THE EFFECT OF MILIEU THERAPY ON PERSONALITY AND CLINICAL SYMPTOM VARIABLES

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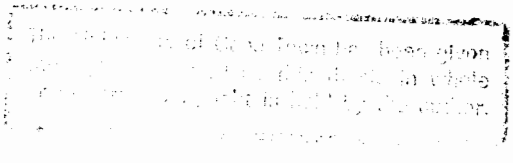

ABSTRACT

The present exploratory study was conducted in Ward G22, a milieu therapy unit at Cape Town's Groote Schuur Hospital. It considers aspects of the unit's selection process, as well as particular treatment-related considerations, using a self-report questionnaire, the revised Millon Clinical Multiaxial Inventory (MCMI-II). The MCMI-II provided information about clinical symptoms and personality styles, which was used to investigate what change may be measured in patients after a 12-week stay in G22. On the strength of this information, the study sought to make suggestions as to what aspects of patient difficulties are most amenable or resistant to the unit's intervention. Lastly, it intended to make recommendations on the value of the routine use of the MCMI-II in assessing patients for admission, and in evaluating therapeutic change. The inventory was administered to thirteen successive admissions to the unit. Of these, five terminated treatment prematurely. It was re-administered to the remaining eight subjects in the final week of their treatment. Protocols were computer scored and quantitatively analysed using t-tests of significance. This analysis indicated that the subjects generally improved after treatment, although more dramatic benefits were shown for clinical symptom variables than for personality variables. Despite significant change ($p < .01$) on 2 of the 13 personality scales, the dominant personality constellation, as measured by the MCMI-II, remains largely stable at discharge. Several personality scales emerge as tending towards elevation after treatment.

Possible reasons for this are considered and the need to take into account treatment context when evaluating change emerged as important. The study concludes that the routine use of the MCMI-II could moderate unrealistic staff expectations of change, allowing for helpful change-related feedback to be given to patients, provided the instrument is used responsibly. At the same time, it cautions on the use of the MCMI-II in assessing change and in decision making on the basis of these results, stressing the need for further research which pays attention to the role of treatment context in change. Finally, it recommends that G22 make only modest claims of success in the treatment of personality disturbances, and points to the possibility that G22 perceive itself as a crisis intervention unit, from which patients are referred, where necessary, for further treatment.

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CHAPTER 1

INTRODUCTION

Rationale

Background to the Study

In 1994, Ward G22 at Groote Schuur Hospital in Cape Town was one of the four-month placements for clinical psychology interns. G22 is a milieu therapy unit (an in-patient psychiatric therapeutic facility staffed by a multidisciplinary team).

The author's experience in G22 raised a number of important issues including: the nature of therapeutic change, and the role of personality in this; whether it is possible to identify which types of patient difficulties are most amenable or resistant to treatment; and whether the routine use of an empirical assessment instrument could be useful in patient selection, monitoring of change, and follow-up planning. The author's clinical experience while in G22 suggested that such an instrument, the Millon Clinical Multiaxial Inventory - II, would be useful in clarifying these difficulties.

Grappling with the issues inevitably involved a critical appraisal of particular aspects of G22's functioning, and it is this process that constitutes the rationale behind this study. A detailed review of milieu therapy literature is beyond the scope of this study, which does not seek to examine the effectiveness of milieu therapy or G22 as such. (For a review of G22's therapeutic programme, please refer to Appendix D).

However, Jones and Rapoport's (1976) examination of the ideology and functioning of milieu therapy programmes will be referred to in order to support the author's observations in outlining the rationale of the study.

Selection of Patients

G22 admits patients in the DSM III-R (1987) categories of eating disorders, depression, anxiety and personality disorders. However, there have also been admissions of patients with bipolar affective disorder, major depression with psychotic features, post-traumatic stress disorder, pain disorders, and dissociative disorders. Psychotic patients are rarely accepted into the unit. If they are, and their psychoses do not remit within a week or so, or if previously apsychotic patients become psychotic during their stay, they are usually transferred to Valkenberg Hospital. This variability among diagnostic categories (of patient admissions) appears to be based upon the principle that patient heterogeneity is mutually benefiting for patients, and has a balancing effect on the patient complement. (Jones & Rapoport, 1976).

Potential admissions to the unit are evaluated by means of an abbreviated history-taking interview, on the basis of which a preliminary diagnosis is arrived at. The majority of patients are admitted for the full (12-week) programme. However, in other cases where there are queries concerning suitability for the unit (based on the presence or suspicion of psychotic features, chronic pain symptoms, or frequently "relapsed" anorectic patients), a two week "assessment" period is contracted for, after which termination of treatment can be decided upon by the staff.

This assessment consists of observation of the patient by staff, and a full assessment through detailed family and personal history-taking. If it is decided in a ward round that a psychotic disorder is no longer suspected, and if the patient appears to be motivated for treatment, he or she is accepted for full admission. Once potential patients have been interviewed, this information is discussed with the team during a ward round. Instead of being used as a forum for team discussion of potential admissions, these ward rounds seem to be used simply to ratify the consultant's decisions about candidates' appropriateness for admission.

What seems to be absent from admission discussion meetings and ward rounds is a routine process of careful thought and discussion about the patient's specific difficulties (clinical symptoms, and personality construction and dynamics), and suitability for the unit in terms of a number of issues which will be raised below. The absence of such a process appears to result in a range of treatment-related difficulties with specific patients that can be avoided, or at least expected and prepared for. This omission echoes Jones and Rapoport's (1976) finding that, despite the recognition of patient heterogeneity in admission policy, milieu patients are treated as a homogeneous entity.

It is the author's impression that this process of selection for admission could be made more efficient by the use of an empirical screening measure in the following ways:

1. By reducing the time spent by the clinician attempting to elicit sufficient information to yield a basic diagnosis and sketch of personality dynamics. Time could perhaps be better spent refining relevant aspects of the Mental State Examination (MSE) such as danger of suicide; and establishing motivation for treatment.

2. By working towards establishing explicit, basic screening criteria for suitability for the unit. This standardisation of the assessment process would be an important development, since a variety of clinicians, with variable levels and types of training, are involved in assessment for admission.

3. Although the diagnostic interview will always be a valuable component of assessment, it could be argued that the introduction of a standardised empirical measure would add to the richness, depth, detail, and validity of information received from the patient (and synthesized and disseminated by the clinician) and would present the information in a clearer, more accessible manner.

Examination of G22's selection process and its "casualties" generated a series of questions and suggestions that would be useful to consider in the assessment of patients for admission. These are explored below. Selected abbreviated case material will be referred to in this discussion by way of illustration of the points raised.

Selection and Assessment Related Considerations

1. How can this patient be helped by the unit?

This relates to the nature of the therapeutic work undertaken in the unit and what kinds of patient difficulties it purports to be effective in treating. The matching of these factors with patient difficulties is the obvious goal.

2. More specifically, is this patient suitable for the insight-oriented approach of the unit?

A patient with a DSM III-R diagnosis of an anxiety disorder, conversion disorder and dependent personality disorder proved to have little insight into her own or other's dynamics, found it extremely difficult to respond to psychodynamic interpretations, and found psychodynamic groups stressful to the extent that they appeared to precipitate her conversion symptoms. It could be argued that this patient's lack of insight and difficulty in benefiting from psychodynamic interpretations made her unsuitable for admission to the unit. More careful assessment and consideration of this patient's suitability would have avoided this unfavourable treatment outcome. (Jones & Rapoport, 1976).

3. How psychologically vulnerable is this patient?

A patient who was admitted was known to be experiencing micropsychotic episodes and dissociative states, despite being heavily medicated.

This should have signalled her vulnerability to a psychotic breakdown (which would be exacerbated by the rigorous, uncovering nature of the programme and the intensity of the interpersonal dynamics within the unit) and she should have been referred to a more suitable facility. Instead, this patient was accepted for admission. Approximately two weeks into her stay, she became floridly psychotic. Her treatment was abruptly terminated, and she was transferred to a "psychotic ward" at nearby Valkenberg Hospital. This proved to be distressing to her and to the G22 patient community, and could have been avoided.

4. Based on an assessment of vulnerability, can the patient be included immediately in all programme activities?

This question tends to be raised only when a patient appears to be overtly vulnerable. A proactive evaluation of each patient's vulnerability should be made, and possible negative reactions to the therapeutic programme anticipated. This would allow for the reduction of a patient's participation in stressful aspects of the programme, or for the provision of special care.

5. In what areas of this patient's functioning can change be expected, and what aspects of the patient's functioning may stay the same? What might the implications of the above be for the patient's course in the unit, for staff expectations, and countertransference difficulties they may experience in relation to this patient.

This question relates to how the patient may settle into the unit and adapt to the routine, rules and conventions involved in its functioning. It appears that nursing staff expect that patients will generally have made this transition within a week, that they will be relatively cooperative, and will participate in social and therapeutic activities. It seems that staff expect patients to show signs of improving (with respect to the most prominent symptoms they were experiencing on admission within about two weeks), and expect that this change will steadily increase until their discharge. Staff tend to subject all patients to the same expectations of improvement, regardless of their relative internal resources, and presenting difficulties (Jones & Rapoport, 1976). How patients either fit in with, or disappoint these expectations, has a bearing on the attitudes of the staff towards them. These attitudes may be overtly or covertly expressed.

A middle-aged patient with recurrent major depression and a diagnosis of schizoid personality disorder remained detached, aloof, distant, relatively uninterested in activities such as "lifeskills", somewhat socially isolated, and less than strictly observant of ward rules and conventions during her 12-week stay. Nursing staff were highly critical of these aspects of her functioning and would routinely raise this with her. Careful consideration of the above question may have generated realistic expectations of this patient, stimulated helpful discussion of possible countertransference feelings of staff, and may have contributed towards the development of a more gentle and empathetic attitude towards her entrenched personality style.

6. How are patients' personality traits represented emotionally and behaviourally? What is the link between them and Axis I clinical symptoms, and how will personality influence treatment outcome?

Such considerations imply a theory of personality and pathology. It is apparent that staff hold divergent perspectives on, and have different levels of training in such theory. While this diversity may be said to be a healthy quality in the functioning of the team, it can be argued that a shared basic model of personality and pathology is essential in creating a unified, coherent approach to patient treatment. Such a theory would constitute the basis for an understanding of change, particularly personality change, and would allow for the development of realistic expectations on the part of staff.

It appears that the dominant perspective in the unit is one which does not recognize the importance of personality in shaping the nature of Axis I pathology. It consequently maintains a strong distinction between Axis 1 and Axis II phenomena. Such a view is contrary to contemporary theory, which refers to an "interplay between long-standing characterological patterns and the distinctive clinical symptomatology a patient manifests under psychic stress" (Millon, 1987, p. 4).

An adolescent girl admitted to the unit gave a complicated family and personal history which, owing to the existence of psychiatric conditions in most other family members, and the state of crisis the family found itself in, was difficult to validate.

In addition, her presentation was such that she posed diagnostic difficulties for the team. It was not until she began to injure herself that the diagnosis of borderline personality disorder emerged as most prominent. The use of a personality assessment instrument would have elucidated her personality dynamics earlier, ideally enabling staff to predict her self-injurious behaviour and perhaps to understand her presenting depressed mood in terms of a borderline personality disorder, which is characterised by "profound feelings of dependence and loneliness, fears of abandonment, and great affective lability" (Blatt & Auerbach, in Choca, Shanley, and Van Denburg, 1992, p. 24).

When this patient's self-injury, "passive-aggressive" behaviour, and suicide threats peaked, nursing staff felt unable to manage her and she was transferred out of the unit. It is possible that if her personality dynamics had been understood on admission, her "acting-out" behaviour could have been predicted and prepared for. This foresight may have empowered and contained nursing staff, who could, in turn, have contained this patient when she broke down.

Having considered issues which relate to the selection process and the need for it to be more efficient, this discussion will turn to issues which concern treatment, with specific reference to therapeutic change.

Treatment-Related Issues

As a milieu therapy unit, G22 values the ethos of change as a central discourse in the unit's therapeutic programme. The nature of this change and the effectiveness of the treatment in facilitating it are, however, not apparent or explicit.

In the first two weeks of their admission, patients are expected to problematize their difficulties, to formulate goals and the means to achieve them. They receive regular feedback from staff and the patient community as to how they are progressing with these goals. At their final, pre-discharge meeting with the patient-staff community, patients are given feedback as to how they've changed. Almost without exception, on completion of a 12-week stay, patients are congratulated on having undergone transformations which are made to sound positively miraculous in their extent and degree.

While placed in the unit, the author co-facilitated a psychodynamic group for recently discharged G22 patients. A unanimous experience these eight patients reported was of heady optimism and awareness of change on discharge.

However, some two to three weeks after returning to their "preadmission lives", their subjective experiences were of the resurgence of many of their symptoms, a resumption of their characteristic ways of approaching stress and problems of living, and often, their submergence in pre-existing problems such as marital conflict. This begs the question of what that "discharge change" was all about, and invites the following speculation:

1. Recourse to objective measures of post-treatment change would allow for more realistic and helpful feedback to be given. In the absence of this, it is possible that staff were communicating a perception of change relative to accurately or inaccurately recalled impressions of a patient's condition on admission; or communicating ideas of change largely influenced by their desire to believe that patients had changed (Jones & Rapoport, 1976), that their work is valuable, and that the unit is effective. .

2. Perhaps real change did occur, but this was limited to clinical symptoms (for example, the remission of depressive or anxiety-related symptoms); basic personality fundamentally remains unaltered.

3. Finally, it is possible that the observed changes were situational (Jones & Rapoport, 1976), making generalization of improvements to the "outside world" difficult, and leaving more enduring characteristics untouched.

The questions and problems highlighted in the preceding discussion of selection and treatment issues constitute the rationale of this study, and have informed its basic aims. These aims will be set out below.

Aims

Using the revised Millon Clinical Multiaxial Inventory (MCMI-II), a self-report personality and symptom assessment schedule, this exploratory study aims to:

1. Establish what measurable change occurs in personality and symptom variables of patients after a 12-week admission to G22 by examining the data yielded by the MCMI-II in conjunction with selected clinical data.

2. To make suggestions as to what aspects of patient difficulties emerge as being most amenable or resistant to therapeutic effects.

3. Explore the possible value of the routine use of a preadmission screening instrument (MCMI-II) in the unit in furthering aims 1. and 2. above.

It is important to note that for the purpose of this study it was necessary to assume uniformity (for all patients) in the delivery of treatment and the therapeutic programme. This assumption is commonly made in therapy outcome research (Messer & Boals, 1981; Norman & Lowry, 1995). Although clearly problematic, it allows for preliminary descriptions of psychotherapeutic change.

Exploration of the aims of the study necessitates referring to contemporary literature on the nature of personality, empirical instruments designed to measure the concepts derived from such theory, and lastly, to review literature on the stability of personality, and therapeutic outcome.

CHAPTER 2

LITERATURE REVIEW

Millon's Biopsychosocial Model of Personality

Millon's theory of personality draws on both trait theory (McCrae & Costa, 1987, 1991, 1992; McCrae & John, in press; Watson, Clark & Harkness, 1994) and developmental constructs (Rothbart & Ahadi, 1994).

In line with contemporary thought, Millon defines personality as

> characteristics that are largely unconscious, cannot be eradicated easily, and express themselves automatically in almost every facet of functioning. Intrinsic and pervasive, these traits emerge from a complicated matrix of biological dispositions and experiential learnings and now comprise the individual's distinctive pattern of perceiving, feeling, thinking, and coping. (Millon, 1981, p. 8)

An important issue in personality theory concerns its understanding of "pathology". In this regard, Millon (1981) notes a historical tendency for personality theories to focus either on normal or abnormal personality. Arguably, this has been at the expense of developing theory that provides an adequate explanation of both.

Current theories, in moving towards an integrated model which is able to account for the development of both normal and abnormal personality, appear to argue in favour of continuity between the two states and their developmental lines. Millon identifies his model of personality as one which incorporates the notion of continuity. Consequently, Millon states that "pathology results from the same forces as involved in the development of normal functioning. Important differences in character, timing and intensity of these influences will lead some individuals to acquire pathological traits and others to develop adaptive traits." (Millon, 1981, p. 9)

Millon's (1969) theory of personality was based on personality prototypes, rather than on single traits. These prototypes correspond to descriptions of DSM personality disorders, but Millon cautions that his personality types should not be thought of as "reified diagnostic entities" (Millon, 1981, p. 60). The prototypes are not mutually exclusive, thus allowing for greater levels of complexity and descriptiveness of personality profiles.

In order to broaden the model's scope, Millon proposed an organizing, circular "map" with a vertical axis representing "affiliation" (with opposite poles of Autonomy vs Enmeshment) and a horizontal axis of "level of emotionality" (with poles of Expressiveness and Impassiveness). The empirical validity of this structure has been borne out by Sim & Romney (cited in Choca et al., 1992). More recently, Millon (1990) has proposed a three factor system of pleasure-pain; active-passive; and self-other, the usefulness of which was noted in a study by Pincus and Wiggins (1990).

The model locates normal and abnormal personality as poles at either end of a continuum. Although the two poles would be qualitatively different, personality styles placed at various points along the continuum may share traits, behaviours and characteristics. Normal personality would evidence the "ability to cope with the environment in a flexible and adaptive manner" (Millon, quoted in Alves, 1993, p. 1). According to Millon, "abnormal" personality may be distinguished from "normal" personality by its deficits in social competence, by inadequate integration, and by impaired ability to cope with stress.

He refers to conditions of persistent adversity under which an individual's already maladaptive personality style gradually decompensates, reflecting the exacerbation of the patient's enduring manner of functioning.

Millon's more recent work has focussed less on the advancement of this theoretical model, and more on the development of psychometric instruments operationalizing his theory of personality pathology, and on the clinical applicability of these instruments. This work has produced the Millon Clinical Multiaxial Inventory I (MCMI-I), (cited in Choca et al, 1992) and the revised Millon Clinical Multiaxial Inventory (MCMI-II), (1987).

The Millon Clinical Multiaxial Inventory -II (MCMI-II)

The MCMI-II is similar to most other contemporary empirical approaches in that it reflects the view that clinical symptom states (Axis I), although precipitated by environmental factors, are shaped by traits and behaviours which are part of the individual's enduring personality style. Axis I symptoms can therefore be considered to represent "disruptions of functioning among the personality types on Axis II" (Millon, 1981, p. 20). The MCMI-II's scales and their construction, as well as its psychometric properties will be considered in detail below.

In the revised inventory (MCMI-II), personality styles are generated by a two-dimensional structure. The first dimension consists of four primary sources of reinforcement, or orientations (Dependent, Independent, Ambivalent, and Detached).
The second dimension classifies patterns of coping as either Active or Passive.

In combination, these dimensions yield 10 basic personality styles [Schizoid, Avoidant, Dependent, Histrionic, Narcissistic, Antisocial, Aggressive-Sadistic (Aggressive), Compulsive, Negativistic (Passive-Aggressive), and Self-Defeating].

In addition, it extracts three so-called severe personality scales (Schizotypal, Borderline and Paranoid). It also generates six transient clinical symptom or "neurotic" scales (Anxiety, Somatoform, Bipolar - Manic, Dysthymia, Alcohol Dependence, and Drug Dependence).

A parallel but more severe variant of this pathology is so-called psychotic thinking, which is measured by means of three scales (Thought Disorder, Major Depression and Delusional Disorder).

An additional indication of severity is provided by cut-off scores for normal and clinical population means, and for increasing degrees of severity of clinical presentations. (This will be explained in detail at a later stage.)

Critique of the MCMI-II

Millon stresses a number of reasons for the usefulness of the MCMI-II which may be summarized as follows: it was specifically intended for the purposes of identification of psychiatric syndromes within a psychiatric population; it has strong construct validity, which is critical in personality assessment (Alves, 1993); and it may be quickly administered and scored.
In addition, the current author's experience of the use of the instrument in a clinical setting suggested that patients found it a relatively non-threatening form of enquiry. It was useful in validating data on personality functioning obtained through so-called subjective assessment measures, clinical histories and collateral information. Its apparent ability to sketch patients' presentations and typical behavioural patterns, through inference from their score profiles was sometimes astounding. Patients who received feedback on their results verified the accuracy of its information. Furthermore, the feedback process commonly deepened rapport.

However, despite these advantages in its use, a number of important criticisms have been levelled at the MCMI-II.

Several concern its psychometric properties, and the lack of verifiable evidence of its links with the DSM III-R (Choca et al., 1992). Various constraints prevent further discussion of these issues in the current study. Criticism of the MCMI-II will be limited to a discussion of the disjuncture between the measure and the theory upon which it is based.

Millon's ideas on continuity between normal and abnormal personality are not clearly evidenced in the construction of the instrument. Choca et al's criticism (1992), that Millon's severe personality styles (Borderline, Schizotypal, Paranoid), and the recent additions of Self-Defeating and Aggressive (Sadistic) types are problematic in that so called normal variants of these maladaptive patterns cannot be found, should certainly be considered.

Further evidence of the disjuncture between the theory and its translation in the MCMI-II lies in the absence (in the instrument) of operationalized measures of prominent theoretical concepts, for example, measures of normal and abnormal personality such as ego strength and adaptability. This leaves the novice user of the test to sort through Millon's somewhat unclear guidelines for classifying personality as disordered and predicting the implications of this for thoughts, attitudes, behaviour and overall functioning of the patient.

The break between theory and its application to the test is further evident in the lack of clear placement of the clinical symptom scales under the influence of the personality variables in the interpretation of the test scores.

As a result of this omission, adequate and accurate interpretation demands a fair degree of diagnostic sophistication on the part of the clinician.

Millon advises extensive caution in the use of his test. He suggests that it never be used on its own, that it should always be supplemented by collateral and clinical interview information, and further psychometric testing. Although caution in clinical assessment is always necessary, these statements may also be argued to suggest gaps or inadequacies in the construction of the inventory which should be addressed. One such gap that may be hypothesised to exist is the absence of a consideration of the social context of, and intersubjective influences on the "pathology" measured by the MCMI-II. This omission may be said to stem from the theoretical perspective on which the inventory was based. Personality theory, as reviewed in this study, operates from the central assumption that personality is a discrete entity that is stable and continuous over time, and that it may be measured and quantified. This is a contentious issue which has been challenged by developmental, and social constructionist theorists such as Atwood & Stolorow (1984).

A further problematic issue lies in the pathological slant of the inventory. This is evident in the construction of its scales, the terms used in the inventory and its associated interpretive narratives, and its strict rules about applicability exclusively to a psychiatric population. It could be said that this defies Millon's stated allegiance to the concept of continuity.

The difficulties in relation to Millon's personality theory and the MCMI-II serve to illustrate what may be argued to constitute a current trend, namely extensive research into, and revision of assessment techniques in order to keep pace with their prolific use in clinical and occupational assessment. This has unfortunately not been matched by personality theory development.

Having considered both the advantages and disadvantages associated with the use of the MCMI-II, discussion will turn to an important issue in personality theory and clinical practice. The extent to which personality is changeable, particularly by therapeutic means, is a key issue examined in the current study.

Personality Stability and Therapeutic Change

According to Millon (1981), a popularly held belief among psychologists from a variety of theoretical backgrounds is that personality is readily modifiable. This has encouraged a proliferation of literature promising dramatic change through self-help.

Contemporary research arrives at conclusions which are contrary to these ideas. Costa and McCrae (1986) cite the existence of a series of longitudinal studies (retrospective and cross-sectional) demonstrating the stability of personality traits over the life span. In so doing, the authors point to the importance of definitions used in conceptualizations of personality and in debates around this.

Taking the trait approach to personality theory, the authors define personality as "the individual's characteristic styles of thought, feeling and behaviour" and refer to "individual differences in patterns of interpersonal relations, emotional reactions, impulse control, and experiential styles". (p. 408).

Longitudinal (retrospective and cross-sectional) studies of the stability of mean levels of personality variables (Costa & McCrae; Siegler, George & Okun; cited in Costa & McCrae, 1986) demonstrate that "there is little change with age in the average level of personality traits" (Costa & McCrae, 1986, p. 412).

Further studies on the stability of individual differences in personality variables by Eron, and Conley (cited in Costa & McCrae, 1986), despite using a variety of instruments, samples, age cohorts and retest intervals, consistently conclude in favour of stability. Costa and McCrae (1986) stress the implications of this research for clinical practice. They argue that it:

1. suggests that current patient problems may be a function of more enduring personality traits (which will in turn influence treatment outcome)

2. fosters more realistic expectations of the extent of therapeutic change possible

3. indicates the need for research into what maintains both adaptive and maladaptive personality traits

In the light of this, the current study's exploration of therapeutic change (in a unit where the mutability of personality is a commonly-held belief) is important. Having emphasised the view that personality essentially remains stable over time, and that therapeutic expectations should be moderated accordingly, it is important to examine research findings on the effect of treatment on personality "pathology" in more detail.

The Treatment-Responsiveness of Personality Disorders

In his (1981) work on personality disorders, Millon proposes a differential response to treatment which is dependent on the particular personality disorder in question.

In a similar vein, Hoglend (1993) cites Green and Reich's (1991) review article which stressed that patients with personality disorders show less favourable treatment responses than those without. In many of these studies, such patients show only symptomatic improvement. Hoglend's study on long-term outcome following brief dynamic psychotherapy with personality disordered patients upheld Reich's first assertion; that patients with personality disorders showed lower levels of both "symptomatic" and "dynamic" change at 2-year follow-up than those without. However, these differences were no longer statistically significant at 4-year follow-up, suggesting that Hoglend's study is somewhat more optimistic in its conclusions. Although this study confirmed Winston's conclusion (cited in Hoglend, 1993) that patients with character pathology required longer treatment periods in order for outcome to be successful, it concluded the following:

1. If personality disordered patients receive dynamic treatment lasting 30 sessions or more, long term dynamic outcome may be as favourable as outcome for patients without such disorders.

2. This relationship between treatment length and dynamic change proved to be far stronger than that between patient characteristics such as initial degree of impairment, suitability, or Axis II cluster category.

Another conclusion of relevance to this study which was reached by Hoglend (1993) is that, contrary to expectations, Cluster B personality disorders (antisocial, borderline, histrionic and narcissistic) did not show the worst outcome. In fact they "tended to be more motivated ... than several of the Cluster C patients" (Hoglend, 1993, p. 179). Furthermore, Hoglend cited the finding of a study by Horowitz (1986), that significant changes occurred in patients with Cluster C pathology (avoidant, dependent, obsessive-compulsive and passive-aggressive) following dynamic psychotherapy of approximately 40 sessions, and this continued in one to five years following treatment termination.

Weiner and Exner (1991), and Exner and Andronikof-Sanglade (1992) in their studies using the Rorschach to measure changes in psychological organization and symptoms (following psychotherapy contracts of various lengths) conclude as follows:

1. Patients seen for brief term therapy (14 weeks of once-weekly sessions) showed improvement on 12 out of 27 variables. These variables concerned affective features, self or interpersonal perception, processing and mediation, coping styles, areas of controls and ideation.

2. These changes were, however, not maintained at follow-up eight to twelve months later, when measures of only 7 of the 12 originally improved variables, showed maintained improvement.

3. A broader range of benefits was observed for patients seen for long term (three to four years) therapy as opposed to brief or short term therapy. The long term therapy patients showed improvement in six dimensions of personality functioning as measured by the Rorschach at follow-up (which was performed four years after commencement of therapy. (These dimensions are: ability to manage stress; ability to deal with experience attentively, openly, conventionally and consistently; ability to modulate and enjoy emotional experience; ability to use ideation effectively; self-preoccupation, and self-contentment; and lastly, interest and comfort in interpersonal relationships.)

These findings conclude with some optimism in favour of the responsiveness of personality disordered patients to treatment, particularly long-term therapy. This view has important implications for the findings of this study.

Milieu Therapy and Ideology

Jones and Rapoport's (1976) review of milieu therapy provides an important context for the interpretation of findings in this study, and will thus be referred to in some detail. They examine the milieu therapy perspective in terms of the commonalities it shares with the concept of ideology. They stress the emotional investment and resoluteness with which these beliefs are held by the staff in such a unit, and the staff's strong resistance to attempts at objective reassessment of these ideas:

> Ideologues not only perceive and interpret the world around them in terms of the precepts of their own system of beliefs, but they tend to be especially convinced of the moral worth and special importance of their own particular orientations. Ideology welds observable aspects of the environment into a kind of unit by filling in gaps in knowledge with various projections that ultimately supply a coherent belief system on which action can be based and justified. (p. 534).

The authors comment that the ideological nature of the (nursing) staff's therapeutic practices, transforms "treatment means into entrenched ends in themselves". (p. 538). A further contention of the authors is that "all too often, established practice bears no relationship to the treatment needs of the patient....they [sic] appear to be an elaborate defense protecting staff against such needs." (p. 565). Staff tend to measure patients against their own values, which they consider to be normal. Departure from these values by patients is considered to demonstrate pathology within them.

In addition, the degree of conformity or "rebelliousness" shown by the patient bears a strong relation to staff perceptions of patients' "health", and their improvement at discharge. Excessive conformism or aggression are equally rejected by staff, and the degree of rebellion tolerated within the unit varies according to the prevailing atmosphere. In times of crisis, for example, when disorganization (stemming from disturbances among either staff or patients) is high, the unit is less tolerant of disruptive patients, and will tend to censure their behaviour more severely, and to transfer or discharge them from the unit. Such patients would tend to be labelled unfavourably by staff and would find it difficult to gain re-admission to the unit at a later stage.

Psychotherapy Outcome Research

This section reviews aspects of literature on therapy outcome. This is not in order to focus on the efficacy of milieu therapy or of the G22 treatment itself. Rather, it is primarily an attempt to provide evidence for the author's evaluation of the results of the MCMI-II in the current study. Its secondary purpose is to inform later discussion on the merits of a larger and more in-depth research project, based on the aims of the current exploratory study.

Outcome studies that examine in-patient treatments adequately are scarce. According to Ellsworth et al. (1979), in-patient outcome research has fallen into a number of different traps, which include: (a) failing to control for the effects of patient input characteristics on the outcome being measured, and (b) the use of poorly selected measures of programme outcome.

In terms of specific outcome-related factors, Jones and Rapoport (1976) indicate that treatment responses are complex in nature. They suggest that those patients who enter the unit with a greater degree of ego strength, and with fewer deficits in relation to social roles, show the best outcomes. Related to this, these types of patients generate more modest expectations amongst unit staff, and are rated as more improved (than other patients) at discharge. These patients, who demonstrate neither extreme aggression nor conformism, tend to adjust better after discharge than other patients.

Significant conclusions on the efficacy of therapeutic intervention emerge from Smith and Glass's (1977) meta-analysis of psychotherapy outcome studies. Most importantly, they concluded that the research demonstrated the benefits arising from counselling and psychotherapy, in that "the typical therapy client is better off than 75% of untreated individuals" (p. 752). Furthermore, the study concluded that the differences that emerge between various types of therapy are negligible, and that this held true for a broad comparison of behavioural and non-behavioural therapies.

Although these findings have been subject to critiques by, among others, Rachman and Wilson (1980), more recent studies (Shapiro & Shapiro (1982) have confirmed Smith and Glass's (1977) conclusions of the general efficacy of therapy versus placebo treatments.

Furthermore, Shapiro and Shapiro (1982) have shown that the problem under treatment accounts for far more variance in treatment outcome than therapeutic modality. However, they have failed to confirm convincingly the contention by Rachman and Wilson (1980) that behaviour therapy is significantly superior to "dynamic" therapies.

CHAPTER 3

METHODOLOGY

The Millon Clinical Multiaxial Inventory -II (MCMI-II)

Application

The personality inventory consists of 175 brief, self-descriptive statements which respondents are asked to mark as true or false. It may either be individually or group administered. It is intended for people over the age of 17, with a reading level at or above about a Std 7 grade.

Standardization

The reference group used for the test was an American nationally representative but undifferentiated psychiatric sample, as opposed to a normal sample. The MCMI converts raw data to a base rate score (BR) as opposed to a normalised standard score. According to the MCMI-II manual (1987), the scale cut-offs and profile interpretations are oriented to the majority of patients who complete the inventory. These patients tend to fall within the category of moderately severe emotional difficulties or distress, as opposed to a mild or severe category. In terms of its applicability to population groups outside of the U.S. its standardization sample poses problems for its use outside of that country. For discussion of the implications of this issue for the current study, please refer to "Methodological Considerations" (p. 37).

Millon stresses the need for the use of the instrument only by adequately qualified clinicians, such as those with a masters degree in clinical or counselling psychology, a psychiatric social residency position, or those involved in supervised research.

Scoring

The inventory may be hand scored, although Millon indicates that computer scoring (which produces a printed profile report) is preferable. As previously mentioned, the MCMI-II generates BR scores. This method was employed in order to provide optimal cut-off points for the purpose of differential diagnosis, and effectively "places an individual in the same position relative to the standardizing population" (Choca et al., 1992, p. 19).

This is achieved by the establishment of four cut-off points, namely a BR score of 35 (the median score for a non-psychiatric population), a BR score of 60 (the median for a psychiatric population), a BR score of 75 (indicates the definite presence of the particular characteristic being measured), and a BR score of 85 (the point at which a particular characteristic is the predominant one for that individual). Furthermore, the BR score also takes into account the prevalence of a particular characteristic in the population. The BR score may be understood as "indicating the probability that the individual has the particular characteristics being measured rather than the simple placement that he or she occupies in the normal distribution" (Choca et al., 1992, p. 19). Consequently, a low BR score does not imply anything about the individual being assessed, whereas a low T score (which is the score commonly generated by tests) would indicate the absence of the trait being measured.

The Weighting Factor

The MCMI-II includes differential weighting of items in order to simultaneously reduce the effects of item overlap and increase validity. This scoring adjustment has been criticised by Streiner and Miller (cited in Choca et al., 1992), who argue that the differential weighting of raw scores fails to enhance validity in any significant way.

Validity

There are several built-in checks which evaluate the validity of the individual's responses. These come into operation if any of the following conditions are met:

a) 2 or more of the 4 validity items are marked true.

b) 12 or more items are omitted or double-marked.

c) The raw score on Scale X (Disclosure Level) is less than 145 or more than 590.

Furthermore, if an individual's responses result in BR scores below 60 for all 10 basic personality scales, an interpretive report may not be generated, since the results recorded do not allow for sufficient discrimination.

The MCMI-II's validity checks include (a) The Validity Index, (b) Disclosure Level, (c) Desirability, (d) Debasement, (e) The Denial-Complaint Adjustment Correction, and (f) The Weight Factor. These are detailed below:

(a) The Validity Index:

This index, comprising four items, was constructed in order to detect extreme response tendencies.

According to Millon (cited in Alves, 1993) studies of random responding on the test show that almost 100% of such respondents were detected by this index. Computer-scored protocols with index scores of 2 or more contain the statement "invalid". Those with a score of 1 are labelled "questionable validity", whilst those with a score of 0 on the validity index are regarded as "valid".

(b) Disclosure Level (Scale X):

This refers to the openness or secretiveness of the individual's response style. A BR score of less than 35 on this scale suggests either reticence or a general reluctance to be self-revealing, whilst a BR score of 75 and over on this scale suggests unreserved frankness of responses.

(c) Desirability (Scale Y):

The degree to which the individual's responses are affected by a desire to be perceived as socially acceptable and emotionally healthy is denoted by this scale. Once again a BR score of 75 is the cut-off point for this measure. High scores should be carefully considered and the individual's motives investigated.

(d) Debasement (Scale Z):

BR scores above 75 on this scale indicate a tendency towards self-depreciation and negative self-representation to the extent that this conflicts with the perceptions of others. A high score on Scale Z may accompany a high score on Scale Y.

(e) The Denial-Complaint Adjustment Correction:

This refers to an additional BR modification for defensiveness in protocols featuring Scale 7 (Compulsive), Scale 5 (Narcissistic), or Scale 4 (Histrionic), as their highest score. The reasoning behind this is that the adjustment effected by Scale Y needs to be supplemented in order to raise the scores to "clinically judged levels of disturbance" (Alves, 1993, p. 8). The same rationale underlies the reduction of scores to compensate for overreporting of symptoms, for example, where the highest personality scale is either Scale 2 (Avoidant) or Scale 8B (Self-Defeating).

(f) The Weight Factor:

The MCMI includes a weight factor, on the basis of which adjustments are made in order to counteract denial and exaggeration. It was designed to detect so called fake good and fake bad response sets.

Reliability

Choca et al. (1992), comment that the MCMI-II's scales have good test-retest reliability, which has improved relative to the first version of the inventory.

Non-Inclusion of Control Groups

The setting up of a comparable group of patients to act as a control group in milieu therapy research is not feasible. According to Norman & Lowry (1995, p. 17), this is due to the "field setting" of such studies.

Furthermore, the findings of Smith and Glass's (1977) study are relevant in this context. Some therapy is more effective than none at all in reducing patients' symptoms, suggesting that measurement of that symptom reduction is in itself important. While a control group would provide information on the efficacy of milieu therapy, as opposed to other treatment modalities, this was not the aim of the current study, which was concerned primarily with measurement of patient change. If the focus had been to evaluate outcome in general, an attempt at the inclusion of a control group may have been important. However, for the limited aims of the study, which were chiefly concerned with the introduction of the MCMI-II into Ward G22, this was not necessary.

In addition, the study was not intended as a validation study for the MCMI-II. The validity of this instrument was an assumption of the study, based on research to this effect (Choca et al., 1992; Millon, 1987).

Uniformity of Therapeutic Programme and Treatment Delivery

Once again, the aims of the study are relevant to this discussion. The assumption of uniformity rests upon the following reasoning: If the difference in effectiveness of varying therapeutic modalities is negligible (Smith & Glass, 1977), then it becomes possible to investigate change in milieu patients without necessarily attempting to specify the active ingredients of the milieu therapy programme, such as how various components of the programme address symptom reduction or personality change.
It also becomes unnecessary to measure the efficacy of milieu treatment in comparison to any other sort of therapy.

Subjects Used in the Study

All subjects were aged between 18 and 35, and were admitted to Ward G22 for the 12-week therapeutic programme. All patients were female, simply as a result of the pattern of admission to the unit at the time when data collection occurred. All were in possession of at least a standard 8 education. In total, 13 patients were tested on admission. However, 5 of these terminated treatment prematurely and therefore could not be reassessed.

Procedure

Over a three month period (September 1994 to November 1994), patients admitted successively to G22 were approached by the author and asked if they would agree to take part in a study. They were told that the research was interested in their subjective experience of how their admission to G22 affected them, and that in order to investigate this, they would be assessed twice, once on admission and once on discharge. They were also asked if they would agree to their therapists being given "basic" feedback on their results in order that the therapists could be informed should the patients wish to discuss in therapy anything that may have arisen in connection with the assessment and feedback.

All patients were assessed within the first week and a half of their admission and in the last week before their discharge, using the MCMI-II.

Protocols were computer scored (this took an average of one to two weeks). MCMI-II personality profile narratives set out in Choca et al. (1992) were used as supplementary information.

Patients were then seen for a 30 minute feedback appointment where the findings of their assessment were discussed with them. The terms and language used in the personality profile narratives were altered to be less psychiatric and non-pejorative. Patients were asked how relevant and accurate they experienced the feedback information to be, and were invited to ask any questions they may have concerning the results of the test itself or the feedback. The format of the second feedback appointment was to compare the results of the first test with those of the second, discussing with the patients the areas of their functioning which had changed, according to the MCMI-II. Once again, they were invited to ask questions, and their impressions of the accuracy of the information given was elicited. This was not in order to gather formal data of subjects' impressions, but rather its purpose was to facilitate their feeling less threatened, and to dispel any perceptions that the test results constituted incontrovertible evidence which subjects were obliged to accept.

CHAPTER 4

RESULTS AND ANALYSIS

Methodological Considerations

The research findings of the current study need to be evaluated in the context of certain methodological considerations.

Sample Size and Interpretation of Results

The small size limits the extent to which the study's findings may be generalized to milieu therapy patient populations. However, closer consideration of certain individual results suggests trends which warrant further investigation. Such an approach views scores in a clinical and social context, and will be used in this study to complement information yielded by statistical analysis of the data.

Sample Size and Type 1 Errors

A Type 1 error in significance testing refers to the risk of accepting a difference between scores as significant when it is not. This error becomes relevant when a study has a small sample size, such as that of the current study. However, since this study is a clinical one, these difficulties become unavoidable. The length of the G22 programme made extraction of a statistically respectable sample size difficult in the period of time available.

The size of the sample, relative to the number of observations for each subject, has also dramatically decreased the type of statistical investigations which may be performed on the data, and implies that caution should be taken when making inferences on the basis of the information yielded. (Howell, 1987). In order to attempt to counteract the danger of making a Type 1 error, the significance level may be lowered from the usual 5%, to 1%. However, this then causes the statistical evidence to tend towards making a Type 2 error. This refers to the risk of failing to recognize differences as real, even when they are. This should be considered when evaluating the statistical procedures presented in this study.

Norms for the MCMI-II

There are no South African norms available for this inventory. However, this study has accepted the available norms as adequate for its use. Concurrence between clinical groups across cultures is commonly assumed to outweigh the influence of cultural differences. The decision to use the available MCMI-II norms in this study was made accordingly. This reasoning is reflected in the wide-spread use in this country of the DSM. Furthermore, all subjects used in this study are from so-called middle class social backgrounds, speak either English or Afrikaans, live in suburbs in and around Cape Town and share similar family backgrounds and religious origins. These facts were accepted as measures of subject similarity, which constitute support for the decision to use the MCMI-II despite the unavailability of South African norms.

Validity Checks as Disqualifiers

It should be noted that scores for Scales V and X (Validity and Disclosure) have been excluded from the statistical analysis because all subjects' scores on these scales are within acceptable levels.

When the MCMI-II Scales X, Y and Z are above 75, Millon (1987) cautions that the clinician needs to take particular care in interpreting such protocols, and should attempt to establish the reasons underlying the patient's response set.

In the current study, 2 of the 8 subjects who completed the study had Scale Y (Desirability) elevations above 75 before beginning treatment. At post-treatment assessment, these scores remained at this level. A further 4 subjects' Scale Z (Debasement) scores were elevated above 75 on initial assessment, although these all dropped below 75 after treatment.

Ideally, perhaps, these protocols should have been omitted from the study. However, owing to the sample size, this was not possible. For this reason, and because they add valuable information to interpretive profiles (as will be discussed further), Scales Y and Z's scores were included among the personality and clinical symptom scores in statistical investigations.

Protocols Without Elevations

Millon (1987) states that profiles where all the basic personality scales have BR scores below 60 should not be interpreted.

In the current study, a similar profile is that of subject 8, who has only one scale with a BR score of 60 (Aggressive). The decision to include this protocol was made on the basis that this patient was admitted to G22 with various post-traumatic stress disorder (PTSD) features (flashbacks, dissociative, and physical symptoms), and was considered by staff to be urgently requiring treatment. She was thus part of a clinical population and should therefore be considered along with the other subjects in this study. Her unexpected profile should in no way be taken to imply that she did not require treatment. Rather, it highlights the inability of the MCMI-II to detect PTSD. This has been supported in research by Choca, Shanley, Peterson and Van Denburg (cited in Choca et al., 1992) on the MCMI-II and PTSD. A conclusion such as this implies caution when using the MCMI-II as a selection or exclusion measure. Its results should be supplemented with clinical interview material and collateral, as urged by Millon (1987). The need for further research, in order to render the inventory's diagnostic categories more inclusive, is clear.

Results

TABLE 1: ANALYSIS OF "PRE"-"POST" SCORE CHANGES ACROSS MCMI-II SUB-SCALES FOR ALL SUBJECTS

Scale	Pre Mean	Post Mean	P(T=t) Two Tail
Scale 1 Schiz.	65.25	46.25	0.02*
Scale 2 Avoid.	79.63	60.50	0.01**
Scale 3 Dep.	73.38	50.25	0.01
Scale 4 Hist.	70.13	75.38	0.42
Scale 5 Nar.	60.88	71.25	0.19
Scale 6A Ant.	67.00	66.13	0.76
Scale 6B Aggr.	64.75	70.38	0.44
Scale 7 Comp.	55.88	55.38	0.93
Scale 8A P.Agg.	78.50	76.63	0.72
Scale 8B S.Def.	84.88	61.88	0.00**
Scale S Sch.Typ.	64.88	46.25	0.13
Scale C Bord.	80.63	63.63	0.03*
Scale P Para.	68.88	64.50	0.33
Scale A Anx.	76.13	18.75	0.00**
Scale H Soma.	68.25	41.63	0.00**
Scale N Manic.	59.88	58.50	0.86
Scale D Dysthy.	78.00	27.50	0.00**
Scale B Alc.	56.50	52.13	0.30
Scale T Drug	62.63	60.50	0.61
Scale SS Thought	65.88	48.50	0.00**
Scale CC Maj.Dep.	61.50	42.38	0.02*
Scale PP Delu.Dis.	60.75	50.13	0.14
Scale Y Desir.	55.88	57.75	0.84
Scale Z Debas.	71.50	39.75	0.00**

Note. Pre Mean = Mean of pre-treatment scores for all subjects on relevant MCMI-II sub scale. Post Mean = Mean of post-treatment scores for all subjects on relevant MCMI-II sub scale.
*$p < .05$. **$p < .01$.

The analysis in Table 1 was performed using t-tests of significance. The aim was to compare the scores of all subjects across scales in order to establish whether the post-treatment changes were significant or not.

Of the 24 scales compared before and after completion of treatment, the following 7 yielded significant results at the 1% level ($p < .01$): Scale 2 (Avoidant); Scale 8B (Self Defeating); Scale A (Anxiety) Disorder); Scale H (Somatoform Disorder); Scale D (Dysthymic Disorder); Scale SS (Thought Disorder); and Scale Z (Debasement).

Results which were only significant at the 5% level ($p < .05$) were: Scale 1 (Schizoid); Scale C (Borderline); and Scale CC (Major Depression).

From the results in Table 1, it is clear that a greater number of significant results was found within the clinical symptom scales than within the personality scales.

TABLE 2: MCMI-II SUB-SCALE BR SCORE INCREASES AFTER TREATMENT

Scale	Subject 1		Subject 2		Subject 3		Subject 4	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Scale 4 Hist.					44	83	77	81
Scale 5 Nar.	80	86	81	86	53	69	55	71
Scale 6B Aggr.	69	87			44	60	81	82
Scale 8A P.Agg.	72	79					110	118
Scale Y Desir.					45	71	50	71

Scale	Subject 5		Subject 6		Subject 7	
	Pre	Post	Pre	Post	Pre	Post
Scale 4 Hist.			81	86	75	84
Scale 5 Nar.	33	71	68	79	69	92
Scale 6A Ant.	57	66	57	64		
Scale 6B Aggr.	35	72	79	83	63	69
Scale 8A P.Agg.	69	77			100	109
Scale T Drug.	51	60			64	76
Scale Y Desir.	10	50				

Note. "Pre" and "Post" as used in tables for this study = pre and post-treatment respectively.

Despite score changes being non-significant, a closer examination of pre and post-treatment scores for Scale 4 (Histrionic), Scale 5 (Narcissistic), Scale 6A (Antisocial), Scale 6B (Aggressive), Scale 8A (Passive-Aggressive), and Scale Y (Desirability) shows increases after treatment. These results are discussed at a later stage.

In accordance with the clinical approach of this study, certain patients' results warrant discussion. The scores that will be highlighted are those which increased after treatment. Seven subjects registered increased elevations (to BR scores of 50 and over) on at least one scale. These increases were predominantly among the personality scales.

Although statistically non-significant, these scores could be suggestive of a trend towards increased elevations on particular scales after treatment in G22.

TABLE 3: CHANGES IN SUBJECTS' THREE HIGHEST MCMI-II PERSONALITY SCALE ELEVATIONS AFTER TREATMENT

	Subject 1 [4/6A/5]		Subject 2 [6A/8A/C]		Subject 3 [2/8B/S]		Subject 4 [C/8A/8B]	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Eleva. 1	106	94	111	100	116	64	118	85
Eleva. 2	81	76	111	100	116	71	110	118
Eleva. 3	80	86	111	70	116	44	104	80
Mean	89	85	111	90	116	60	111	94

	Subject 5 [2/8B/3]		Subject 6 [7/3/4]		Subject 7 [2/S/C]		Subject 8 [6B/1/P]	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Eleva. 1	91	76	94	84	110	93	60	30
Eleva. 2	90	76	91	68	110	61	52	45
Eleva. 3	84	71	81	86	110	97	50	32
Mean	88	74	89	79	110	84	54	36

Note. "Eleva." = scale elevation. [4/6A/5] = MCMI-II annotation of three highest personality Scale elevations (in descending order), for example, Scale 4 (Histrionic), Scale 6A (Antisocial), and Scale 5 (Narcissistic).

The comparison in Table 3 was made in order to evaluate the effect of the treatment on the predominant personality constellation of the subjects.

No two subjects shared the same three personality elevations, making comparisons of personality clusters impossible.

However, examination of subjects' means after treatment shows that, of the 7 subjects whose means were 85 or above before treatment, 3 maintained elevations within this range after treatment. Of the remainder, 3 subjects' post-treatment elevations were above 75.

TABLE 4: COMPARISON OF PRE-TREATMENT MCMI-II SUB-SCALE SCORES FOR TREATMENT "COMPLETERS" AND "DROPOUTS"

Scale		C. Pre Mean	D. Pre Mean	P(T=t) Two Tail
Scale 1	Schiz.	65.25	59.00	0.44
Scale 2	Avoid.	79.63	49.00	0.04*
Scale 3	Dep.	73.38	64.00	0.65
Scale 4	Hist.	70.13	85.60	0.14
Scale 5	Nar.	60.88	89.80	0.03*
Scale 6A	Ant.	67.00	77.40	0.33
Scale 6B	Aggr.	64.75	72.00	0.34
Scale 7	Comp.	55.88	62.20	0.67
Scale 8A	P.Agg.	78.50	69.00	0.58
Scale 8B	S.Def.	84.88	70.20	0.39
Scale S	Sch.Typ.	64.88	50.40	0.27
Scale C	Bord.	80.63	73.00	0.67
Scale P	Para.	68.88	67.60	0.87
Scale A	Anx.	76.13	47.80	0.19
Scale H	Soma.	68.25	54.40	0.11
Scale N	Manic.	59.88	74.20	0.34
Scale D	Dysthy.	78.00	51.20	0.21
Scale B	Alc.	56.50	55.20	0.91
Scale T	Drug	62.63	65.20	0.75
Scale SS	Thought	65.88	56.20	0.16
Scale CC	Maj.Dep.	61.50	56.60	0.64
Scale PP	Delu.Dis.	60.75	59.40	0.85
Scale Y	Desir.	55.88	74.40	0.15
Scale Z	Debas.	71.50	54.60	0.20

Note. C. Pre Mean = Mean of pre-treatment scores for all treatment completers on relevant MCMI-II sub scale.
D. Pre Mean = Mean of pre-treatment scores for all treatment "dropouts" on relevant MCMI-II sub scale.
*$p < .05$.

Again, t-tests were used to establish whether the sample of pre-treatment subjects who later "dropped out" were significantly different in any way from those who went on to complete the programme.

The following results were significant at the 5% level ($p < .05$) only: Scale 2 (Avoidant) and Scale 5 (Narcissistic). Directional analysis indicates that those who terminated treatment prematurely had lower scores on Scale 2 (Avoidant) and higher scores on Scale 5 (Narcissistic) than those who completed the treatment programme.

CHAPTER 5

DISCUSSION OF RESULTS

The results suggest a general trend towards improvement after treatment. However, this trend was upheld largely by results on clinical symptom scales as opposed to personality variables, which registered less dramatic change. In fact, this study argues that the dominant personality constellation of the subjects remained largely unchanged on discharge. In terms of the recommendation by Ellsworth et al. (1979) that post-hospital adjustment is the most adequate measure of treatment outcome, the limitations of the current study become clear. Information obtained informally via the G22 out-patient psychotherapy group appears to confirm the finding by Ellsworth et al. that the real test of treatment success is patients' post-hospital adjustment. For this reason, the group of patients in this study should have been followed up formally in the months after their discharge, in order to establish to what extent their measured improvement was maintained. This would be a strong recommendation that would need to be taken into account in the conducting of a more in-depth study in this area.

Furthermore, the findings of Ellsworth et al. (1979), with reference to outcome measures, suggest that the pre- and post ratings used to assess change in the current study could certainly be supplemented, or even replaced by the measure of "judged improvement" (as perceived by patients, staff and perhaps family members).

The means of assessing outcome would be an important consideration if more in-depth research were to be undertaken using the current study as a basis.

Turning to the results that concern personality scale change, it is clear that, of the 13 scales pertaining to personality, 9 showed no significant improvement after treatment. The more extensive improvement in clinical symptom scales (5 of the 9 scales showed improvement) relative to personality scales, is partly to be expected, since (according to Millon, 1987) the former are regarded as more transient states often representing a personality structure in crisis. It is also expected that those aspects of human functioning tapped by the personality scales are more enduring qualities. In general, the modest response to treatment is in accordance with findings of psychotherapy outcome research (Norman & Lowry, 1995; Smith & Glass, 1977; Shapiro & Shapiro, 1982).

The significant improvements of Scale 2 (Avoidant), Scale 8B (Self-Defeating), and less significant improvement of Scale 1 (Schizoid), may be suggestive of a cluster which responded well to the treatment. In a similar vein, had the sample size in this study been greater, the score changes on Scales 4 (Histrionic), 5 (Narcissistic), 6A (Antisocial), 6B (Aggressive), and 8A (Passive-Aggressive), may have constituted a trend towards unchanged or increased elevations after treatment.

These results are puzzling, and could be interpreted in a number of ways.

They could be suggestive of clusters of personality styles which can be identified as either resistant or responsive to the kind of treatment offered at G22. For a so-called change- resistant group this could imply refusing admission, or cautiously admitting patients with the expectation that treatment response may possibly be poor. This argument rests upon the assumption that the treatment context has no effect on patient outcome. It is the view of the author that this assumption is implicit in the MCMI-II, which implies that pathology is located within the individual, and that measures may be made of this more or less stable intrapsychic structure that is personality.

However, considering the findings of Jones and Rapoport (1976) that "too little attention has been paid to the effect of the hospital community on the individual patient" (p. 563), this would be a dangerous conclusion to reach.

It has become apparent that in the current study, there is insufficient consideration of the many factors which may intervene during, and affect patient outcome after, a 3-month hospitalization. These factors include unspecified characteristics brought to the treatment situation by patients, factors related to the milieu itself, such as staff characteristics, and staff and inter-patient dynamics. (Ellsworth et al., 1979). In the undertaking of a further study, such characteristics would have to be specified and their effect carefully tracked.

A consideration of treatment context could assist in explaining the results of those patients with increased Scale 4 (Histrionic), Scale 8A (Passive-Aggressive), and Scale Y (Desirability) elevations after treatment. In order to explore this point, it is necessary to consider selected case material in this discussion. The omission of formal clinical or interview information for each patient in the design of this study was largely due to the study's initial aims. These were not to compare clinical information with "objective assessment" data, but rather to explore the possible value of an objective assessment measure (the MCMI-II) in G22's selection process. However, in retrospect, it is apparent that clinical and interview data constitute an essential source of information against which the results of the MCMI-II should be evaluated.

Based on the content of items constituting Scale 4 (Histrionic), patients with post-treatment elevations on this scale were reporting, at the time of discharge, that they were more verbally expressive, attention-seeking, needy, impulsive and more easily frustrated than at admission. It is possible that patients entering the unit quickly establish that those patients who are highly expressive and attention-seeking, receive attention (both positive and negative) from an over-extended staff group. The theory of modelling, as advanced by Bandura (1976), could explain why some new patients then begin to produce similar behaviours, thereby accounting for the increase in their post-treatment scores on this scale.

One such patient was subject 3, who after an initial "quiet" period of two weeks, began to "act out". These incidents tended to take place shortly after the acting out of another patient, and took a similar form. Nursing staff were eventually split over this issue, with some staff responding sympathetically, whilst others began to challenge and verbally discourage her behaviour. This varied attention continued unabated until her discharge, when her increased Scale 4 elevation was recorded.

Another such trend, which may point to treatment context as an important area of additional consideration, is that of increased Scale 8A (Passive-Aggressive) elevations after treatment. This was suggested when feedback discussions with subjects 1, 4, 5 and 7 concerning their experience of G22 yielded similar sentiments, namely: that patients grew to resent being in what they perceived to be a powerless position relative to the ward's authority figures; and objected to being unable to determine many of their daily activities, such as bed and meal times. Due to the concurrence between the MCMI-II scales, this trend would also affect scores on Scales 5, 6A, and 6B.

The issues raised by these patients constitute one side of an ongoing debate in milieu therapy programmes about optimum levels of "permissiveness" in such units (Jones & Rapoport, 1976). It is possible that the ideal therapeutic unit should be less structured, and should allow patients greater opportunity for choice in their day-to-day living. Such a change may work to lessen patients' reported difficulties in adjusting to non-institutional conditions after discharge.

Individual increases on this scale may be explained by considering the course of individual subjects in ward G22. Subject 7, who has a history of sexual exploitation as a child, was diagnosed with a borderline personality disorder, an eating disorder not otherwise specified (DSM III-R, 1987), and was depressed and suicidal on admission. She presented in a largely compliant manner (in relation to staff and patients) during her stay. She was "adopted" by one of the members of the nursing staff who is, according to patients, generally experienced as controlling in her manner, pressuring them into accepting her numerous and constant interpretations of their difficulties, despite their attempts at disagreement. Furthermore, this patient was negatively evaluated by staff in private, and occasionally confronted directly for her manner, and style of dress, which were perceived as provocative and inappropriate for a married woman. On discharge, her Scales 6B (Aggressive) and 8A (Passive Aggressive) were elevated. It is possible that, with her unaltered post-treatment sensitivity to the staff expectations (suggested by her maintenance of a highly elevated Desirability rating at discharge), her increased aggression was in accordance with the staff's dislike of excessive compliance as a patient characteristic. (Jones & Rapoport, 1976). More simply, it may also represent a reaction to being controlled by nursing staff. This process of consideration of context in treatment outcome provides a perspective which does not define pathology as an exclusively individual, intrapsychic phenomenon, but recognizes that it is intersubjectively constituted.

The tendency towards increased Scale Y (Desirability) scores becomes informative once one considers the kinds of item statements that constitute this scale. Items include those that

> make the subject look confident and gregarious and allege a regard for authority and a respect for the rules of society...the subject is efficient and organised, avoids confrontation, has a moralistic but fun-loving attitude, experiences elevated moods, and denies the presence of alcohol abuse (Choca et al., 1992, p. 27).

It is possible that these increased scores in some way reflect patients' awareness that they were being studied, and that therapeutic change was being evaluated. An additional possibility, supported by Jones and Rapoport (1976) is that these qualities may be implicitly, and possibly explicitly, valued by staff.

Patients' awareness of these expectations, could thus be reflected in the adoption of these standards at the time of their discharge. This could be argued to be true for the three patients in the study whose Scale Y (Desirability) scores were increased after treatment. These patients registered concomitantly high scores on Scale 2 (Avoidant) and Scale 3 (Dependent) at both admission and discharge, suggesting the hypothesis that patients with these traits could be particularly vulnerable to internalising staff expectations and conforming to them. One such patient is subject 7, whose profile has been discussed above.

A process as important as examining the scores of patients who get worse after treatment is that of considering what factors underlie improvement after treatment. According to the MCMI-II, subject 2 was generally much improved at discharge. In terms of the contextual factors selected as relevant to the outcomes of patients with post-treatment MCMI-II scale increases, one might have expected her to become more aggressive after treatment. Her course in the unit was not smooth; she was critical of staff, both overtly and covertly, and blatantly disregarded the ward's prohibition of substance abuse over weekends. She was apparently disliked by staff, who had negative feelings around her sexuality. It also appeared that, as a white, Afrikaans-speaking woman from a wealthy, farming background, she evoked race and class issues among the predominantly "coloured", Afrikaans-speaking staff of largely working-class origins, who experienced her attitude as arrogant and superior. Despite this, she showed significant decreases on most of her previously elevated MCMI-II scales at discharge. Her favourable response to treatment may be understood by considering certain factors. Her adjustment prior to admission appears to have been only mildly affected. She was still attending classes at the tertiary institution where she was studying, had a fair number of close friends with whom she maintained frequent contact, and was not isolated from her family of origin. She was articulate and socially competent. These factors appear to suggest resources which she was able to draw on in a crisis situation, and which facilitated good adjustment after discharge. Shortly after discharge, she was holding down a part-time job and was socially active. This corroborates research findings which suggest that pre-hospital adjustment is related to treatment outcome. (Ellsworth et al., 1977).

"Non-specific factors" affecting treatment response are those factors which are "inherent in one or more treatments but not of direct interest to the investigator." (Kazdin, 1979, p. 847). According to Kazdin, these include patients' perception of the credibility of the treatment, and expectations for improvement. Subject 8 was referred to G22 by her counsellor, who recommended the programme. This subject's functioning had been deteriorating progressively over a period of several months. She was experiencing severe dissociative states and "flashbacks", and was aware of being in desperate need of in-patient containment. She is psychologically sophisticated and has always taken an active role in seeking to reduce her long-standing symptoms through various traditional and alternative treatments. It is the view of the author that this patient entered treatment with a hopeful attitude and with confidence in the ability of the unit to address her difficulties using its particular therapeutic modality. During the course of her stay in the unit, these beliefs became somewhat moderated, although she remained optimistic about the value of selected aspects of the treatment. These factors may have played a strong role in her response to treatment, which is unfortunately not able to be judged from her MCMI-II results (see discussion of "profiles without elevations" p. 39). However, information obtained informally during feedback interviews with this patient after her discharge indicates that she responded moderately well to the treatment, experiencing some active relief from her symptoms. This was despite her very difficult experience in the programme, where she was actively disliked by nursing staff, whom she challenged on issues such as therapeutic competence and inconsistency.

This discussion highlights the complexity of the task of measuring and understanding patients' outcome after treatment. It further stresses the need to consider each patient's outcome in terms of a range of factors, many of which derive from the context of the milieu therapy unit. In the light of the somewhat ambiguous findings of this study, the need for further research, which pays closer attention to treatment-related factors, and which entails rigorous assessment of outcome, is clearly indicated.

An interesting and tentatively optimistic result obtained from this study concerns severe personality scales, namely Scale C (Borderline). Patients diagnosed with borderline personality disorder are, at best, often regarded pessimistically by therapeutic staff. Although a further study using a larger sample size is indicated, the decrease in Scale C elevations suggests that these patients' difficulties are perhaps less intractable than is often presumed. Atwood and Stolorow (1984) take the view that Borderline pathology is intersubjectively constituted, rather than being an invariable, intrapsychic phenomenon. Interpretation of the Scale C improvement in this study in terms of treatment context supports this hypothesis.

This has implications for treatment attitude, suggesting careful reassessment of the often adversarial position adopted by therapeutic team members in relation to borderline patients. It further highlights the need for clinicians to explore which contextual conditions facilitate the emergence or remediation of the borderline condition.

Although Scales Y and Z (Desirability and Debasement) are not personality scales, in line with Choca et al. (1992), their interpretation can be regarded as adding useful information to the patient's personality profile. Scale Z (Debasement) improved for all subjects after treatment. In line with a research finding by Wetzler and Marlowe (cited in Choca et al., 1992) it may be possible to use this scale clinically as an indicator of psychic distress arising from negative self-perception.

Another important consideration with respect to admission decisions is the extent to which the MCMI-II is able to detect those patients likely to drop out of the treatment programme. In the current study, these subjects constitute too small a sample to make meaningful comparisons with the already small group of subjects who went on to complete the programme. On the whole however, it would appear that the MCMI-II is not useful in predicting which patients will drop out of, or remain in treatment. This would confirm findings by Cantrell and Dana (cited in Choca et al., 1992) in their research on the MCMI-I's ability to predict premature termination of treatment.

By way of a final summary of the results of this study, it is apparent that, despite the significant changes which have been noted for clinical symptom scales and for certain of the personality scales, there is strong evidence to suggest that patients' most prominent personality traits remain largely unchanged after 12-week milieu therapy treatment. This clearly suggests the need for caution on the part of staff in the unit.

This should become evident in the expectations of change that they hold with regard to their patients, in the possibilities for change they communicate, both to patients seeking admission, and to their families, and lastly in the kinds of claims made by staff to other mental health professionals on behalf of the unit.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

In discussing the results of this study, it has been recommended that there is a need for further research in G22, based upon the current, exploratory study, but taking into account its suggested modifications of the research design. The following conclusions should be evaluated in the light of this recommendation:

Change

It can be concluded from the results of this study that patients' difficulties generally improve as a result of a 12-week admission to a milieu therapy unit. The bulk of this change can be expected in the area of clinical symptom variables. Although personality disturbances may improve somewhat, the dominant personality constellation of the individual remains largely unchanged at discharge. This strongly suggests caution in relation to expectations of the mutability of personality, and with respect to claims of efficacy by a unit such as G22.

Difficulties Amenable or Resistant to Treatment

There is some evidence to suggest that personality profiles with a strong presence of MCMI-II's Histrionic, Narcissistic and Aggressive traits are not particularly amenable to G22's treatment programme. In contrast, the following MCMI-II cluster could possibly be more amenable to the unit's intervention: Schizoid; Avoidant; and Self-Defeating.

However, as discussed at length, factors related to treatment context may account for what appears to derive from individual, internal pathology, thereby casting doubt on the above findings.

MCMI-II's Borderline "severe personality style" appears to be more amenable to treatment than generally thought, although this requires further research.

The Usefulness of the MCMI-II in Patient Selection

The initial intention of this study was to examine the usefulness of an objective assessment device (the MCMI-II) in a unit such as G22, where it could attempt to form a counterbalance to the more subjectively based opinions, understandings, expectations and evaluations of patients by staff (predominantly nursing staff). In line with the evidence provided by Jones and Rapoport (1976), it is possible that the dominant ideology will resist the introduction of this assessment device at G22, particularly if the ideas it proposes are perceived as a challenge to the status quo. If staff are pressured into broadening their discourse to include the instrument, there is a strong possibility that the MCMI-II will be adapted to fit in with the ideology of the unit, and will be used in such a manner as to strengthen this ideology. The bias of the test towards locating "pathology" as intrapsychic, and its use of DSM personality disorder terminology, is likely to encourage the stereotyping of patients in a negative manner.

It is the view of this study that the MCMI-II is problematic in and of itself, since its construction ignores contextual factors which this study has demonstrated have a strong bearing on therapeutic outcome.

A difficulty pertaining to its prospective use in G22 is the absence of South African norms for the test, which calls into question its applicability in this country. The arguments around clinical symptom variability across cultures (Kleinman, 1980, 1988) would have to be taken into account in a more in-depth study.

If the instrument were to be introduced, it would have to be with extreme caution. Its use would need to be reserved for the unit's psychologist and supervised intern psychologists only. The responsible use of the instrument, the taking into account of contextual information in the interpretation of results, and the communication of findings to the team and patients, in non-prejudicial terms would be a necessity.

Assuming that this is possible, it is the view of this study that the patient selection process in G22 could be improved by the introduction of an empirical personality and clinical symptom assessment device, such as the MCMI-II. Such an instrument would make the admission-assessment process standardised and rigorous. The assessment would then provide a clear idea of patient dynamics, thereby facilitating the careful consideration of patient vulnerability, suitability for the G22 treatment, and expected capacity for change.

Admission decisions could be facilitated in the following manner: A series of "warning bells" could be established with respect to patient profiles. These may include high Desirability and/or Debasement scores, and elevations on those personality scales which, in this study, have not improved after treatment in G22.

In the absence of such markers, admission could be fairly rapidly approved. When one or more of the markers is present, the need for careful consideration and discussion would be signalled. Such discussion could entail examination of the personal and family history of the patient for evidence of, for example, violent behaviour [where a high Scale 6B (Aggressive) elevation was present]. Further assessment may also be necessary. Together, these additional investigations would provide evidence which may weigh in favour of admission, or referral elsewhere.

The MCMI-II as an Adjunct to Treatment

The responsible use of an instrument such as the MCMI-II could assist staff in formulating realistic treatment expectations, and in communicating these to their patients.

G22 would perhaps benefit from the teaching of a common theoretical perspective, which would flow from the use of the MCMI-II. This could serve to update staff's understanding of personality and pathology, thereby helping to eliminate therapeutically "unhelpful" practices and beliefs. However, in the context of the tendency of milieu staff to adopt theory, to apply it rigidly and uniformly, and to resist objective appraisal of beliefs and practices (Jones & Rapoport, 1976), this benefit would possibly be lost. Once again, this implies the need for the judicious use of the MCMI-II in this way.

It is advised that the MCMI-II be used with caution in the evaluation of change, and in decision making that would be based on such an evaluation, because of the lack of consideration of the role of treatment context inherent in the instrument.

Such decisions include the extension or termination of treatment, and follow-up recommendations.

Length of Treatment

Although this has not directly been the subject of the current study, on the basis of research pointing to the benefits of long-term psychodynamic therapy with personality disordered patients (Hoglend, 1993; Weiner & Exner, 1991; Exner & Andronikof-Sanglade, 1992), it may be hypothesised that the subjects in this study could perhaps have shown more extensive benefits had their treatment been of longer duration. This suggestion is supported by the finding of Jones and Rapoport (1976, p. 544) that "Patients who stay more than six months get better much more frequently than those who stay less than six months."

This finding implies that units such as G22 should either extend their length of treatment, or perceive themselves as crisis-intervention units that address a basic level of disturbance, and carry patients onto another stage of treatment. For example, patients who continue to register high levels of personality pathology and functional impairment on discharge, should be referred for long-term therapy. This is of additional importance when considering the conclusion reached by Exner and Andronikof-Sanglade (1992) that, with treatment durations of 14 weeks, subjects tended not to sustain improvements at eight month follow-up. This finding serves to bear out the experiences of patients in the weeks following their discharge from G22 and indicates the need for further treatment outcome studies for both milieu and long term psychodynamic therapies.

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APPENDIX A: PRE-TREATMENT SUMMARY STATISTICS FOR COMPLETERS

Scale 1 Schiz.	Scale 2 Avoid.	Scale 3 Dep.
Mean 65.25	Mean 79.63	Mean 73.38
S.D. 17.69	S.D. 28.01	S.D. 28.28
Scale 4 Hist.	**Scale 5 Nar.**	**Scale 6A Ant.**
Mean 70.13	Mean 60.88	Mean 67.00
S.D. 25.42	S.D. 16.59	S.D. 23.95
Scale 6B Aggr.	**Scale 7 Comp.**	**Scale 8A P.Agg.**
Mean 64.75	Mean 55.88	Mean 78.50
S.D. 18.21	S.D. 25.41	S.D. 29.20
Scale 8B S.Def.	**Scale S Sch.Typ.**	**Scale C Bord.**
Mean 84.88	Mean 64.88	Mean 80.63
S.D. 28.39	S.D. 32.57	S.D. 37.27
Scale P Para.	**Scale A Anx.**	**Scale H Soma.**
Mean 68.88	Mean 76.13	Mean 68.25
S.D. 20.10	S.D. 34.12	S.D. 20.27
Scale N Manic	**Scale D Dysthy.**	**Scale B Alc.**
Mean 59.88	Mean 78.00	Mean 56.50
S.D. 30.79	S.D. 33.18	S.D. 27.55
Scale T Drug	**Scale SS Thought.**	**Scale CC Maj.Dep.**
Mean 62.63	Mean 65.88	Mean 61.50
S.D. 21.20	S.D. 16.01	S.D. 27.54
Scale PP Delu.Dis.	**Scale Y Desir.**	**Scale Z Debas.**
Mean 60.75	Mean 55.88	Mean 71.50
S.D. 12.14	S.D. 29.65	S.D. 28.63

APPENDIX B: POST-TREATMENT SUMMARY STATISTICS FOR COMPLETERS

Scale 1 Schiz.	Scale 2 Avoid.	Scale 3 Dep.
Mean 46.25	Mean 60.50	Mean 50.25
S.D. 21.66	S.D. 25.24	S.D. 39.72
Scale 4 Hist.	**Scale 5 Nar.**	**Scale 6A Ant.**
Mean 75.38	Mean 71.25	Mean 66.13
S.D. 21.90	S.D. 23.86	S.D. 21.42
Scale 6B Aggr.	**Scale 7 Comp.**	**Scale 8A P.Agg.**
Mean 70.38	Mean 55.38	Mean 76.63
S.D. 18.54	S.D. 21.42	S.D. 34.06
Scale 8B S.Def.	**Scale S Sch.Typ.**	**Scale C Bord.**
Mean 61.88	Mean 46.25	Mean 63.63
S.D. 24.13	S.D. 10.43	S.D. 25.62
Scale P Para.	**Scale A Anx.**	**Scale H Soma.**
Mean 64.50	Mean 18.75	Mean 41.63
S.D. 17.19	S.D. 20.43	S.D. 12.94
Scale N Manic	**Scale D Dysthy.**	**Scale B Alc.**
Mean 58.50	Mean 27.50	Mean 52.13
S.D. 18.21	S.D. 24.80	S.D. 22.84
Scale T Drug	**Scale SS Thought.**	**Scale CC Maj.Dep.**
Mean 60.50	Mean 48.50	Mean 42.38
S.D. 22.75	S.D. 17.76	S.D. 17.50
Scale PP Delu.Dis.	**Scale Y Desir.**	**Scale Z Debas.**
Mean 50.13	Mean 57.75	Mean 39.75
S.D. 20.48	S.D. 29.40	S.D. 19.02

APPENDIX C: PRE-TREATMENT SUMMARY STATISTICS FOR DROPOUTS

Scale 1 Schiz.	Scale 2 Avoid.	Scale 3 Dep.
Mean 59.00	Mean 49.00	Mean 64.00
S.D. 10.68	S.D. 18.84	S.D. 38.41
Scale 4 Hist.	**Scale 5 Nar.**	**Scale 6A Ant.**
Mean 85.60	Mean 89.80	Mean 77.40
S.D. 7.57	S.D. 19.85	S.D. 13.07
Scale 6B Aggr.	**Scale 7 Comp.**	**Scale 8A P.Agg.**
Mean 72.00	Mean 62.20	Mean 69.00
S.D. 7.68	S.D. 24.32	S.D. 28.34
Scale 8B S.Def.	**Scale S Sch.Typ.**	**Scale C Bord.**
Mean 70.20	Mean 50.40	Mean 73.00
S.D. 28.35	S.D. 8.99	S.D. 24.41
Scale P Para.	**Scale A Anx.**	**Scale H Soma.**
Mean 67.60	Mean 47.80	Mean 54.40
S.D. 3.78	S.D. 34.99	S.D. 7.16
Scale N Manic	**Scale D Dysthy.**	**Scale B Alc.**
Mean 74.20	Mean 51.20	Mean 55.20
S.D. 20.71	S.D. 35.77	S.D. 10.66
Scale T Drug	**Scale SS Thought.**	**Scale CC Maj.Dep.**
Mean 65.20	Mean 56.20	Mean 56.60
S.D. 4.32	S.D. 6.76	S.D. 5.03
Scale PP Delu.Dis.	**Scale Y Desir.**	**Scale Z Debas.**
Mean 59.40	Mean 74.40	Mean 54.60
S.D. 11.59	S.D. 12.52	S.D. 15.88

APPENDIX D: THE THERAPEUTIC PROGRAMME AT G22

There is no uniformly applied therapeutic orientation in the unit, with therapists adopting a range of perspectives from broadly psychoanalytic through self psychological, eclectic, to more behavioural approaches. It is the author's view that the therapeutic programme is based on the theme of "rehabilitation through reality confrontation", a phrase coined by Jones and Rapoport (1976) in their research on milieu therapy units. Generally the staff at G22 appear to believe that their patients have personalities which are deformed due to early negative socio-environmental influences, and which thus result in deficient functioning in adulthood. In turn, so-called remediation may be effected by the utilization of therapeutic socio-environmental forces in the milieu's therapeutic programme. The treatment programme at G22 includes various therapeutic interventions, which will be outlined below:

Group Therapy

This is considered by staff to be one of the most important aspects of the programme. Groups are conducted three times weekly and all patients enter group within one to two weeks of their admission. Groups have two facilitators drawn randomly from a pool which includes most staff (nurses, occupational therapist, registrar, psychologist, intern psychologists, and social worker). Groups are generally supervised every second session by the psychologist. Each pair of facilitators performs a six week block of therapy, with a two week overlap in order to change facilitation gradually.

Groups are open, with patients constantly entering and leaving them as they are admitted to and discharged from the unit. The number of groups being conducted depends on the number of patients in the unit at any one time. There are usually two groups running concurrently.

The orientation of this group therapy is eclectic, and depends entirely on the facilitators involved. Styles range from very directive to non-directive, and staff all have various levels and types of training.

Individual Therapy

All patients are assigned an individual therapist on admission to the ward. In the first two weeks after admission, the therapist is responsible for taking the history of the patient, for diagnosis, and for therapeutic management recommendations (in consultation with the team). Thereafter, the therapist sees the patient weekly for therapy. Therapy is performed by intern psychologists, the registrar, the social worker, and rarely, by the psychologist. Intern psychologists are supervised by the psychologist, and the social worker is supervised by the ward psychiatrist. Once again, the therapeutic modality depends on the therapist involved, and to some extent, the supervisor's style.

Family Therapy

Most patients receive at least some family therapy during their stay. Family therapists are assigned during the ward round where the patient is "presented". They are drawn from the same pool of staff as group therapy.

Depending on the judged necessity for family therapy for the patient, the family (or partner) will be involved. Here too, styles are eclectic and decided by the orientation of the therapist involved.

Other therapeutic activities include a so-called weekly "evocative group" co-facilitated by nursing staff, or the occupational therapist. During this session, patients' emotions around a range of issues are evoked using various techniques, such as guided imagery, or drawing, and group discussions are then held.

Twice weekly "Community" sessions are held in which all patients and some members of staff participate. The purpose of these sessions is to explore any issues (usually conflict-related) that may have arisen amongst patients or between staff and patients. This is also the forum where, two weeks after their admission, patients are asked to publicly formulate their treatment goals, and staff and fellow patients give them feedback on this. Once they reach the midpoint of their stay, patients are required to assess their progress, and once again, staff and fellow patients give feedback. Just prior to discharge, patients evaluate what they have achieved during their stay, relative to their treatment goals and are given final feedback.

Other ward activities include daily "feel wall", an early morning session run by nursing staff during which patients are required to indicate their mood. Finally, the occupational therapist facilitates twice-weekly craft sessions, social skills training sessions, and guided relaxation exercises.

Medication

The use of psycho-active medication tends to be the norm in G22. Provided (adult) patients do not withhold consent, medication may be prescribed at the discretion of the psychiatrist. Medication that is commonly used at G22 includes various types of anti-depressants, and low doses of anti-psychotic medication for the treatment of anxiety.