research Masters in Psychology. One psychologist previously worked as a registered nurse and another as an occupational therapist. One psychiatrist had also completed a course in hypnosis and another qualified with BA Logopaedics.

**TABLE 5.5
CLINICIAN PERIOD OF REGISTRATION**

	SOCIAL WORK	PSYCHOLOGY	PSYCHIATRY	TOTAL
0-2 YEARS	-	-	1	1
2-6 YEARS	-	1	2	3
7-15 YEARS	3	7	4	14
16+ YEARS	7	2	3	12
TOTAL	10	10	10	30

**TABLE 5.6
CLINICIAN EXPERIENCE**

	SOCIAL WORK	PSYCHOLOGY	PSYCHIATRY	TOTAL
0-2 YEARS	1	-	3	4
2-6 YEARS	3	5	3	11
7-15 YEARS	6	5	4	15
16+ YEARS	-	-	-	-
TOTAL	10	10	10	30

**TABLE 5.7
EMPLOYMENT SETTING**

	SOCIAL WORK	PSYCHOLOGY	PSYCHIATRY	TOTAL
GOV'MENT	4	1	2	7
PRIV PRAC	2	6	6	14
GOV + PRIV	-	2	2	4
LECT + PRIV	1	1	-	2
NGO + PRIV	2	-	-	2
SVISION+PRIV	1	-	-	1
TOTAL	10	10	10	30

TABLE 5.8
WORK INVOLVEMENT

	SOCIAL WORK	PSYCHOLOGY	PSYCHIATRY	TOTAL
PART TIME	1	4	1	6
FULL TIME	9	6	9	24
TOTAL	10	10	10	30

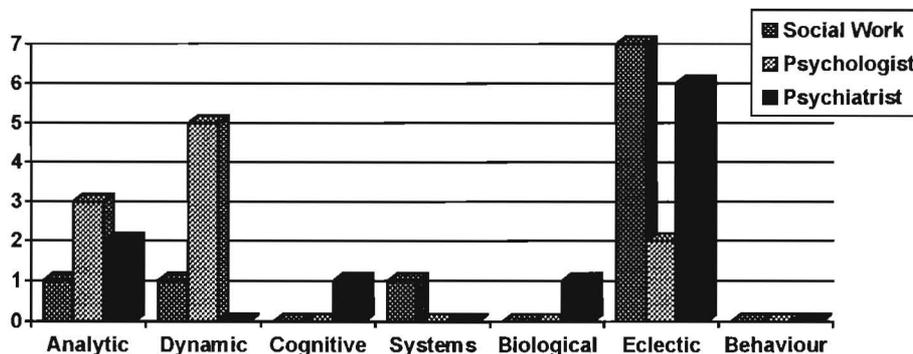
5.5 PROFESSIONAL PRACTICE

The second part of the interview schedule dealt with aspects of professional practice, ranging from work methods and treatment modules to personal responses and beliefs in working with patients diagnosed with personality disorder.

5.5.1 THEORETICAL ORIENTATION

Question 1 explored theoretical orientation. Half of the respondents followed an eclectic approach while 40% followed either the psychoanalytic or psychodynamic approach. None of the respondents followed the behavioural model. Gelder et al (1991) and Giovacchini (in Lax, 1989) believe that analytic therapies are less helpful when working with personality disorders, and that the focus should be on the therapeutic relationship and coping skills. Yet, a high proportion of respondents (90%) used the analytic, dynamic and eclectic approaches. Figure 5.1 illustrates the preferred theoretical approach.

FIGURE 5.1
THEORETICAL ORIENTATION

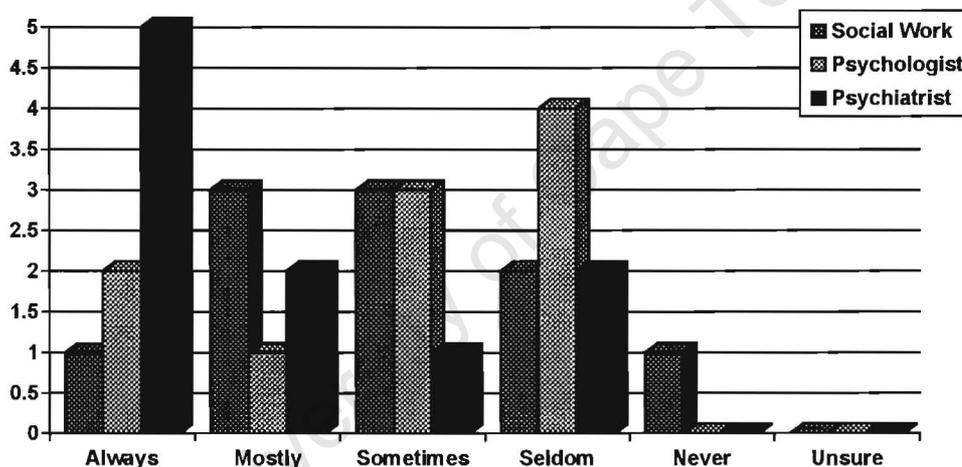


5.5.2 DIAGNOSTIC STATISTICAL MANUAL

Questions 2 and 3 explored the use and value of the DSM IV, with responses confirming theoretical findings, as described by Williams (1981), that this diagnostic tool is helpful in treatment. It was Kutchins & Kirk (1988) who reported objections to the DSM in a survey of social workers. They found that the only respondents who never made use of the DSM, are social workers.

Respondents made use of the DSM IV as reflected in figure 5.2

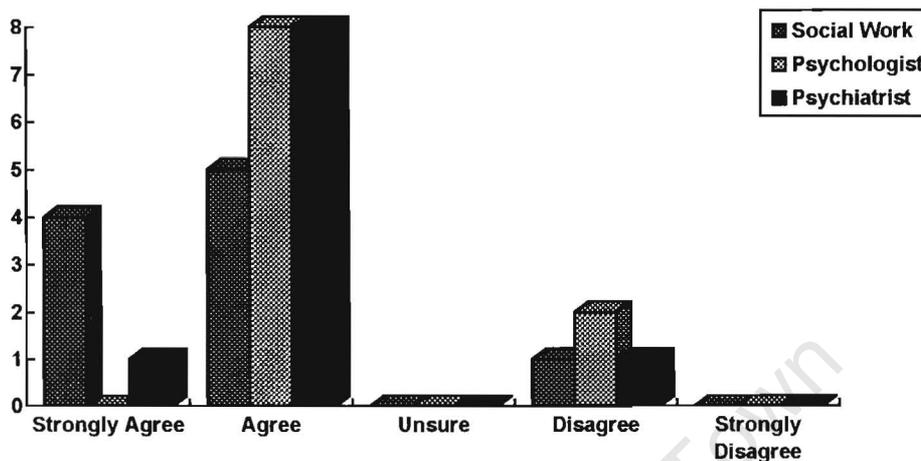
**FIGURE 5.2
USE OF DSM IV**



The respondent who never used the DSM IV for diagnostic purposes, followed a Systems Theory framework. Respondents who worked psychoanalytically or psychodynamically tended to make less use of the DSM IV for diagnosis. Only three of the eight respondents who *always* used the DSM IV, followed the psychoanalytic or psychodynamic approach and five of the eight respondents who *seldom* used the DSM IV, followed the same approach.

The responses to the statement in question 3 that the DSM IV is useful for diagnosis are illustrated in Figure 5.3

FIGURE 5.3
VALUE OF DSM IV



Williams (1981) refers to diagnosis based management as being more efficient and this is in keeping with the above finding whereby only 13,3% of respondents disagreed on the usefulness of DSM IV as a diagnostic tool.

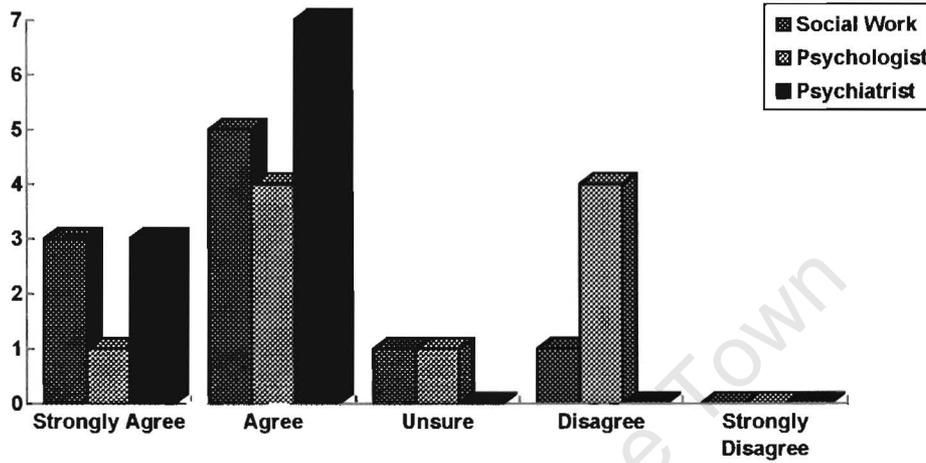
5.5.3 DIAGNOSIS AND THE PATIENT

Kutchins and Kirk (1988) list objections to using diagnostic tools as inhibiting understanding of clients and their problems, as well as sometimes leading to inappropriate treatment. This was reflected in responses to question 4 which dealt with the influence of diagnosis on treatment. It should be noted that one responded preferred to use “guide” and another “inform” rather than “influence” treatment.

Despite objections as mentioned above, 76,6% of respondents agreed that diagnosis influences treatment, (Figure 5.4) but then responded in an almost contradictory manner in the very next question by placing the focus on the person rather than the illness (Figure 5.5). This would

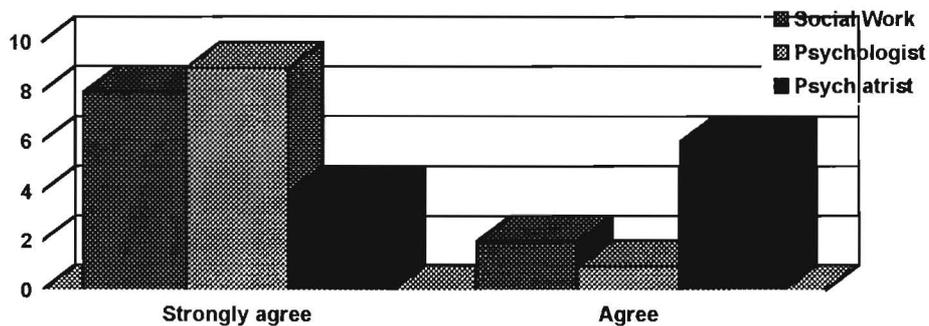
suggest a less significant influence of the diagnosis, but this was unfortunately not measured in the survey.

**FIGURE 5.4
INFLUENCE OF DIAGNOSIS ON TREATMENT**



In order to establish the focus of therapy, respondents were asked to comment on the statement in question 5 that they focus on the person rather than the diagnosis. None of the respondents were unsure or disagreed in any way. The majority, 70% of the respondents, strongly agreed while 30% agreed. The breakdown for different professions is as follows:

**FIGURE 5.5
PERSON VERSUS ILLNESS**

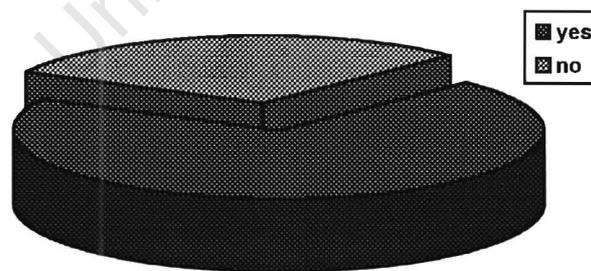


5.5.4 CASELOADS

In exploring current caseloads in questions 6 and 7, three social workers and two psychologists indicated that they were not currently treating patients suffering from personality disorder as defined in the DSM IV. However, these respondents seldom or never made use of the DSM IV for diagnosis and had been practicing for 7 - 15 years (four) or 2 - 6 years (one). These two psychologists used the psychoanalytical model and indicated that they would refuse referral of an anti-social personality disorder (as reflected later in Table 5.12). The social workers used systems or eclectic models and denied refusing referrals of patients diagnosed with personality disorder.

Doroff (in Horner, 1984), Kohut (1971, in Horner, 1984) and Kernberg (1975, in Horner, 1984) suggest that therapists should be aware of countertransference feelings towards the narcissistic personality disordered patient and therefore limit the number of narcissistic personality disorders in their caseloads.

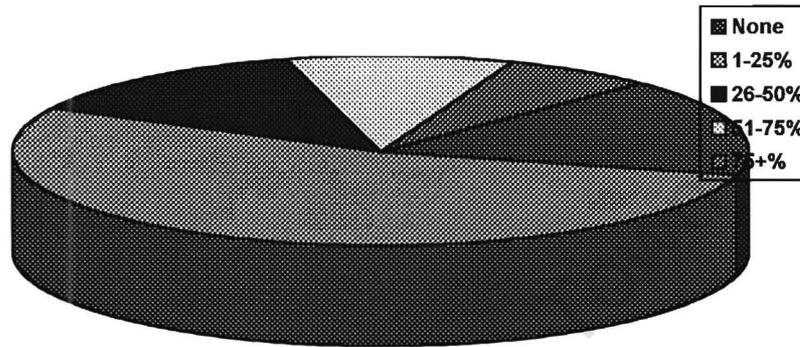
FIGURE 5.6
CASELOAD OF PERSONALITY



The proportions of caseloads consisting of patients diagnosed as suffering from personality disorder as defined in the DSM IV was estimated to be mainly in the 1-25% category. This is in keeping with the literature on prevalence of disorders as stated in the DSM IV. The two

respondents who reported caseloads of as high as 75+% are both employed in government settings, one of whom combined limited private practice with formal employment in government setting. Distribution in caseloads was explored in question 7 and is illustrated in figure 5.7.

**FIGURE 5.7
CASELOAD DISTRIBUTION**



5.5.5 PREFERENCE AROUND DIAGNOSIS

For question 8, respondents were asked to list their preference in working with different disorders on a scale of one to five, five being the highest preference and one being the lowest.

The results are recorded in table 5.9.

**TABLE 5.9
PREFERENCE IN CASELOAD**

	1	2	3	4	5	TOTAL
Psychotic Disorders	8	6	5	4	7	30
Anxiety Disorders	1	2	8	13	6	30
Mood Disorders	0	0	7	10	13	30
Organic Disorders	8	7	6	5	4	30
Personality Disorders	3	7	9	7	4	30
Mental Retardation	14	9	4	2	1	30
V Codes	2	1	6	8	13	30
TOTAL	36	32	45	49	48	210

Mood disorders and problems related to social stressors were allocated higher preference, while

working with mental retardation was not a high preference. Working with patients suffering from personality disorder is spread across the board of preference. Considering the different professions, psychologists were more consistent in preferring to work with mood disorders and not preferring mental retardation. Working with patients suffering from personality disorder was least preferred by social workers and psychiatrists. This could be related to the Kaplan et al (1994) description of personality disorder as consisting of traits of inflexibility and impaired functioning.

In order to establish beliefs around working with patients diagnosed with personality disorder, respondents were asked to comment in questions 9 to 11 on degree of difficulty experienced in the different clusters. Responses to the statements that it is more difficult to work with patients diagnosed with cluster A, B, or C personality disorder, are reflected in fig. 5.8 to 5.10 below. When breaking the data down into professions, it appeared that social workers responded strongly to degree of difficulty when working with cluster B, but psychologists on the other hand responded stronger to degree of difficulty when working with cluster A personality disorders. Psychiatrists found it most difficult to work with cluster B followed closely by clusters C and A.

FIGURE 5.8
TREATING CLUSTER A

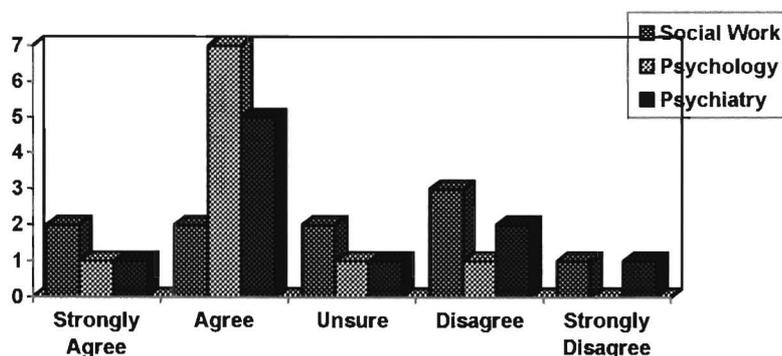


FIGURE 5.9
TREATING CLUSTER B

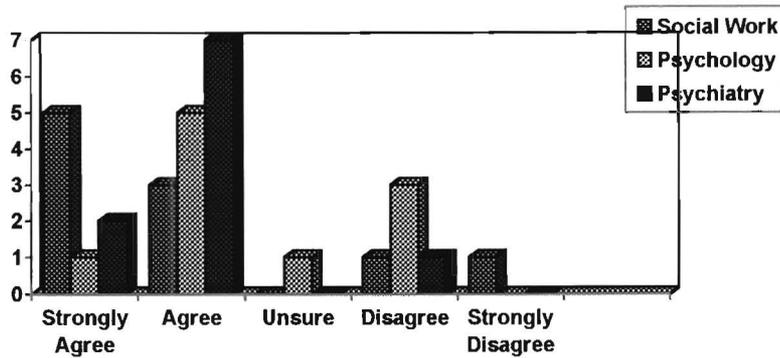
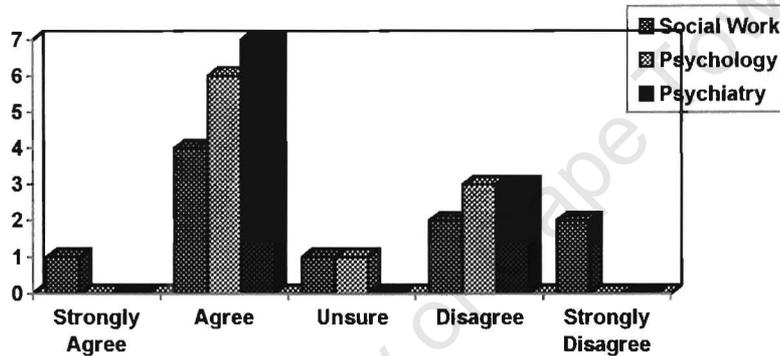


FIGURE 5.10
TREATING CLUSTER C



Comments made by respondents addressed the need for awareness of:

- individual differences in patients with the same diagnosis
- co-morbidity with social stressors, organic disorders and psychiatric disorders which can invite a label of personality disorder if the patient does not respond positively to intervention or treatment
- insufficient training for social workers which delay diagnosis
- presenting problem can focus on symptom directed treatment and neglect assessment of personality

5.5.6 REACTIONS TO REFERRALS

Reactions to referrals of patients diagnosed with personality disorder were explored in question 12. These reactions can also be linked to the Kaplan et al (1994) description of personality disorder as consisting of traits of inflexibility and impaired functioning. Reported countertransference feelings should be considered as well when assessing reactions to referrals.

TABLE 5.10
REACTIONS TO REFERRALS

	Narcissis	Borderl	Anti-soc	Histrion	Cluster A	Cluster C	Total
Positive	2;6;2	1;3;3	0;0;1	4;6;4	3;3;3	7;7;6	61
Hesitant	7;4;8	6;6;5	3;0;3	5;4;4	6;5;4	3;3;4	80
Reluctant	1;0;0	3;0;1	5;6;4	1;0;2	0;2;3	0;0;0	28
Refuses	0;0;0	0;1;1	2;4;2	0;0;0	1;0;0	0;0;0	11
Total	30	30	30	30	30	30	180

Refusals pertained mostly to the anti-social personality disorder (72,7%). Amongst those who would refuse referrals were two social workers in private practice for periods between seven and fifteen years, two psychologists in private practice for the same period, two psychologists in private practice for two to six years, one psychiatrist in private practice for seven to fifteen years and a psychiatrist in part-time private practice for less than two years. It should be noted that nobody in government employment or in a new full time practice indicated that they would refuse a referral.

5.5.7 THERAPY PROBLEMS

Questions 13 and 14 explored problems experienced in working with patients diagnosed with cluster B personality disorder in both initial stages as well as ongoing work.

TABLE 5.11
THERAPY PROBLEMS

	Initial Work			Ongoing Work			Total
	Soc w	P-gy	P-try	Soc w	P-gy	P-try	
Lack of Insight	2	1	0	1	0	2	6
Relationship ability + therapy space	4	9	2	3	3	1	22
Lack of commitment	2	3	2	3	1	2	13
Impulsivity	1	0	0	1	0	0	2
Manipulative behaviour	1	0	2	1	0	1	5
Resistance	1	1	0	0	0	0	2
Inconsistency	2	0	0	0	0	0	2
Difficulty with trust	2	2	1	1	2	2	10
Dependency/idealisation	1	1	0	0	0	0	2
Capacity for transference	1	0	0	0	2	0	3
Countertransference	1	0	3	2	0	0	6
Capacity for change	2	2	0	1	1	0	6
Lack of responsibility + blaming	1	0	0	1	0	0	2
Testing + acting out behaviour	0	2	2	4	1	3	12
Unclear expectations	0	0	1	0	0	0	1
Diagnostic problems	0	0	3	0	0	0	3
Maintaining frame + boundaries	0	0	0	5	5	5	15
Use of defenses	0	0	0	1	1	0	2
Difficulty with termination	0	0	0	1	1	0	2

One psychiatrist preferred not to comment on problems as the questions did not leave room for individual differences. A psychiatrist employed in a government setting also commented on the absence of one central database and inappropriate use of resources. These comments were not included with the above problems relating directly to therapy.

Relationship ability and use of the therapeutic space seemed most problematic in the initial work with patients with cluster B personality disorder, while maintaining the therapeutic frame and boundaries were considered more problematic in ongoing work. Lack of commitment, difficulty with trust and testing and acting out behaviours were also most

commonly considered to be problems in therapy. The literature highlights the same when Gelder et al (1991) suggest exploring patterns of relating and behaving rather than reframing past events. Giovacchini (in Lax, 1989) refers to patients with fragmented egos who have difficulty tolerating and benefiting from a therapeutic alliance. Schneider (in Gelder et al, 1991) also writes about the unreasonable demands from the histrionic patient and acting out behaviour of the borderline patient in therapy. Kernberg (in Stone, 1986) lists defenses mostly used by borderline patients. Doroff (in Horner, 1984) describes the entitlement of the narcissistic patient. These behaviours lead to problems in therapy for which Nurnberg (1982) suggests the need for limitsetting.

5.5.8 COUNTERTRANSFERENCE

Corey (1977) sees countertransference as an inevitable part of the therapeutic relationship. Countertransference feelings were explored in question 15. Countertransference towards persons diagnosed with Histrionic Personality Disorder are reported in Table 5.12.

**TABLE 5.12
COUNTERTRANSFERENCE AND THE HISTRIONIC PERSONALITY
DISORDER**

	Social Work	Psychology	Psychiatry	Total
Emotionally seduced	0	1	0	1
Amusement/Humour	1	2	2	5
Entertained	0	1	0	1
Energised + uplifted	0	1	0	1
“too good to be true”	0	1	0	1
Understanding	0	0	1	1
Calm in extreme	0	1	0	1
Anxiety	1	0	0	1
Frustration	2	0	0	2
Anger	1	0	1	2
Desperation	1	0	0	1
Irritation	2	1	5	8
Exasperated	0	1	0	1

Bored	0	0	1	1
Nil of note	2	0	1	3
Unable to comment	1	2	0	3

Irritation was reported by eight respondents with five respondents reporting humour or amusement. If the first seven feelings above can be considered as positive feelings and the next seven as negative, the negative countertransference feelings are reported as 48,5% while positive feelings are reported as 33,3% of responses. The three respondents unable to comment clarified that countertransference depended on the individual rather than the diagnosis.

Countertransference feelings towards persons diagnosed with Narcissistic Personality Disorder are reported in Table 5.13.

**TABLE 5.13
COUNTERTRANSFERENCE AND THE NARCISSISTIC PERSONALITY
DISORDER**

	Social Work	Psychology	Psychiatry	Total
Pity/Sympathy	2	0	1	3
Caught up in belief system	1	1	0	2
Challenged	0	0	1	1
Desperation	1	0	0	1
Frustration	1	0	4	5
Irritable	1	2	0	3
*Arrogance	1	0	0	1
Misunderstood	1	1	0	2
Defensive	0	1	0	1
Cautious	0	1	0	1
Vulnerable	0	1	0	1
Anger	0	2	4	6
Contempt	0	1	0	1
Despondent	0	0	1	1
Engulfed and useless	0	0	1	1
Unable to comment	2	2	0	4

*The arrogance referred to as countertransference was reported as experienced by the patient which illustrates the different understanding of the concept countertransference.

Only the first three responses (17,6%) can be considered positive feelings. A total of 70,6% of reported feelings that can be considered as negative countertransference. As above, respondents unable to comment would relate to the individual rather than the diagnosis or had not recently worked with narcissistic patients.

In response to persons diagnosed with borderline personality disorder, countertransference reported is reflected in Table 5.14.

**TABLE 5.14
COUNTERTRANSFERENCE AND THE BORDERLINE PERSONALITY DISORDER**

	Social Work	Psychology	Psychiatry	Total
Challenged to form relationship	0	0	1	1
Invited into inner world	0	1	0	1
Needed/the need to rescue	1	1	0	2
Empathy	0	1	0	1
Concern	0	1	0	1
Helpless/impotent	0	0	1	1
Incompetent/inadequate	1	0	1	2
Anger	1	0	1	2
Fear	1	2	0	3
Desperation	1	0	0	1
Confusion/inner chaos	1	2	0	3
Frustration	1	0	2	3
Restless	1	0	0	1
Irritability	1	1	1	3
Rejected	1	0	0	1
Anxiety	0	2	0	2
Alarmed	0	0	1	1
Disinterested/cut off	0	0	2	2
Unable to comment	3	1	0	4

Similar to the narcissistic personality disorder, the borderline personality disorder evoked 70,6% negative responses in reported countertransference. Graziano (1986) believes that clinicians without a sound understanding of the disorder, are likely to feel helpless, bewildered and disorganised. Helpless, confused and inner chaos were indeed reported by

four respondents as above. Respondents unable to comment again related to the individual rather than the diagnosis.

The person diagnosed with anti-social personality disorder evoked mainly negative feelings as reflected in Table 5.15

**TABLE 5.15
COUNTERTRANSFERENCE AND THE ANTI-SOCIAL PERSONALITY
DISORDER**

	Social Work	Psychology	Psychiatry	Total
Anger	3	2	2	7
Fear	1	0	1	2
Aggression	0	0	1	1
Dislike	0	0	1	1
Disgust	1	0	0	1
Self-doubt	1	1	0	2
Desperation	1	0	0	1
Frustration	1	0	1	2
Distrust	1	1	1	3
Impotence	1	0	0	1
Disbelief/shock	0	2	0	2
Nervous	0	1	0	1
Cautious	0	0	1	1
Irritation	0	0	1	1
Unable to empathise	0	0	1	1
Resistance	0	2	0	2
Avoidance	0	0	2	2
Rejection	1	0	0	1
Uncomfortable	0	1	0	1
Unable to comment	3	2	0	5

The anti-social personality disorder is the only disorder previously indicated as likely to be refused for referral. Hare (1976) states that traditional therapeutic procedures have not been effective. This belief can possibly leave clinicians feeling self-doubt, impotence, rejection, resistance or avoidance as reported above. Holmes (1991) describes the mood

symptoms of the anti-social personality disorder as lack of attachment, shallowness of feeling, lack of remorse, and others. It can be speculated that the mood state of these patients contribute to the countertransference feelings evoked in therapy.

Other personality disorders were presented as clusters. Countertransference feelings in work with clusters A and C personality disorder are reflected in Tables 5.16 and 5.17.

**TABLE 5.16
COUNTERTRANSFERENCE AND CLUSTER A PERSONALITY DISORDER**

	Social Work	Psychology	Psychiatry	Total
Envy re seeing another world	0	0	1	1
Intrigued	1	0	0	1
Need to reassure	1	0	0	1
Empathy	1	0	0	1
Tolerance	1	0	0	1
Acknowledged	1	0	0	1
Sadness/grief	0	2	0	2
Vacuum/emptiness	1	0	1	2
Frustration	1	1	1	3
Confusion	1	0	4	5
Helpless	1	2	0	3
Alienated	1	1	1	3
Uncertain	1	0	0	1
Cautious	0	2	1	3
Bored	0	0	1	1
Irritable	0	1	0	1
Persecuted	0	1	0	1
Nil of note	2	0	0	2
Unable to comment	1	2	0	3

**TABLE 5.17
COUNTERTRANSFERENCE AND CLUSTER C PERSONALITY DISORDER**

	Social Work	Psychology	Psychiatry	Total
Challenged	1	0	0	1
Tolerance	1	0	0	1
Empathy	0	3	0	3
Effective/needed	0	2	0	2
Inspired/helpful	0	2	0	2
Need to hold on	1	0	0	1

Out of control	1	0	0	1
Reluctant to engage	1	0	0	1
Frustrated	2	1	3	6
Stifled	0	1	0	1
Despondent	0	1	0	1
Irritated	0	1	3	4
Impatient	0	0	1	1
Helpless	0	1	1	2
Nil of note	1	0	1	2
Unable to comment	0	1	0	1

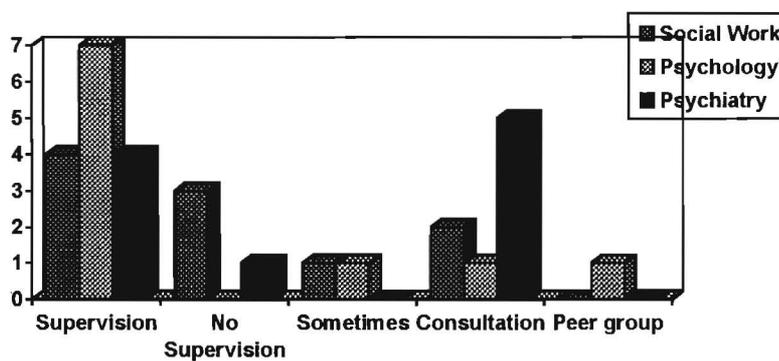
The questions around countertransference were left open to facilitate most accurate responses. Yet, when compared to a feelings checklist used in another study (Holmqvist & Armelius, 2000), the feelings described were mostly similar. Please see appendix B for the feelings checklist.

5.5.9 SUPERVISION

Nurnberg (1982) suggests supervision for the untrained therapist, without which therapeutic interventions could become volatile.

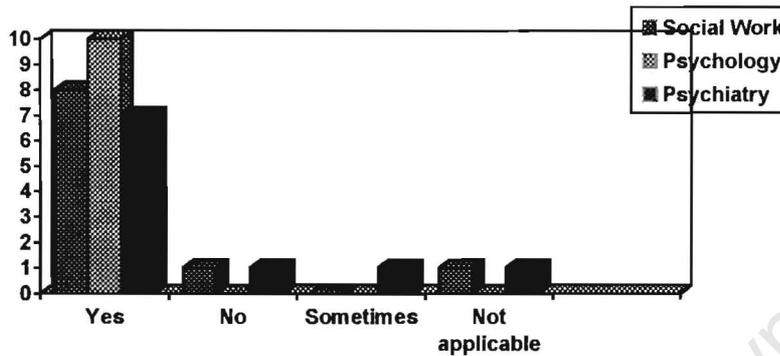
Respondents were asked about the use of formal supervision in questions 16 and 17.

FIGURE 5.11
USE OF SUPERVISION



Respondents assessed the option of discussing countertransference in supervision even in cases where they do not receive formal supervision in figure 5.12.

FIGURE 5.12
SUPERVISION AND COUNTERTRANSFERENCE



Comments from social workers referred to inadequate training to work “in the transference” as a leading source of information. Supervision is seen as protection for patients against therapists’ feelings interfering and damaging patients. Psychologists reported that supervision is compulsory and valuable as a tool to open up dynamics and informing the work done with patients.

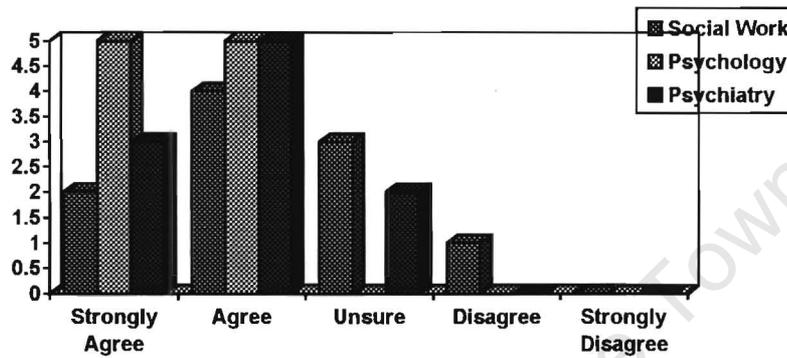
Supervision is a specialist field respected by the researcher as essential in clinical practice and was therefore included in the structured interview, even though the literature review did not extend to exploring the vast subject of supervision.

5.5.10 THERAPEUTIC ALLIANCE

Corey (1977) states that most therapies appreciate the importance of the therapeutic relationship.

The statement that it is possible to form a therapeutic alliance with persons diagnosed with different personality disorders, was tested in question 18 and the results are reflected in Figure 5.13 through Figure 5.18.

**FIGURE 5.13
THERAPEUTIC ALLIANCE AND THE NARCISSISTIC PERSONALITY DISORDER**



**FIGURE 5.14
THERAPEUTIC ALLIANCE AND THE BORDERLINE PERSONALITY DISORDER**

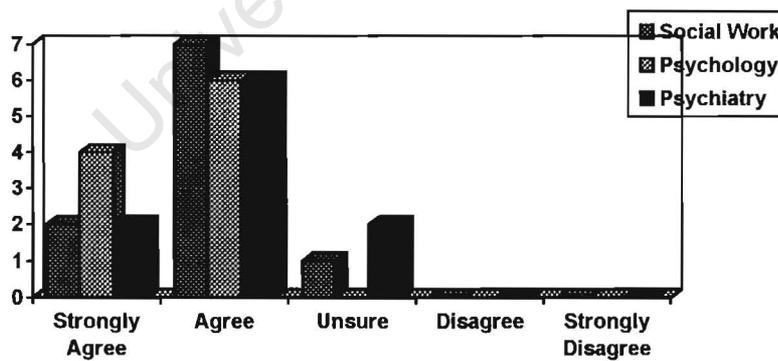


FIGURE 5.15
THERAPEUTIC ALLIANCE AND THE HISTRIONIC PERSONALITY DISORDER

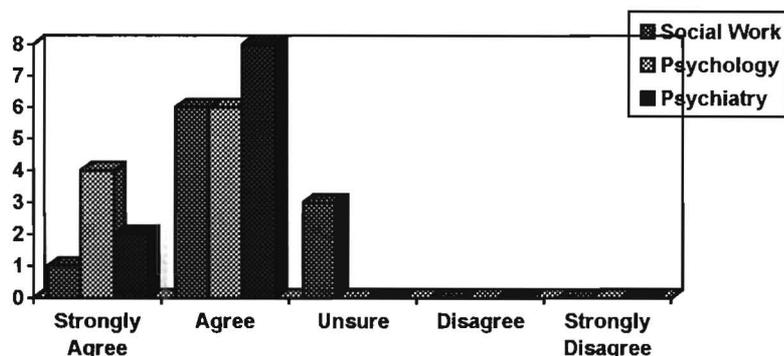
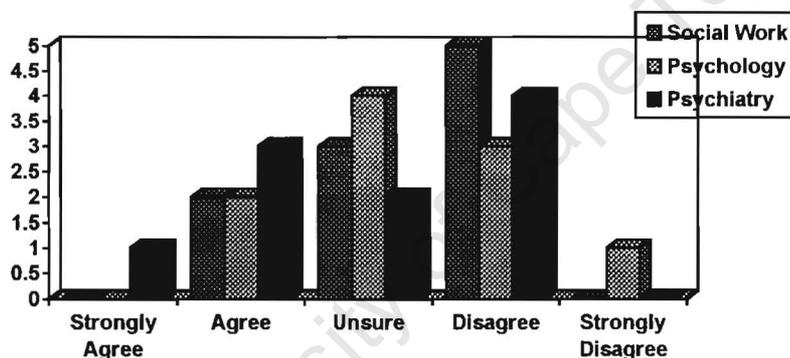


FIGURE 5.16
THERAPEUTIC ALLIANCE AND THE ANTI-SOCIAL PERSONALITY DISORDER



Kaplan et al (1994:739) suggest that the clinician should address the anti-social personality disorder's fear of intimacy through confronting the need to avoid "honest human encounters". This suggests that the therapeutic alliance is not a natural development in therapeutic work with these patients, and could be a possible explanation for the differences in responses as above, when compared to the capacity of patients with other diagnoses, to form a therapeutic alliance.

FIGURE 5.17
THERAPEUTIC ALLIANCE AND CLUSTER A PERSONALITY DISORDER

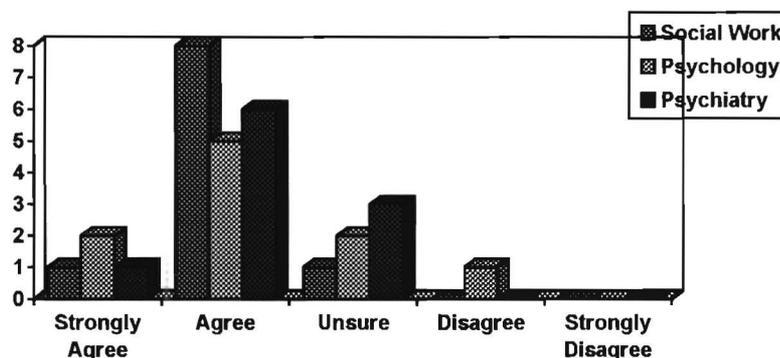
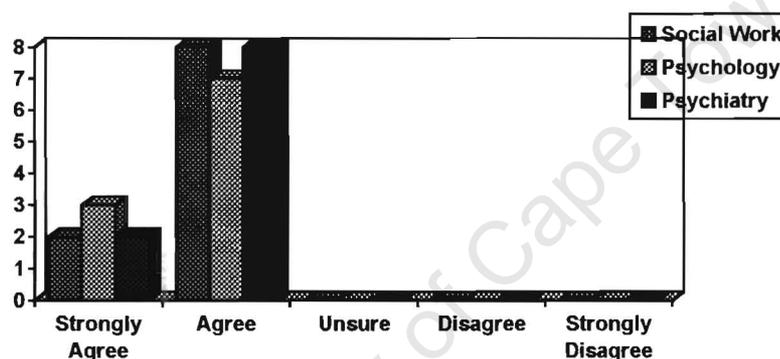
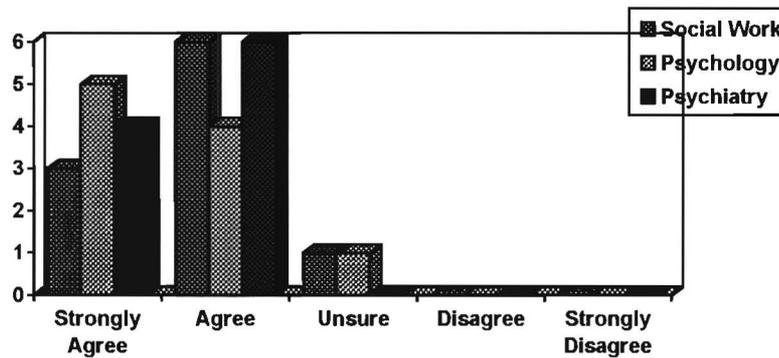


FIGURE 5.18
THERAPEUTIC ALLIANCE AND CLUSTER C PERSONALITY DISORDER



Respondents seemed most positive about the possibility of forming a therapeutic alliance with cluster C personality disorders, followed closely by cluster A personality disorder. Histrionic and borderline personality disorders each left three respondents unsure. The narcissistic personality disorder evoked uncertainty from five respondents with one respondent disagreeing with capacity for relationship in these patients. The exception was the anti-social personality disorder where only 26,7% of respondents positively considered relationship ability.

FIGURE 5.19
THERAPEUTIC ALLIANCE AND OTHER PSYCHIATRIC DIAGNOSES



Comments from social workers indicated that middle to end stage organic disorders would limit relationship ability. Social workers further commented that the therapeutic alliance is considered to be the greatest tool, and that the clinician's own relationship ability should also be assessed. Psychologists commented that a therapeutic relationship is possible even if it takes a lot of work. Diagnoses queried by psychologists included autism and psychosis. However, if the patient feels understood, a therapeutic alliance is mostly possible. Psychiatrists commented that most people have personality problems even if personality disorder is not the presenting complaint or the primary diagnosis. Therefore other factors such as the milieu, social circumstances and crises should be considered.

Giovacchini (in Lax, 1989) reported on the low tolerance of analytical relationships by patients with fragmented egos. This does not exclude supportive relationships in facilitating personal growth of the same patients.

Question 19 invited respondents to name features that helped and hindered the therapeutic alliance. Open questions facilitated respondents' own insights.

Helping features are summarised in the table 5.18.

TABLE 5.18
HELPING FACTORS

	Social Work	Psychology	Psychiatry	Total
Training + use of transference	2	1	0	0
Experience	2	0	0	2
Supervision	2	1	1	4
Realistic expectations	1	1	0	2
Clear frame and boundaries	1	4	3	8
Clarity on countertransference	0	2	0	2
Manageable defense structure	1	0	0	1
Ego Resources	2	0	1	3
Awareness of ability + limits	4	0	6	10
Good rapport	0	0	2	2
Absence of substance abuse	0	0	1	1
Continuity	0	0	1	1
Sufficient resources	0	0	1	1
Commitment to change	0	1	0	1
Sufficient time	1	0	1	2

Hindering features were in some instances the direct opposite of helping features and are summarised in table 5.19

TABLE 5.19
HINDERING FACTORS

	Social Work	Psychology	Psychiatry	Total
Age of the patient	1	0	0	1
Social circumstances	1	0	0	1
Criminal involvement	1	0	0	1
Lack of resources	0	0	1	1
Lack of time	1	0	1	2
Unrealistic expectations	4	0	0	4
Cross treatment (GP)	0	1	0	1
Poor commitment	0	1	0	1
Rigid defence structure	0	1	1	2
Psychotic transference	0	1	0	1

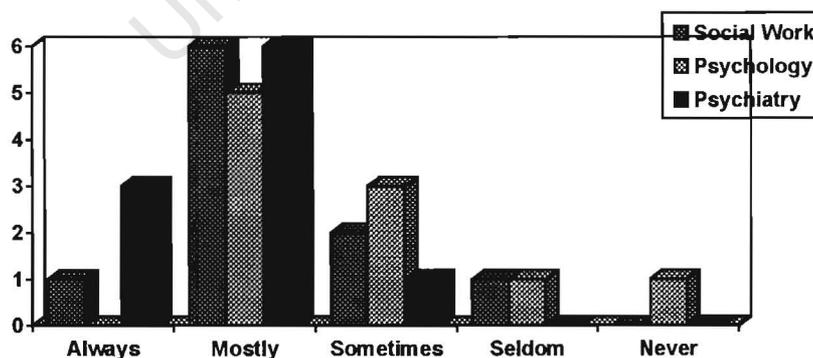
Substance abuse	0	0	1	1
Unaware of limitations	0	0	2	2
Patient's need to spoil	0	0	1	1
Countertransference	2	2	1	5
Therapist pathology	1	1	1	3
Breaking therapeutic frame	1	4	4	9

Awareness of ability and limits as well as clear frame and boundaries were considered most helpful in clinical work with patients suffering from personality disorder. Supervision was acknowledged as significantly helpful. Breaking the therapeutic frame, on the other hand, was most consistently considered as a hindering factor. Countertransference and unrealistic expectations from clinicians also rated highly as hindering factors.

5.5.11 TREATMENT

Treatments offered by respondents are explored in question 20 and reflected in figures 5.21 through 5.24.

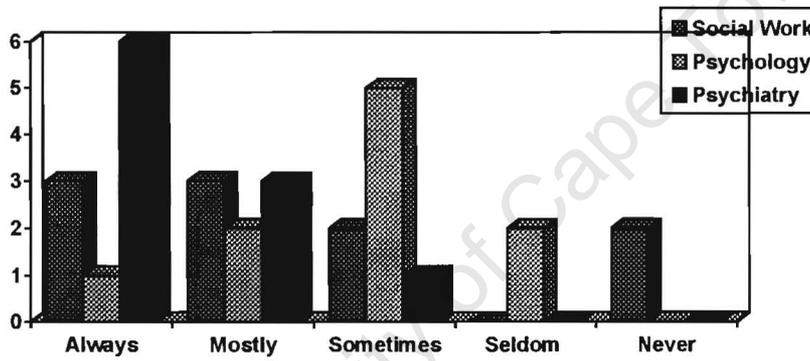
FIGURE 5.20
SUPPORTIVE THERAPY



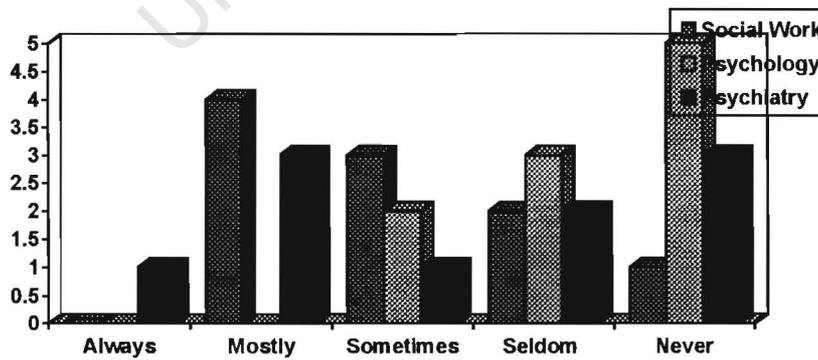
**FIGURE 5.21
INSIGHT THERAPY**



**FIGURE 5.22
CRISIS INTERVENTION**



**FIGURE 5.23
BEHAVIOUR MODIFICATION**



Supportive therapy and crisis intervention were offered by more clinicians while insight therapy was offered less often. Behaviour modification seemed least offered, especially by psychologists.

Other therapies offered by therapists from all categories included work with couples, families and support systems. Assistance with practical problems as well as gestalt and non-verbal techniques were also offered by social workers. Psychologists offered hypnosis, referral for pharmacotherapy, dynamically informed brief term intervention and assessment of risk. Psychiatrists referred for milieu and group therapy, screened for substance abuse and co-morbid psychiatric disorders and made regular use of medication.

Comments on treatment offered stressed individual approaches which differ from consideration of clusters, consideration of presenting complaint and needs of the patient as well as availability of resources.

Reich (in Lax, 1989) acknowledges the strengthening of the ego through supportive therapy. Cumming and Cumming (1962) and Whitely (1994) support milieu therapy.

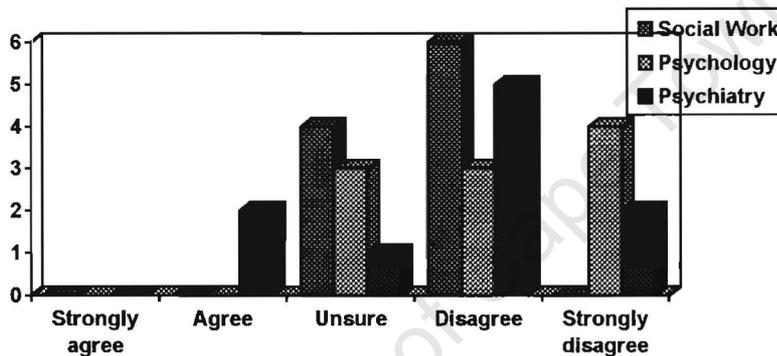
5.5.12 PROGNOSIS

Truax and Carkhuff (in Corey, 1977) suggest a better prognosis for patients with a lower degree of behavioural disturbance. The diagnostic criteria for patients diagnosed with

cluster B personality disorder refer mostly to behavioural disturbance. This could lead to a negative expectation around the value of therapy.

Opinions on prognosis were assessed in questions 21 to 24. Question 21 measured beliefs on the influence of gender in prognosis. Respondents were asked to comment on the statement that gender does influence prognosis.

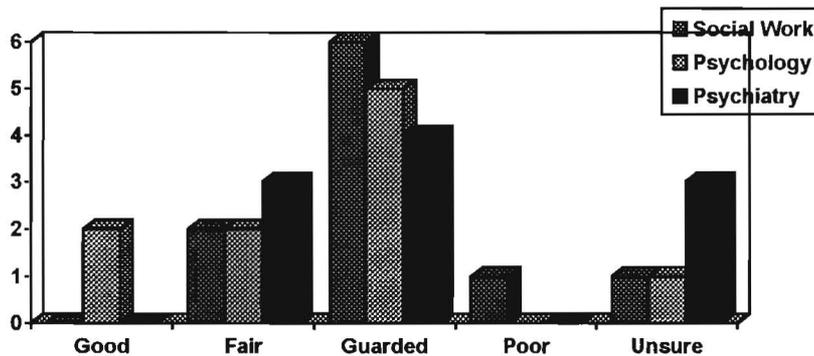
**FIGURE 5.24
PROGNOSIS AND GENDER**



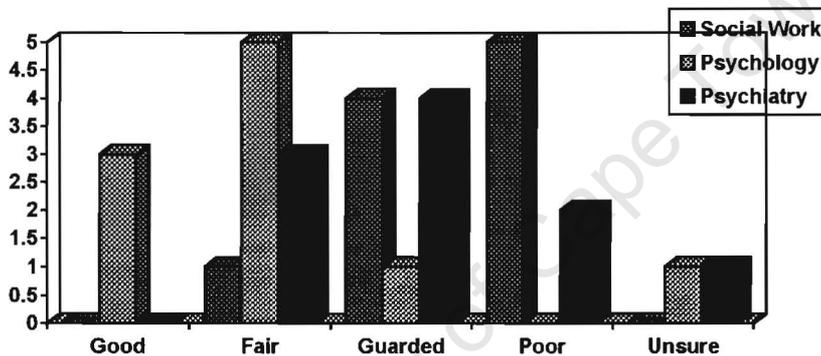
Only three psychiatrists believed that gender influences prognosis. These findings are in keeping with the findings of Ford and Widiger (1989) who could not elicit gender bias in their study. However, Erikson (1993) suggests that change is more difficult for men as they are considered rigid and reluctant to give up power.

General beliefs on prognosis were assessed for the different clusters of personality disorder:

**FIGURE 5.25
PROGNOSIS AND CLUSTER A**

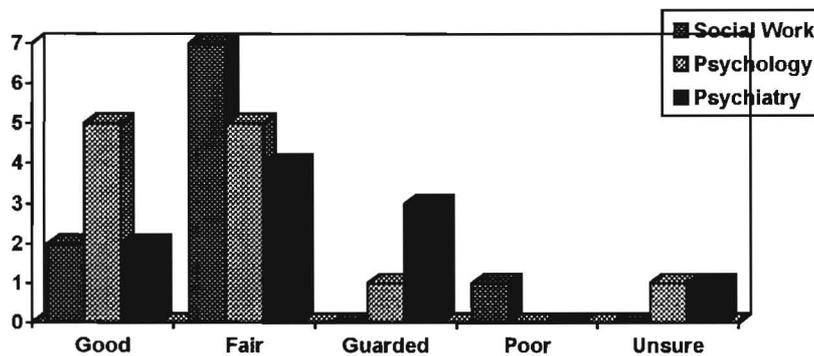


**FIGURE 5.26
PROGNOSIS AND CLUSTER B**



One psychologist who chose good prognosis and one who chose fair prognosis stated that they wish to exclude the anti-social personality disorder from their choices.

**FIGURE 5.27
PROGNOSIS AND CLUSTER C**



A psychologist gave three different responses to this cluster: Good prognosis for the avoidant personality, fair prognosis for the dependent and poor prognosis for the obsessive compulsive personality.

Respondents seemed most positive about the prognosis of cluster C personalities and mostly guarded about cluster A. Interestingly, cluster B evoked responses across the spectrum with psychologists mostly positive and social workers mostly negative about prognosis.

Comments reflected that prognosis was also dependent on pre-morbid functioning. Clinicians and patients may also have different objectives or measures for success. Labels were considered nonconstructive and influencing impressions unfairly. Mostly the concept of clustering individuals were found to be unacceptable, especially since the DSM IV describes quite severe pathology.

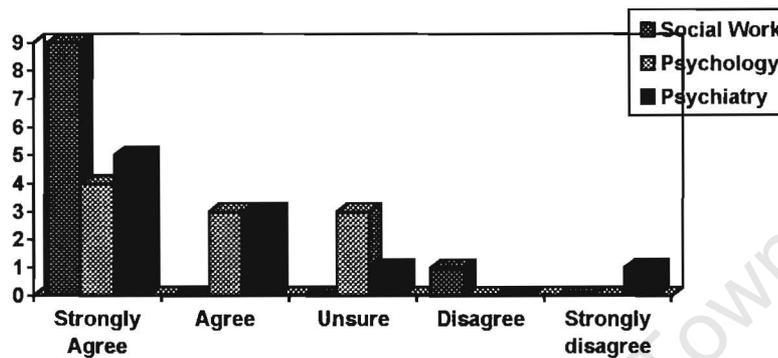
Kaplan et al (1994: 732) suggest that patients with personality disorder are reluctant to present for treatment, because they are reluctant to give up their defenses. This supports the somewhat ambivalent responses on prognosis.

5.5.13 BURNOUT

Cooper (1986, in Lax, 1989) explains how lack of reward and isolation of the therapist can lead to burnout and suggests the therapist's own therapy to deal with defenses.

Question 25 measured beliefs around caseload and burnout. Respondents were asked to respond to the statement that a high caseload of persons diagnosed with personality disorder influences burnout.

**FIGURE 5.28
BURNOUT**



One psychologist chose an unsure response, but clarified that her choice would change to strongly agree if supervision is unavailable or not used constructively.

Cooper (in Lax, 1989) further believes that burnout, which is linked to lack of reward, can be linked with a lower confidence in prognosis and unrealistic expectations of clinicians identified earlier as a hindering factor in clinical work.

Final comments by respondents were recorded as follows:

- there is not enough emphasis on social workers going into own therapy
- generalisation does not accommodate individual differences within diagnoses or clusters
- disagreement with concept of clustering

- operating from the medical model is unhelpful
- personality cannot be changed. At best it is possible to move from a personality disorder to a personality style

5.6 SUMMARY

This chapter discussed the results of the research, and where appropriate, linked these to relevant literature. The following chapter will discuss recommendations and conclusions.

University of Cape Town

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter contains the conclusions and recommendations which will be discussed in the light of the results, and following the sequence as laid down in chapter five.

6.2 THERAPIST PROFILE

From the results of the study, it was found that therapists' professional registration was significant in choice of treatment model, belief in ability to form a therapeutic alliance, and prognosis. Psychologists seemed slightly more tolerant and optimistic when working with histrionic, borderline and narcissistic patients, yet responded with more ambivalence to cluster A personality disorders.

Clinicians' ability to recognize and treat appropriately, those patients with a diagnosis of cluster B personality disorder, is often dependent on the level of training and experience. While social workers had the lowest rate of specialised training, those without post-graduate qualifications worked in psychiatric settings and therefore had experience to make relevant contributions. The only respondent who conveyed a different understanding of countertransference was, however, a social worker without post-graduate training.

Employment setting proved significant in terms of acceptance or refusal of referral for treatment, when only therapists with established private practices opted to refuse patients diagnosed with anti-social personality disorder.

6.3 USE AND USEFULNESS OF THE DSM IV

The DSM IV is used less often by clinicians who follow the psychoanalytic or psychodynamic approaches. The DSM IV is nevertheless considered useful by most respondents. They also acknowledged that diagnosis influences treatment, but preferred to focus on the person rather than the illness. These seemingly contradictory responses are clarified by mentioning the difficulties with diagnostic criteria as highlighted in previous chapters.

A diagnosis of personality disorder creates a label which is helpful to inform the therapy. Thus, for example, respondents were aware of the necessity to maintain the therapeutic frame and professional boundaries when treating patients with a diagnosis of cluster B personality disorder.

6.4 THE CONCEPT OF CLUSTERING

Respondents objected throughout to the use of clusters, as responses differ for different disorders. The anti-social personality disorder elicited a markedly different response when the different disorders of cluster B were considered separately. Clustering seemed particularly inappropriate in cluster B where the main focus of the study was placed.

Even though comments throughout recognised the need to see patients as individuals and manage them individually, it seemed possible to generalise about suitability for treatment and prognosis based on diagnosis.

6.5 PATIENT PREFERENCE

From the results, it was found that respondents prefer to work with mood disorder and anxiety and least prefer to work with mental retardation. Preference in working with personality disorder mostly elicited an average response. This response may have been less neutral if the question in the interview accommodated the personality disorders separately. More than half of the respondents found it more difficult to work with patients diagnosed with cluster A and cluster C personality disorder. Significantly higher, is the degree of difficulty when working with cluster B personality disorder. From this cluster, the anti-social personality disorder invites the highest rate of refusal of referral. Respondents reacted mostly positively to referral of cluster C personality disorder.

6.6 THERAPY PROBLEMS

Therapy problems identified in initial and ongoing work with patients diagnosed with cluster B personality disorder, referred mostly to the patient's ability to form a therapeutic relationship, building trust necessary to maintain the relationship and to stay committed to the therapy, as well as problematic behaviour that threatened the therapeutic alliance. More than 70% of respondents were unsure or believed that it is not possible to build a therapeutic alliance with the anti-social personality disorder.

6.7 COUNTERTRANSFERENCE

Countertransference feelings were mostly negative, especially in response to the anti-social and narcissistic personality disorders. Feelings most often nominated were anger, frustration and irritation. These feelings would also threaten the therapeutic alliance, unless dealt with in supervision.

6.8 TREATMENT MODELS

Supportive therapy proved to be the most applied treatment model. Given the expected lack of insight into own behaviour from personality disorders, a surprising number of respondents elected insight therapy as treatment of choice. Behaviour modification was least favoured and can be explained given the theoretical orientation of respondents.

6.9 PROGNOSIS

Patient gender was not considered contributory to prognosis. The point of consideration seemed to be diagnosis. The anti-social personality disorder evoked the worst expectation of treatment outcome. The cluster C personality disorder, on the other hand, evoked a very positive expectation, despite earlier reference to negative countertransference feelings and difficulties in treatment.

6.10 SUPERVISION

The use of supervision seemed to be essential in managing transference and countertransference feelings and in preventing burnout. It is alarming that 4 respondents

do not have regular supervision. Clinicians who have their own therapy, could use the greater awareness to separate patient issues from own issues.

6.11 CONCLUSION

Revisiting the research questions:

- are clinicians more prepared to accept for treatment those patients who are diagnosed with disorders other than personality disorder?

The lowest preference proved to be mental retardation with highest preference that of mood disorder and anxiety. Personality disorder evoked a varied response with refusals to accept for treatment, those patients diagnosed with the specific diagnosis of anti-social personality disorder.

- are clinicians negatively influenced in their decision making when accepting for treatment those patients who are diagnosed with cluster B personality disorder?

A significant number of respondents would refuse referral of an anti-social personality disorder, and to a lesser extent, borderline personality disorder. One respondent, however also indicated refusal of a cluster A patient. Many variables, such as countertransference, prognosis, and the patient's ability to form a therapeutic alliance, could contribute to refusal of referrals.

- are there differences in the attitudes of clinicians according to their training or professional registration?

To some extent, psychologists made less use of the medical model, responded more positively to treatment and prognostic questions relating to cluster B personality disorder, excluding the anti-social personality disorder, and mostly applied psychoanalytic and psychodynamic therapies. Psychologists seemed less positive about patients diagnosed with cluster A personality disorder. Social workers mostly followed the eclectic approach and responded with more reluctance to treatment of cluster B personality disorder, again singling out the anti-social personality disorder as the disorder with least treatment prospectives.

- does the clinician's place and or duration of employment influence acceptance for treatment of those patients diagnosed as suffering from cluster B personality disorder?

The only respondents to indicate that they would refuse referrals, were in established private full time or part time practices.

- does availability and constructive use of supervision influence countertransference issues and burnout?

Supervision was accepted as the space where countertransference feelings could be discussed, and is thus seen as a constructive in professional practice.

6.12 RECOMMENDATIONS

In summary, recommendations are as follows:

- Greater focus in the training of social workers on the diagnosis and treatment of personality disorder. Social workers often encounter clients in a variety of settings, who suffer from cluster B personality disorder. Problems that social workers are confronted with, result from the chaotic behaviour and interpersonal problems of the cluster B personality disorder, and do not usually present in psychiatric settings. A greater awareness of the particular difficulties these patients experience and evoke, could assist the social worker in competent client care.
- Compulsory supervision for clinicians treating patients with personality disorder. Supervision was considered helpful in dealing with countertransference responses and feelings. It often happens that senior workers contact their supervisors on a consultation basis only. This limits the social worker's opportunity to further develop confidence in the care of a patient suffering from personality disorder, especially cluster B personality disorder.
- Personal therapy for clinicians treating patients with personality disorder. Considering the nature of countertransference feelings as reported in the study, it is necessary to retain an awareness of the often intense feelings evoked by cluster B personality disorders. These feelings can easily become enmeshed with own personal difficulties. The personal therapy of the clinician will support the boundary between patient and therapist.

- Selective use of diagnostic categories. The clustering of personalities was found to be unhelpful even though it can be motivated from a developmental point of view. Diagnostic categories limit the individuality of the patient even more than the diagnosis itself, especially in cluster B where the anti-social personality disorder evokes a stronger negative attitude.
- Assessment and treatment focusing on the individual rather than the diagnosis. This can be linked with the recommendation above, but creates an even greater awareness of the patient's vulnerability to being labelled. Once a diagnosis is formulated, the patient is vulnerable to bias and prejudice from the therapist. There would be little room for misinterpretation of diagnostic criteria and the patient will not be served in his or her best interest.
- Diagnosis should inform treatment and not dictate treatment. The DSM IV as a diagnostic tool holds a predictive value to inform treatment and should be used in balance with recognition of individual differences.

6.13 SUMMARY

This chapter described the final conclusions and recommendations and revisited the research questions.

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APPENDIX A

INTERVIEW SCHEDULE

THERAPIST PROFILE

1. Professional Registration: Psychiatrist
Psychologist
Clinical Social Worker
2. Gender: Male
Female
3. Place of Training: University (Please specify) _____
College (Please specify) _____
Other (Please specify) _____
4. Educational Qualifications: BA/BSoc Sc
Honours degree
Masters degree
PhD
FF. Psych/FC Psych
Other (Please specify)
5. Additional Specialised Training: Please specify _____

6. How long have you been practising: 0 - 2 years
2 - 6 years
7 - 15 years
16+
7. Type of Practice: Government Setting
Private Practice
Government plus Limited Private Practice
Other(Please specify) _____
8. Part time or full time: Part time
Full time
9. Period of current employment status: 0 - 2 years
2 - 6 years
7 - 15 years
16+ years

PROFESSIONAL PRACTICE

1. Theoretical Orientation: Psychoanalytic
Psychodynamic
Cognitive
Behavioural
Systems
Biological
Eclectic
2. I make use of the DSM IV for diagnosis: Always
Mostly
Sometimes
Seldom
Never
Unsure
3. I find the DSM IV useful for diagnosis: Strongly agree
Agree
Unsure
Disagree
Strongly disagree
4. Diagnosis influences treatment: Strongly agree
Agree
Unsure
Disagree
Strongly disagree
5. I focus on the person rather than the illness: Strongly agree
Agree
Unsure
Disagree
Strongly disagree
6. Are you treating persons with a diagnosis of personality disorder as defined in the DSM IV at present? yes
no
unsure
7. Please give a rough estimate of percentages in your caseload of patients who have been diagnosed as suffering from personality disorder: None
1 - 25%
26 - 50%
51 - 75%
75+%

8. Please rate on a scale of 1-5 your preference in working with patients suffering from:

- Psychotic disorders
- Anxiety Disorders
- Mood Disorders
- Organic Disorders
- Personality Disorders
- Mental retardation
- Problems related to social stressors
(V code)

9. It is more difficult to work with persons with a main diagnoses of schizoid, schizotypal or paranoid personality disorder than with people without this diagnosis:

- Strongly agree
- Agree
- Unsure
- Disagree
- Strongly disagree

10. It is more difficult to work with persons with a main diagnoses of narcissistic, borderline, histrionic or anti-social personality disorder than with people without this diagnosis:

- Strongly agree
- Agree
- Unsure
- Disagree
- Strongly disagree

11. It is more difficult to work with persons with a main diagnoses of dependent, avoidant or obsessive compulsive personality disorder than with people without this diagnosis:

- Strongly agree
- Agree
- Unsure
- Disagree
- Strongly disagree

Please comment:

12. What is your first reaction to a *referral* of a person diagnosed with:

Narcissistic PD

- Positive
- Hesitant
- Reluctant
- Refuses

Borderline PD

- Positive
- Hesitant
- Reluctant
- Refuses

Anti-social PD

Positive
Hesitant
Reluctant
Refuses

Histrionic PD

Positive
Hesitant
Reluctant
Refuses

Schizoid/Schizotypal/Paranoid PD

Positive
Hesitant
Reluctant
Refuses

Dependent/Avoidant/Obsessive Compulsive PD

Positive
Hesitant
Reluctant
Refuses

13. Please define pertinent problems experienced in initial work with patients suffering from narcissistic, borderline, anti-social or histrionic personality disorder:

14. Please define pertinent problems experienced in ongoing work with patients suffering from narcissistic, borderline, anti-social or histrionic personality disorder:

15. Please identify countertransference feelings most often experienced in your work with personality disorders.

Histrionic personality disorder

Narcissistic personality disorder

Borderline personality disorder

Anti-social personality disorder

Schizoid/Schizotypal/Paranoid personality disorder (cluster A)

Dependent/Avoidant/Obsessive compulsive personality disorder (cluster C)

16. Do you have formal supervision: Yes
No
Sometimes
Consultation only

17. Are you able to discuss countertransference in supervision? Yes
No
Sometimes

Please comment

18. It is possible to form a therapeutic alliance with a patient suffering from:

Narcissistic PD Strongly agree
Agree
Unsure
Disagree
Strongly disagree

Borderline PD Strongly agree
Agree
Unsure
Disagree
Strongly disagree

Anti-social PD Strongly agree
Agree
Unsure
Disagree
Strongly disagree

Histrionic PD Strongly agree
Agree
Unsure
Disagree
Strongly disagree

Cluster A personality disorders Strongly agree
Agree
Unsure
Disagree
Strongly disagree

Cluster C personality disorders Strongly agree
Agree
Unsure
Disagree

	Strongly disagree
Other Psychiatric illnesses	Strongly agree
	Agree
	Unsure
	Disagree
	Strongly disagree

Please comment

19. Please identify features that help/hinder the therapeutic alliance when working with cluster B personality disorder.

Help

Hinder

20. What treatments would you offer a person with diagnosis of cluster B personality disorder?

Supportive therapy

Always
Mostly
Sometimes
Seldom
Never

Insight therapy(Cognitive and Psychodynamic)

Always
Mostly
Sometimes
Seldom
Never

Crisis intervention

Always
Mostly
Sometimes
Seldom
Never

Behaviour modification

Always
Mostly
Sometimes
Seldom
Never

Other(Please specify)

Please
comment

21. The gender of the patient influences prognosis:

- Strongly agree
- Agree
- Unsure
- Disagree
- Strongly disagree

22. What are your general beliefs and experience on prognosis of cluster A personality disorder?

- Good prognosis
- Fair prognosis
- Guarded prognosis
- Poor prognosis
- Unsure

23. What are your general beliefs and experience on prognosis of cluster B personality disorder?

- Good prognosis
- Fair prognosis
- Guarded prognosis
- Poor prognosis
- Unsure

24. What are your general beliefs and experience on prognosis of cluster C personality disorder?

- Good prognosis
- Fair prognosis
- Guarded prognosis
- Poor prognosis
- Unsure

Please comment

25. A high case load of patients suffering from personality disorder influences burnout in the therapist

- Strongly agree
- Agree
- Unsure
- Disagree
- Strongly disagree

26. Any further comments

27. Would you like feedback?

Yes

No

Postal address:

University of Cape Town

APPENDIX B

FEELINGS CHECKLIST

When I talk with.....I feel

- 1 **Helpful**
- 2 **Happy**
- 3 **Angry**
- 4 **Enthusiastic**
- 5 **Anxious**
- 6 **Strong**
- 7 **Manipulated**
- 8 **Relaxed**
- 9 **Cautious**
- 10 **Disappointed**
- 11 **Indifferent**
- 12 **Affectionate**
- 13 **Suspicious**
- 14 **Sympathetic**
- 15 **Disliked**
- 16 **Surprised**
- 17 **Tired**
- 18 **Threatened**
- 19 **Receptive**
- 20 **Objective**
- 21 **Overwhelmed**
- 22 **Bored**
- 23 **Motherly**
- 24 **Confused**
- 25 **Embarrassed**
- 26 **Interested**
- 27 **Aloof**
- 28 **Sad**
- 29 **Inadequate**
- 30 **Frustrated**