The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis

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ACADEMIC DOSSIER

ADULT MENTAL HEALTH PLACEMENT

PEOPLE WITH LEARNING DISABILITIES ESSAY

CHILDREN, ADOLESCENTS AND FAMILIES ESSAY

OLDER ADULTS ESSAY

SPECIALIST ESSAY
Compare and contrast the effectiveness of cognitive-behaviour therapy and systemic therapy in the treatment of eating disorders

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Introduction

In the last two decades the interest in eating disorders has largely increased, not only within the mental health field but also in the media. Orbach (1993) uses the expression “Anorexia: metaphor for our time” and discusses the implications of the Western culture’s obsession with regulating body size. As a consequence of this there has been a rise in prevalence of these problems especially among women in late adolescence and early adulthood (Orbach, 1993). Due to this fact a search for the best form of treatment for eating disorders has become an important focus within the mental health field. The following essay will present a review of the literature on the effectiveness of cognitive-behaviour therapy and systemic therapy\(^1\) in the treatment of eating disorders.

The DSM-IV distinguishes between three different diagnoses within the eating disorders category: anorexia nervosa, bulimia nervosa and eating disorder not otherwise specified. This last group includes patients who exhibit some but not all of the criteria for anorexia and/or bulimia nervosa and patients presenting with binge eating disorder. This last group is defined as the presence of recurrent bulimic episodes without the accompanying compensatory behaviours. The present review will not discuss binge eating disorder and for more information the reader is referred to the reviews by Wilson and Fairburn (1998) and Wilson (1999). Anorexia nervosa and bulimia nervosa were chosen for the present discussion due to the larger number of studies focusing on these disorders and to the paucity of studies on family therapy for binge eating disorder. The studies on obesity are outside the scope of the present review since this is not recognised as a psychiatric disorder per se (although psychiatric problems might be associated with it).

It is a surprising fact that although both family therapy and cognitive therapy have been widely associated with the treatment of eating disorders there appear to be no studies

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\(^1\) The terms systemic therapy and family therapy will be used interchangeably. Family therapy is the common term found in the literature and it will be used here to refer to interventions involving families where cognitive behavioural techniques are not used.
comparing the two approaches. Furthermore, the literature reflects a lack of studies on family therapy for bulimia nervosa and conversely a lack of articles on cognitive behavioural approaches for anorexia nervosa. This is so despite the fact that the two disorders seem to be closely linked, with anorexia nervosa patients frequently exhibiting bulimic symptoms and sometimes developing bulimia nervosa (Roth & Fonagy, 1996).

In the following review anorexia nervosa and bulimia nervosa will be discussed separately in the interest of clarity. In each section there will be a brief description of the disorder followed by a presentation of the approaches to treatment and finally a discussion of the literature on the effectiveness of the two approaches.

**Anorexia Nervosa**

In DSM -IV (American Psychiatric Association, 1994) anorexia nervosa (AN) is described as a refusal to maintain a minimally normal body weight. The individual is intensely afraid of gaining weight and overvalues the significance of body weight and shape. There is also the presence of amenorrhea, usually due to weight loss. Some patients engage in episodes of binge-eating and purging (Binge-eating/Purging type) whereas others accomplish and maintain low weight by dietary restriction, fasting or excessive exercise (Restricting type).

Many individuals present with depressive symptoms such as low mood, irritability, insomnia, social withdrawal and diminished interest in sex. These are usually thought of as secondary effects of starvation. They may also complain of constipation, abdominal pain, intolerance to cold, lethargy and present hypotension, hypothermia and dryness of skin.

The prevalence of this disorder is estimated in DSM-IV as 0.5% to 1.0% of females in late adolescence and early adulthood. However individuals who do not meet the full criteria for AN but exhibit some of the symptoms are more commonly encountered (Eating Disorder not Otherwise Specified).
AN usually develops in adolescence and young adulthood and seems to be more common in industrialised societies. The vast majority of patients with this disorder are female.

Treatment Approaches

Family Therapy

Family therapy has become strongly associated with the treatment of AN and some authors (Dare & Eisler, 1995, 1997) present the idea that this disorder has become a paradigm for this approach. Although, at present, systemic conceptualisations can be applied to a wide variety of diagnostic categories, AN was one of the first problems addressed by family therapists and consequently the model developed in close relation to the evolution of the theories on AN.

The term Family Therapy encompasses a wide range of approaches and more recently there have been efforts to integrate more traditional models with other therapeutic ones (Partridge, in press). The models developed by Minuchin and colleagues (1975, cited in Dare & Eisler, 1997) and by Selvini Palazzoli (1974, cited in Dare & Eisler, 1997) were the first to assert the importance of involving the family in the treatment of AN. In this section the Minuchin and colleagues’ model will be briefly described since it has been very influential not only in theoretical and clinical terms but also in research.

Minuchin’s approach (1975, cited in Dare & Eisler, 1997) known as Structural Family Therapy presents a “psychosomatic family model”. In this model a family presents with several specific characteristics which are related to the illness of one child: physiological vulnerability of the child; enmeshment, overprotectiveness, rigidity and lack of conflict resolution as family transactional patterns; and the child playing a role in the avoidance of conflict within the family. Enmeshment refers to the overclose relationship between some members of the family where there is no clear personal space. There are frequent
intrusions on each person's emotions and thoughts and closeness is more valued than autonomy (Eisler, 1993). The family members are often overprotective of each other and experience a great level of responsibility in keeping the family together. The interactional patterns are rigid and limited in quantity, remaining equal even in the face of external changes. In the families described by Minuchin, conflict is avoided and often the ill child plays a role in this avoidance. For example, the child might form an alliance with one parent against the other making the parental subsystem less well defined.

The goal in therapy is to alter the family organisation into a more adaptive one. To achieve this the therapist tries to address the issue of conflict and reinforce the parental and sibling subsystems. The family members are encouraged to adopt a more open style of communication with each other and the outside world. The therapist adopts a directive style to help the parents take control over their child's eating (Dare & Eisler, 1997).

**Cognitive-Behaviour Therapy**

The Cognitive-Behavioural model proposed by Vitousek (1995, 1996) states that the beliefs and values about body shape and weight held by the patient with anorexia are central to the maintenance of symptoms. These belief systems originate from an interaction between stable personality characteristics (such as perfectionism, asceticism and affect regulation difficulties) and socio-cultural ideals of female appearance. Once these assumptions are established the individual will develop a range of stereotypical behaviours related to eating and elimination which will in turn reinforce and maintain the dysfunctional assumptions. As part of the maintenance process of these beliefs anorexic patients will also process information in accordance to these beliefs and will develop further irrational automatic thinking. Also the physiological changes observed due to starvation will also strengthen the basic assumptions. The central premise of this model is that the patient will associate the weight and shape of the body to her/his sense of self worth.
The treatment of this disorder includes the basic premises of cognitive-behavioural therapy proposed by Aaron Beck (Freeman, 1997). The therapist gently encourages the patient to test their beliefs by collecting evidence for and against them and engaging in a process of re-evaluation. The emphasis is on the analysis of conscious or pre-conscious levels of experience as opposed to unconscious conflicts. The idea of meaning and cognitions constituting mediating variables for maladaptive behaviours and feelings is made explicit. The therapist adopts an active and directive role and uses questioning as the main therapeutic technique. Emphasis is put on objective measuring of progress and outcome.

More specific strategies used in treatment are presented by Vitousek (1995). Due to the egosyntonic nature of this disorder the initial phase of treatment is crucial and considerable time can be spent engaging the patient in treatment. Clients are encouraged to examine the advantages and disadvantages of their problem instead of accepting an authoritarian truth about their maladaptive behaviours. The emphasis is also put on gaining weight since the effects of starvation interfere with the active engagement of the client in the therapeutic process. In a later stage of treatment attempts are made to address the beliefs about food and weight and their relation to views of the self.

More recently, Fairburn, Shafran and Cooper (1999) proposed an innovative cognitive-behavioural model for AN. They introduce the idea of control as a central feature in the maintenance of the disorder and propose three mechanisms whereby this operates. It is a well known fact that the anorexic patient experiences a high level of ineffectiveness and low self-esteem which might precipitate the need for control over eating. Once this process is initiated the dietary restriction enhances the person’s sense of control over herself and her environment (mechanism 1). The effects of starvation and the extreme concerns about shape and weight encourage further dieting (mechanisms 2 and 3). Although at present this model is theoretical in nature, it is promising since it introduces specific hypotheses about the disorder which can be tested in research and has clear implications for treatment.
It can be seen by the formulations presented that the family therapy and cognitive-behavioural models are very different in both conceptualisation of the disorder and treatment. The family therapy approach focuses on an ill family as opposed to an ill person and views the change in interactional patterns within the family as essential for recovery. The cognitive-behavioural approach on the other hand works with the individual and attempts to change dysfunctional thinking. An analysis of outcome literature will facilitate further comparisons between the two models.

**Outcome Research**

Studies on the effectiveness of treatment for AN are sparse and are difficult to design due to the characteristics of the disorder and its severity. For example, the inclusion of a no-treatment control group raises ethical questions since the effects of starvation can include serious physical sequelae and, in more extreme cases, death. Therefore, the studies discussed in the following section compare different forms of treatment. Although inpatient treatment is often chosen for this disorder, it will not be reviewed here since it usually involves a range of different approaches which make it difficult to understand the effects of each one of the interventions.

Hall and Crisp (1987) compared the effectiveness of dietary advice for AN with a treatment approach including individual and family psychotherapy. At one year follow-up both groups showed improvement in weight measures but showed differences in social and sexual adjustment measures in favour of the psychotherapy group. These results are difficult to interpret since there were several non-controlled variables. For example, the two interventions were not pure in the sense that family problems were also addressed in the dietary advice group with occasional family sessions and diet issues were also discussed in the psychotherapy group. Also some patients received further treatments
elsewhere. However, these results indicate that an approach focusing solely on eating behaviour is less effective than one addressing psychological and relationship issues.

In a second study by Crisp et al. (1991), four treatment conditions were compared: inpatient treatment; out-patient individual and family psychotherapy plus separate dietary counselling; out-patient group psychotherapy (patient and parents) plus separate dietary counselling; and an assessment only condition. In the no-treatment, assessment only condition patients tended to look for help elsewhere. Dropouts occurred in all three treatment conditions and all showed weight gains at one year follow-up which were greater than the no-treatment (assessment only) control group. All four conditions showed improvement in sexual and social adjustment. The interpretation of results is difficult since the family seemed to have been involved in all three treatment conditions, but it appears that an intervention involving the family produces positive results.

Gowers et al. (1994) saw patients from the previous study for a two-year follow-up. Only patients from the individual and family psychotherapy group and from the assessment only no-treatment group were seen. The treatment gains observed at one-year follow-up were maintained at two years and there was a tendency for continuation of improvement for the psychotherapy group. The authors acknowledge that it is not possible to evaluate the effectiveness of family therapy from these results since there are many confounding variables (such as the inclusion of the parents in all treatment conditions).

Two other studies which took place at the Maudsley Hospital in London (Russell et al., 1987; le Grange et al., 1992) compared a family approach for AN with supportive individual therapy and a form of family counselling.

In the first of these studies (Russell et al., 1987) family therapy was compared with a form of supportive psychotherapy. The sample consisted of 80 patients, 57 of whom suffered from AN and 23 suffered from bulimia nervosa. In this section, only the results referring to
AN will be discussed. The patients were randomly allocated to one of the two therapies after discharge from an in-patient unit where their weight was restored to a healthy level. Family therapy consisted of sessions with all family members where the organisation of the family was assessed, the effects of the illness discussed and strategies for change were introduced. Supportive individual therapy was educational and problem-centred involving cognitive, interpretative and strategic elements. Due to the belief that a late age of onset and a longer duration of the illness is associated with a poor prognosis (Hsu, Crisp & Harding, 1979, cited in Russell et al., 1987) the AN group was divided into three subgroups according to age of onset and duration of illness. At one year follow up all groups showed weight gain. The results show that only subgroup 1 (where the age of onset was less than or equal to 18 years and duration of illness less than three years) showed greater improvements at follow-up for family therapy compared with individual supportive therapy (and this applied to weight measures, nutritional status, menstrual function, psychosexual adjustment and socio-economic status). For patients whose age of onset was at or after 19 years the reverse results were found with supportive individual therapy achieving greater improvements. These results were maintained at a 5 year follow-up (Dare et al., 1990, cited in Eisler, 1993).

The authors (Russell et al., 1987) conclude that family therapy seems to be effective for younger patients whose illness has not become chronic and that for older patients individual therapy might be more beneficial. They hypothesise that with younger patients pathological family processes have a central role in the development of the illness and therefore, treatments which address family factors have a clear advantage over others. However, it can also be hypothesised that with this group the family still plays an important role in the adolescent’s life and, as with children the involvement of the family in treatment is important. For older patients where a greater level of autonomy might have been achieved, individual approaches which focus on the person’s responsibility for their own well-being might be more beneficial.
A second study (le Grange et al., 1992) attempted to evaluate the assumption that seeing the whole family together provides an opportunity to gain a unique insight into the family's organisation allowing the therapist to intervene directly in the system. Family therapy was compared with a form of family counselling where both the parents and the anorexic patient were seen, but separately. Both adolescent groups (ages between 12 and 17 years) showed weight gain at 6 month follow-up but no differences were found between the two groups (both on individual and family measures). These results seem to suggest that family interactions can be changed even if the family is not seen together. However, interpretations have to be cautious since the sample in this study was small (18 patients in total) and some patients exhibited bulimic symptoms.

Robin, Siegel and Moye (1995) compared outcomes of a family therapy intervention with an individual approach. The family intervention involved helping parents to gain control over their child's eating and using strategies to change family organisation. The individual approach focused on issues of individuation, growth and the relationship of these issues with weight and food. The parents were also seen and support and education about normal adolescent development were offered. Both groups showed improvement on weight, menstruation and family interactions and no difference was found between groups. As in the previous study presented the authors conclude that conjoint family therapy is not essential to change family interactions.

These studies appear to indicate that family therapy is beneficial for younger patients, however it is clear that further research is needed to evaluate this stance. Furthermore it seems that approaches involving the family in different ways have equivalent results and this should be taken into consideration when designing interventions. It is not essential to have the whole family present in each session to achieve improvement. For older patients the results are less clear and studies with this population should be a priority. There is some indication that individual therapy might be more effective than family therapy for this group but this finding needs to be further examined.
Cognitive-behaviour therapy for anorexia nervosa has been far less studied and there appears to be only one study focusing on its effectiveness (Channon, de Silva, Hemsley & Perkins, 1989). Three treatments were compared: cognitive-behavioural, behavioural and a control treatment, eclectic in nature and focusing on weight restoration. The sample consisted of 24 patients diagnosed with AN. The cognitive-behavioural approach focused on identifying and changing dysfunctional beliefs about eating, weight and body image. The behavioural approach involved building graded hierarchies and exposure to feared foods and it used relaxation and distraction techniques. At one-year follow-up all three groups showed improvements and no differences were found between groups. However, no group showed complete recovery from AN. Compliance was higher for the cognitive-behavioural group which seems to indicate that the collaborative approach used is an advantage when dealing with an egosyntonic problem. These results cannot be fully interpreted since the comparison groups were very small (8 patients in each group) and not equivalent on pre-treatment measures.

The comparison between family and cognitive-behavioural approaches is difficult due to the lack of studies. It seems that the involvement of the family in the treatment of adolescent patients is important but it is unclear if a systemic approach is required. It can be hypothesised that having sessions with the parents following a cognitive-behaviour perspective (for example, focusing on problem-solving skills and the beliefs held about parenting) might be effective. For older patients the findings are less clear, although there is some indication that individual therapy might be more appropriate. There remains the question of which type of therapy would be more effective. Since cognitive-behavioural approaches were found to be useful in the treatment of other disorders including bulimia nervosa (Wilson & Fairburn, 1998), it might be a valuable alternative and it should encourage further research.
Bulimia Nervosa

According to DSM-IV (American Psychiatric Association, 1994) the main features of bulimia nervosa (BN) are recurrent episodes of binge eating and inappropriate compensatory behaviours to prevent weight gain. Binge eating occurs during a discrete period of time and involves the consumption of large amounts of food. During these episodes there is a sense of lack of control over one's eating behaviour. The inappropriate compensatory behaviours to prevent weight gain might involve vomiting, misuse of laxatives or diuretics, excessive exercise and fasting. Individuals are diagnosed if binge eating and inappropriate compensatory behaviours occur on average at least twice a week for no less than three months. BN patients tend to judge their self-worth largely on the basis of weight and shape perceptions. Two subtypes are described: purging type, where the person regularly engages in vomiting or misuses laxatives; and the nonpurging type, when these do not occur, although other compensatory behaviours, such as exercise and fasting, are present.

Typically bulimic patients are within the normal range in weight. Other psychiatric symptoms associated with BN are depressive or anxiety symptoms and alcohol and substance abuse. One third to one half of patients meet the criteria for personality disorder, usually borderline personality disorder. Patients often exhibit interpersonal difficulties and low self-esteem.

The physical consequences of vomiting include metabolic disturbance, parotid gland swelling, gastric reflux, dental enamel erosion, gastric ulcers, dehydration, cardiac arrhythmia and renal damage.

BN usually develops in adolescence or young adulthood and is more common in females (only 10% of bulimics are male). The estimated prevalence is 1%, although this might be
an underestimation since individuals are usually embarrassed and secretive about their symptoms.

**Treatment Approaches**

Family therapy approaches to BN seem to resemble the ones for AN and there does not seem to be a different conceptualisation of the problem. Therefore in this section only the cognitive-behavioural approach will be described.

The cognitive-behavioural model for BN focuses on the factors which maintain the disorder (Fairburn & Cooper, 1995). There is the assumption that, as with AN, the significance of weight and shape is overvalued and this leads to extreme dietary restriction. This in turn leads to loss of control and binge eating occurs with consequent compensatory behaviours such as vomiting. In general terms, treatment aims to re-establish normal eating patterns, develop strategies to deal with identified high risk situations that precipitate bingeing and modify dysfunctional assumptions about body weight and shape (Wilson, 1999).

In the initial stages of treatment (Fairburn & Cooper, 1995) the cognitive model of BN is discussed with the patient, monitoring of eating patterns is initiated and the patient is instructed on how to identify problematic thoughts. Information is given on the regulation of body weight and on the adverse effects of vomiting, purging and dieting. A regular pattern of eating is also prescribed and stimulus control techniques are used to prevent binge eating. Techniques of cognitive restructuring are used to change dysfunctional thinking and training on problem solving skills is given. The final stages of treatment involve the use of relapse prevention techniques.
Outcome Research

There has been a substantial amount of research on the effectiveness of cognitive-behavioural therapy for BN, although this is not the case for family therapy.

The study by Russell et al. (1987) discussed above compared a family intervention with individual supportive therapy. Twenty-three patients with BN were randomly allocated to a form of therapy. At one year follow-up there were no differences between the two forms of treatment.

It is clear that there is insufficient data to allow inferences on the efficacy of family therapy for BN. This is a surprising fact since this approach has been strongly associated with the treatment of AN and the two disorders appear to be closely linked. Family therapy seems to achieve good results with AN, especially with younger patients, and further research is needed to evaluate its efficacy in the treatment of BN.

The literature on the effectiveness of cognitive-behavioural therapy, on the other hand, is vast and usually studies are well controlled. In a study by Garner et al. (1993) cognitive-behavioural therapy was compared with a form of supportive-expressive therapy. At one year follow-up no differences were found between the two conditions. Some marginal differences were found in favour of cognitive-behaviour therapy in reducing vomiting and on most measures of concern about eating and weight. These results seem to indicate that interventions specifically focusing on eating patterns are not essential to produce beneficial results for clients with BN. However, one needs to be cautious in drawing conclusions since the sample used was at the less severe end of the disorder.

Other studies (Thackwray et al., 1993; Cooper & Steere, 1995) compared cognitive-behavioural therapy with behavioural approaches to assess if the latter alone could achieve beneficial results. Both studies found that post-treatment effects were equivalent for both
approaches but the results were not maintained at follow-up (6 months and one year) for purely behavioural interventions. Thackwray et al. (1993) conclude that BN is a multifactorial illness and therefore requires interventions that target its several components.

In a well controlled series of studies by Fairburn and colleagues (Fairburn et al. 1991, 1993, 1995), three different psychological treatments for BN were compared: cognitive-behaviour therapy, behaviour therapy and interpersonal therapy. The authors attempted to test the hypothesis that the results achieved with cognitive-behaviour therapy were achieved due to specific characteristics of this approach rather than non-specific factors common to other forms of psychological treatment. They also wanted to evaluate the effects of a simpler behavioural approach compared to the more encompassing cognitive-behavioural model of therapy. Seventy-five patients who met the diagnostic criteria of DSM-III-R for BN were recruited for the study. The three treatments were conducted on an out-patient basis, each consisting of 19 sessions. The cognitive-behavioural treatment followed the model described above. The behaviour therapy treatment used purely behavioural techniques aiming at the normalisation of eating habits excluding any discussion on the patients views about shape and weight. The interpersonal approach consisted of an adaptation of a form of treatment developed by Klerman and colleagues (1984, cited in Fairburn et al., 1991) for depression. This approach involved techniques derived from psychodynamic therapies, but focused on current relationship difficulties. In the initial stages of treatment one main theme related to interpersonal issues was identified and it became the focus of the intervention. At the final stages of treatment, feelings about termination were explored. No attention was paid to the patient’s eating habits and beliefs about shape and weight. The results of this study showed that at post-treatment, cognitive-behaviour therapy was more effective than behaviour therapy in reducing attempts to diet and attitudes to shape and weight but no differences were found with respect to overeating, vomiting and the level of general psychiatric symptoms. At one and five year follow-ups cognitive-behaviour therapy was found to be superior to the
behavioural approach. Compared to interpersonal therapy, cognitive-behavioural therapy was more effective at post-treatment in changing attitudes to shape and weigh, attempts to diet and vomiting but was equally effective in reducing overeating and psychiatric symptoms. At one year and five year follow-ups, however, interpersonal therapy showed equivalent results to cognitive-behaviour therapy on all measures.

Fairburn and colleagues studies support the results found by Thackwray et al. (1993) and Cooper & Steere (1995) in relation to the superiority of cognitive-behaviour therapy for BN when compared with behavioural approaches. On the other hand, therapies which do not focus on eating and weight, focusing instead on interpersonal issues, seem to be as effective as cognitive-behaviour therapy (Fairburn et al., 1993,1995; Garner et al., 1993). However, the mechanisms of change might be different in the two approaches since it seems that with cognitive-behaviour therapy the effects are achieved at the end of the intervention and maintained at follow-up, whereas with therapies focusing on interpersonal issues the patients seem to continue to improve after the treatment is over. This finding needs to be taken into consideration when designing interventions since there might be situations where fast results need to be achieved and therefore cognitive-behaviour therapy should be used and other situations when interpersonal difficulties are central to the problem and interpersonal therapy should then be used. It would be interesting to study the hypothesis that different subsamples of patients benefit from each form of therapy.

It is difficult to compare the effectiveness of family therapy and cognitive-behaviour therapy due to the lack of studies evaluating the former. However, the results presented above indicate that interpersonal difficulties are central to the disorder and family therapy could be an approach to use since it addresses these issues in the context of the family. Also, this approach might prove effective with younger patients who still live at home, as seems to be the case for AN. It is also clear that early claims of cognitive-behaviour therapy being the treatment of choice for BN (Fairburn & Cooper, 1995; Vitousek, 1996;
Wilson & Fairburn, 1993) can be questioned, and research on matching treatments to clients would be useful.

**Conclusion**

The research literature on the effectiveness of treatments for eating disorders is sparse and it is difficult at present to draw definite conclusions. The search for effective treatments should constitute a priority for a number of reasons: these disorders constitute a significant proportion of psychiatric morbidity (Fairburn & Cooper, 1995); AN can be a life threatening illness (Roth & Fonagy, 1996); the course of AN might involve frequent relapses or it can have a chronic development (American Psychiatric Association, 1994); and BN tends to run a chronic course (Fairburn et al., 1993).

The research on AN seems to indicate that the involvement of the family in the treatment process is beneficial, although this seems to be the case for younger patients with a short duration of the illness. For older patients, some form of individual therapy might be more appropriate, although it is unclear which approach would be more effective. Cognitive-behavioural therapy might be a valuable alternative due to its emphasis on a collaborative approach which appears to be a positive way of dealing with the egosyntonic aspect of this illness.

Treatments for BN appear to be more established and research better controlled. Cognitive-behaviour therapy is an effective treatment for this disorder, although not the sole treatment of choice since there are others that appear to be equally effective. The finding that interventions focusing on interpersonal relationships have a good outcome might indicate that family therapy could be an alternative treatment and this could be the focus of further research. Also, research on which clients benefit from which treatment is needed.
References


What is the impact of others' expectations on the communicative abilities of people with learning disabilities and how might a clinical psychologist work with these issues?

People with Learning Disabilities Essay

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Introduction

Communication is defined as "the imparting or exchanging of information, ideas or feelings" (McLeod, 1986). Effective communication is a powerful vehicle to influence and control one's environment and to fulfil one's needs and aspirations. To be effective, a common system needs to be shared by all the parts of the communicative exchange. When this does not occur, the individual has extreme difficulty in influencing the course of the exchange.

Different systems can be used to communicate such as verbal language, signs, symbols and behaviour. Language is considered to be the most sophisticated form of communication and is also the most common. For people with learning disabilities the development of language skills can be delayed or absent. Although different authors report different prevalence rates of communication difficulties in this population, some have indicated that up to 80% of people with severe learning disabilities fail to acquire fully effective speech (Garcia & DeHaven, 1974, cited in Remington, 1997). The extent to which communication and language develop in someone with a learning disability depends on the severity of the disability and the opportunities available for stimulation and learning (Lindsey, 1989).

Difficulties in using and understanding language have a great impact on the individual as well as his/her environment. Therefore, the study of communication difficulties has been a topic of great interest for psychologists working with learning disabilities, both in trying to understand the basis of these difficulties and in providing interventions to overcome or ameliorate them.

The following essay will focus on the impact of others on the communicative abilities of people with learning disabilities. It will start by reviewing literature on the interactions between children with learning disabilities and their parents or carers and the differences
between these and dyads of non-disabled children and their parents. This will be followed by focusing on the interactions observed between adults with learning disabilities living in residential care and their carers. The final section addresses the relationship between challenging behaviour and communication difficulties. Each section will also include a discussion of psychological interventions which have been used to facilitate development and to ameliorate difficulties in communication.

Initially, however, it is relevant to provide a brief overview of theories of language and communication development.

The development of communication and language

The development of language has been explained in different ways by different authors in relation to the importance they attribute to environmental influences. Chomsky (1965, cited in Remington, 1997) has been an influential theorist in this area and takes a strong nativist position. According to his theory language develops from a highly specialised brain mechanism (Language Acquisition Device - LAD) which mediates the emergence of a basic universal grammar that is common to all human languages. This perspective states that the environment is only necessary for fine adjustments to this basic innate mechanism.

Although this theory has its strengths, it leaves little space for developing alternative strategies to help people who have difficulties in acquiring language. Also it does not account for the function of language as a form of social influence which can be better understood through analyses of person - environment interactions (Remington, 1997).

One author that provided a different view of language was Vigotsky (1978, cited in Beveridge, 1989) with his theory of social cognition. According to Vigotsky the rules that underpin reasoning between people are essentially the same as the ones used for individual thinking (Fernyhough, 1997). This perspective implies that cognition is closely associated
with and originates from language, since these are the means used to interact in the social world. The environment is therefore critical for the development of both cognition and language. Research on its specific effects and ways of optimising them for the benefit of the child would therefore be useful.

The interaction and communication with the environment starts as soon as the child is born and although there is no intention as such on the part of the child, he or she is already exerting control over the environment. As a result of these early interactions infants soon start recognising the voice of their primary carer and learn to discriminate words and sentences (Law, 2000). At about one year, the child is able to use one-word sentences which then evolve to two-word sentences at two years of age (Gleitman & Gleitman, 1991).

Environmentally, it has been observed that caregivers alter their style of interaction when relating to the infant (Nind & Hewett, 1994). This different style has been called "motherese" and it is characterised by a slower speech rate, a different intonation, a high number of questions and simpler sentences. The effects this different style have on the infant’s development of speech remain unclear, but it seems that it draws the child’s attention to language in a meaningful way making it more interesting (Law, 2000).

From these different accounts it seems that development is in fact a dynamic process between infant and caregiver in which each participant adapts to the other. This perspective views the infant as an active element of the interactive process, capable of altering its environment and in turn being altered by it (Nind & Hewett, 1994).

Viewing development in this way has implications for research in learning disabilities. It raises questions relating to the effects a child with learning disabilities will have on the environment and what the environment can provide which will foster the child’s development. This will be addressed next, focusing on communication and language.
Interactions between adults and children with learning disabilities

It is widely acknowledged that the early interactive patterns of infants and their parents or primary carers are powerful means of influencing the future development of the child (Berger, 1990). For this reason there has been extensive research in this area. However, there are several methodological limitations in most research studies due to the complexity of this topic and the findings are often open to many interpretations.

Despite this, there are accounts relating the characteristics of maternal speech and interactional style to children’s acquisition of language. This research has pointed to certain dimensions of maternal speech (such as expansions, imitations, acceptance of child language productions and conversation elicitation) as facilitative aspects of children’s language development (Marfo, Dedrick & Barbour, 1998).

The interest in parent-child interactions in learning disabilities has been to find differences, if any, between these and interactions between non-disabled children and their parents and to understand the effects these differences might have on the child’s development.

An interaction is defined by Berger (1990) as “any situation in which a behaviour or action by either the parent or the child can be seen (or assumed) to be contingent upon an immediately preceding behaviour or action (intentional or unintentional) by the other partner” (p. 102). The interactive process is thus seen as bi-directional in which the behaviours of each partner influence and shape the responses of the other.

It can then be inferred that disabled children will offer cues to their parents that are different from those of non-disabled children and which will in turn influence the parents’ communicative style. Examples of this are the appearance and development of eye-contact and vocalisations. Although interactions start as soon as the child is born (for example, the
baby cries and the mother comes to feed it), an important change in their style seems to occur when the infant becomes able to establish eye-contact and starts to vocalise. Mothers report that they feel the infant has started to recognise them and they tend to spend more time playing with their child. Some studies have indicated that the appearance of eye-contact and vocalisations may be slightly delayed in children with Down syndrome (DS) and the quality of these is impaired (Berger, 1990). This probably influences the way mothers feel towards their child and the quality of play between the dyad. The studies summarised by Berger (1990) showed that vocal clashes and maternal output tended to increase in dyads with a children with DS when compared to non-disabled children.

Another aspect of interactions that has been extensively studied is the relationship between the linguistic environment and the development of language. Buium et al. (1974, cited in Marfo et al., 1998) analysed mother-child interactions in a laboratory situation and showed that mothers of infants with DS used a higher number of utterances with a lower mean length, a higher number of sentences grammatically incomplete and a higher frequency of single-word sentences. The authors went on to imply that this different linguistic environment was related to the children’s deficient development. However, the children in this study were not matched on mental age or linguistic competence. Consequently another interpretation could be that the mothers of children with DS adapt their communicative style to their child’s linguistic abilities and development.

Contrary to these early findings which were methodologically weak, there is one aspect of mother-child interaction which seems to have been consistently found by researchers. It is the finding that mothers of learning disabled children tend to be more controlling and directive (Marfo et al., 1998). However, the interpretation of this observation is still a matter of discussion. The question is whether mothers of disabled children deter them from developing by taking more control or whether mothers are only compensating for and adapting to their children’s difficulties.
In one study by Jones (1980, cited in Berger, 1990) play interactions between six infants with DS and their mothers and between six non-disabled developmentally matched infant-mother dyads were recorded. The results showed that there were more unsuccessful invitations to interact from the mothers of DS children; the mothers of DS children were more directive and the children experienced less support for their activities. The author concluded that DS children have less control over interactions with their mothers. Interviews with the mothers in this study revealed that mothers of DS children had more difficulty in interpreting their infants’ messages. Also mothers tended to refer to their activities more in terms of ‘teaching’ and less in terms of play and enjoyment. This seems to indicate that these mothers were overly concerned about their children’s achievements and less with the quality and pleasure these interactions could provide. This anxiety about performance could adversely affect the child and turn interactions into frustrating situations both to the mothers and the children, preventing the child from developing in a rewarding interactive environment (Berger, 1990).

Other authors questioned the view that directiveness is inherently negative and attempted to relate maternal directiveness with other maternal behaviours. Marfo (1992, cited in Marfo et al., 1998) measured maternal directiveness as well as warmth, sensitivity, responsiveness, elaboration and wait time. The author found that there was a negative correlation between directiveness and wait time but no relation between the first and other dimensions. He concluded that directive mothers may tend to deny their children response opportunities but this does not prevent them from being warm, sensitive, responsive and to elaborate on their child’s behaviour. Marfo (1998) argues that seeing directiveness as inherently negative is a narrow and simplistic view and further research needs to account for other aspects of mother-child interactions.

Interventions aimed at communication development in the first years of life have only recently received attention. Traditionally, interventions focused on older children (school age), adolescents or adults in institutional care (Warren & Yoder, 1997). They were also
highly didactic in nature and took little account of developmental and environmental issues. Since the 1980s, there have been attempts to develop more naturalistic interventions, focusing on the child’s attentional lead during routine activities across the day. Warren and Yoder (1997) suggest that interventions should be based on a developmental continuum of effective communication and language. This continuum starts with naturalistic interventions that use imitation and prompting until the child reaches 2.5 word mean length utterances and then switching to the uses of expansion and growth of the child’s utterances. As the child becomes more sophisticated, formal teaching methods can be utilised as well as generalisation techniques which will make formal teachings meaningful to the child.

Marfo et al. (1998) suggest that although the ultimate goal is the stimulation of the child’s development, interaction-focused interventions should aim at increasing parents’ competence and confidence in their parenting. These authors present what they called “the mutual enjoyment model” which is based on the view that optimal development of the child is related to a strong emotional parent-child attachment. By promoting mutually pleasurable parent-child interactions, the child’s development will be optimised. Bromwich (1983, cited in Marfo et al., 1998) developed an assessment instrument (Parent Behaviour Progression) which operationalised the focus of intervention. It is structured around six maternal behaviours: capacity to enjoy the infant; ability to read the infant’s cues; ability to engage in interactions which enhance secure attachment and early communication skills; parent’s awareness of activities appropriate to the child’s developmental stage; parents’ ability to initiate new activities; and parents’ skills in generating a broader range of play activities (different from the ones used in intervention). This approach appears to be promising and there have been some reports of its success, however, longitudinal studies are needed to evaluate its impact on the child’s long-term development (Marfo et al., 1998).
Another intervention approach was proposed by Rowland and Schweigert (1993), focusing on increasing functional communication in the classroom. Functional communication is understood as communication which occurs in natural settings, results in real consequences and includes spontaneous communication. They identified six environmental variables which affect communication: nature of the activity, communication system, adult’s interaction style, materials used, group dynamics and opportunities to communicate. The authors developed an inventory to help the teacher identify the variables already present in the communication environment of the child and the ones which could be optimised. This then provides a framework for the development of an intervention.

Although there has been great progress in understanding the development of communication and language in young children and developing early intervention approaches, there are methodological problems which make it difficult to produce unequivocal results. One problem is that most studies focus on children with DS, mainly because DS is diagnosed at birth which is not the case for other disabilities. However, this does not account for the great heterogeneity of development and behaviours associated with different disabilities. One can expect that different diagnoses will have a different impact on the parent-child interactive pattern and different consequences for the child’s development. Interactive patterns are also likely to change over time and more longitudinal studies are needed to address this issue. Other methodological problems include observer and context effects (laboratory vs. naturalistic contexts and structured vs. non-structured tasks, etc.). Research in general has also used comparison methods between disabled and non-disabled children. This introduces the problem of finding adequate criteria for group matching (Johnston & Stansfield, 1997).

Marfo et al. (1998) also point to the role of parental emotions, perceptions and expectations which are usually not taken into account in research. Discovering that one’s child has a disability has effects on how the parent will feel about him/herself and about the
This in turn will have an impact on how the parent interacts with the infant and his/her expectations about what children will achieve, irrespective of their real abilities. These factors should be taken into account when carrying out research in this area.

One other limitation of research is the lack of generalisation analyses of intervention gains. It is known that a behaviour learned in one context does not necessarily generalise to other environments. This has been partly addressed by developing naturalistic interventions; however, more studies are needed in order to identify the factors which optimise generalisation of new learning (Warren & Yoder, 1997).

**Interactions between carers and adults with learning disabilities**

In the last two decades efforts have been made to help children with learning disabilities overcome their communication difficulties. Despite this, there is still a high number of people who reach adolescence and adulthood with severe language and communication problems. A survey of a population of adults with learning disabilities living in hospital or attending day centres found that 29% of participants were non-verbal and a further 33% showed some communication difficulties (Blackwell et al., 1989). Furthermore, this survey showed that 86% of the non-verbal population were located in hospital and that individuals living in hospital (at all levels of communication ability) were less effective in the environment than individuals attending day centres. The authors conclude that increased opportunities to communicate observed at day centres lead to increased communication abilities.

These results seem to point to the importance of the environment in promoting effective communication. Increased opportunities to communicate have been associated with community care as opposed to hospital care. However, in one study (Hemming, 1986, cited in Kenefick, 1988) it was observed that immediately after deinstitutionalisation to small community homes, there was an improvement in language skills, but a subsequent
decline in these. An interpretation offered for these results was that if there is not a continued practice of skills acquired, these will eventually be lost. Kenefick (1988) points to the importance of staff training to ensure that people with learning disabilities use their communication skills in the community.

Other studies analysed the patterns of interactions observed between staff and people with learning disabilities. Markova et al. (1992) found that the most frequent type of interaction observed was related to functional (as opposed to social) communication, in particular interactions concerned with the physical needs of residents. The study also revealed a lack of interactions concerned with social choices. Furthermore, the duration of interactions was very short and it was unlikely for a resident to interact with a member of staff for more than four minutes. The authors concluded that these patterns of interaction meant that people with learning disabilities had little chance of developing communicative skills which would enable them to develop meaningful relationships.

Kenefick (1986, cited in Kenefick, 1988) analysed taped conversations of disabled people and their caregivers in group home settings. Stable patterns of interaction were identified within and between groups. Interactions between members of staff were mostly comprised of exchanges of information and discussion of personal happenings. In contrast, 70% of interactions between staff and residents involved speech directives (orders or requests). These studies seem to indicate that the quality of interactions involving people with learning disabilities is radically different from interactions between non-disabled adults.

In an attempt to explain these differences, there have been some studies examining the speech of people with learning disabilities to try to identify differences between this and the speech of non-disabled people. For example, it was found that there were differences in the use of referents in the speech of people with learning disabilities and they also seemed to lack sensitivity to the other in the interaction (see Markova, 1990, for a review).
Other authors attempted to study the impact communicative disturbances have on both individuals and their contexts (Leudar, 1989). Leudar (1989) observed that a high number of communications given by people with learning disabilities are echoed by their non-disabled partner. This finding was interpreted as a need for validation of these communications on the part of non-disabled individuals. Another finding was that non-disabled people tend to adopt a didactic posture when interacting with disabled people. This seems to put the disabled person in a "handicapped" position where they cannot utilise the conventions generally used in conversations and it creates a power imbalance between disabled and non-disabled partners. In many situations the only alternative left to re-establish power is for the disabled person to withdraw (Leudar, 1989 and Markova, 1990).

The data presented seem to indicate that there are mutual influences between disabled individuals and their contexts. This is probably also related to the expectations people bring into communication exchanges. The fact that people with learning disabilities have difficulties in some areas might lead others to have low expectations about their communicative abilities which in turn leads them to provide less opportunities to interact. This creates an impoverished environment where people with learning disabilities will appear less able and this reinforces the low expectations of others (O'Brien, 1981, cited in Bartlett & Bunning, 1997).

In the studies presented previously a common recommendation emerged: the importance of training caregivers and providing them with an understanding of communication difficulties in people with learning disabilities. One study (McLeod, Houston & Seyfort, 1995) measured the effectiveness of a training session for staff on the principles of interactive social communication. The topics focused on were being on the same physical level when interacting, establishing eye-contact, waiting for a communication attempt, responding to a communication attempt and structuring the environment. A questionnaire
and a videotape analysis were used to assess staff knowledge about effective communication. The results indicated that the training session was effective in increasing staff's knowledge about the specific topics addressed. The study did not evaluate, however, staff's application of this knowledge in their work with people with learning disabilities. It also did not evaluate the long-term impact of this training session on staff's knowledge.

Other interventions have been suggested to increase the level of communication ability in people with learning disabilities. One approach is called Augmentative Communication which attempts to increase the individual's awareness that the behaviour of other people can be controlled via symbolic communication (Remington, 1997). This approach is important in that it assumes that everyone, independently of level of disability, is able to communicate as long as there is flexibility about the communication mode employed and as long as interactions are ecologically valid for the individual (Remington, 1997). The use of alternative modes of communication is particularly important since verbal language is but one form of communication. The use of signs and symbols has become increasingly important in communication interventions for people with learning disabilities.

**Challenging behaviour and communication**

Communication deficits in people with learning disabilities have been associated with the occurrence of challenging behaviours. Although the percentage of individuals exhibiting challenging behaviours is not high (15% amongst hospital populations according to Fraser, 1991), they represent an area of concern to service providers and carers. Challenging behaviour was defined as "behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities" (Emerson et al., 1987, cited in Thurman, 1997). Several categories of behaviour were identified such as aggression, stereotype behaviours, antisocial conduct
and self-injury (Fraser, 1991). It is clear from this definition that these behaviours pose considerable stress to the environment and attempts to provide effective interventions have been the focus of a great amount of research in the area of learning disabilities.

Individuals may exhibit behaviours that challenge the environment when more acceptable and effective means of expression are outside their repertoire (Thurman, 1997). One study addressed the relationship between speech and challenging behaviours (Bott, Farmer & Rohde, 1997). The authors analysed data on 6625 individuals regarding ability to speak and behaviour patterns. They found that there was a significant decrease in problem behaviours with increased ability to speak.

The behavioural literature has stressed the importance of functional analysis to the understanding of challenging behaviour. Some of the functions identified have been: seeking attention, escaping from demands and avoiding social contacts (Taylor & Carr, 1993). The interventions suggested to decrease the occurrence of these behaviours have targeted carers reactions to try to diminish contingent reinforcement.

There is therefore, the assumption that environmental variables have a direct effect on the occurrence of challenging behaviours. The particular ways in which this occurs differ according to different settings, different members of staff within one setting and different clients. However, some general effects have been observed: as it was described in the previous section, staff spend very little time interacting with clients (specially with regards to social interaction). This situation of deprived social contact may promote the occurrence of challenging behaviours in two ways: attention from staff may become a powerful reinforcer and engaging in challenging behaviour may become an effective means of obtaining it; secondly self-harm and stereotypy may become ways of obtaining positive reinforcement through self-stimulation (Hastings & Remington, 1994).
In one study (Allen, 1989, cited in Hastings & Remington, 1994) it was found that the increases in social contacts following deinstitutionalisation were associated with decreases in challenging behaviours. This was only true when these behaviours had an attention-seeking function and not when clients engaged in challenging behaviours to escape from demands.

Another aspect focused upon in research has been the responses of staff to challenging behaviour. When self-report measures are taken, staff chose verbal responses (such as reasoning with clients and asking them to stop) as their preferred response followed by physical restraint, actively ignoring the behaviour and finally, calling other staff to help. In observational studies it was found that more active ways of responding are used when violent, destructive and withdrawal behaviours occur (Hastings & Remington, 1994). In a further observational study by Warren and Mondy (1971, cited in Hastings & Remington, 1994), they found that between 62% and 79% of the time, staff did not respond to inappropriate behaviour, reprimanded the clients in 11% to 25% and responded in an encouraging way 4% to 9% of the time. Although positive responses were not frequently used, they may have been sufficient to maintain the behaviours through positive reinforcement. Also, the high percentage of non-response by staff may indicate that they ignored the behaviour until it escalated in severity, thus reinforcing the more serious behaviours (Hastings & Remington, 1994).

In one study, carers beliefs about challenging behaviour were examined in an attempt to explain their responses to it (Watts, Reed & Hastings, 1997). Staff in community settings were given a vignette about challenging behaviour and asked to describe how they would intervene in the short and long term and to explain the reasons for their choices. The results showed that staff’s reasons for immediate action were prevention of harm, creation of a positive atmosphere, and the wish to distract the person away from the challenging behaviour. The response most frequently mentioned was communicating with the person in a calm manner. This seems to point to the view, according to the authors, that
apparently counter-productive responses to challenging behaviours may be based on short-term concerns, although these may conflict with more long-term goals set out in behavioural programmes.

Other authors (Taylor & Carr, 1993) point to the bi-directional nature of effects in challenging behaviours. Not only staff’s responses to clients influence their behaviour but also the occurrence of challenging behaviours also influences the way staff respond. Taylor and Carr (1993) conceptualise challenging behaviours as aversive stimuli which influence the behaviour of carers through negative reinforcement (the removal of or from an aversive situation). For example, if challenging behaviour occurs following demands, carers are more likely to reduce the frequency of demands put on the client. The authors point to the importance of taking this aspect into account when developing behavioural interventions. If this aversive effect on staff is not addressed it is likely that programmes will not be complied with.

In terms of intervention there is an emphasis on not only reducing and/or eliminating challenging behaviour but also providing alternative strategies for clients to enable them to obtain what they need and wish. Communication skills training and teaching is thus of central importance. As it was described earlier, the involvement of staff in this process is essential so as to ensure that the communication skills taught will be used in the client’s natural environment. In one report, Thurman (1997) describes how an intervention focusing on communication reduced the occurrence of violent and self-injury behaviour of a resident in a community care home and also how staff perceived and behaved towards the client.
Conclusion

Communication constitutes an essential aspect of being human. As it was discussed above, difficulties in communicating can have serious consequences for the individual’s development and well-being. In the discussion above, communication was viewed as a two-way process in which there are bi-directional influences from both partners. According to this view, others’ behaviour and expectations can impact on the person’s abilities to interact.

Due to the complexity of this subject, the specific influences of others’ in the development of communication are not clear and the question remains as to what constitutes a normal adaptation to a different child and what is preventing the child’s development. However, early intervention aimed at promoting satisfactory interactions between the carers and the child is promising. With adults, the training of care staff in communication is important, since it can have an impact not only on communication abilities, but also on the quality of life of the individual.

Psychologists working in the area of learning disabilities have an important role in developing methodologies to study communication in people with learning disabilities. It would perhaps be important to carry out more longitudinal studies with different disabilities and perhaps study the effect of carer’s cognitions (such as attitudes, expectations and self-concept) on the abilities of people with learning disabilities. Alongside this, it would be expected that further intervention packages could be developed, both for children and for adults. In any intervention, the analysis of the communicative environment should constitute part of the assessment and significant people for the individual should always be involved.
References


Critically evaluate psychological theories of child abuse and their contribution to clinical practice.

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Introduction

Child abuse is one of the most challenging problems presented to professionals working with children, adolescents and their families. Violence against children raises issues related to our responsibility as a society to protect and nurture our most vulnerable members. There is no question now, that child abuse exists and that it can have damaging consequences not only for the quality of life of children and adolescents but also for their lives as adults (Browne, Davies & Stratton, 1988). It is therefore important to carry out research which will contribute to the understanding, treatment and prevention of child abuse.

Child abuse encompasses three different types of abuse: physical, sexual and emotional abuse or neglect. Clinicians working in this area acknowledge that each type of abuse is usually combined with other forms of maltreatment or violence. That is, a child who is physically abused is likely to also suffer emotional abuse or neglect (Ney, Fung & Wickett, 1994). Despite this, most research in this area tends to focus on only one of the three types of abuse. For this reason and also due to space limitations, the following essay will focus on child sexual abuse (CSA).

Sexual abuse was defined by Kempe (1980, cited in Browne, 1988) as “the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent or that violate the social taboos of family roles” (p.17).

Several theories have been proposed to explain CSA in terms of the reasons for its occurrence, risk and protective factors and best ways of intervening. In this essay some of these theories, which address different aspects of CSA, will be presented and evaluated in terms of evidence provided by research. In order to provide a context for this discussion, a broader definition of CSA and its prevalence will be presented first. This will be followed
by a discussion of the consequences of CSA and a brief model addressing the variables which mediate the emergence of different symptoms will be discussed. The third section of this essay will present research focusing on the characteristics of perpetrators of CSA. The two final sections will present and critically evaluate the family systems model (Furniss, 1991) and the four preconditions model of CSA (Filkenhor, 1984). These models were chosen due to their applicability in clinical practice and research. There was also an attempt to address the complexity of CSA by presenting different areas related to this type of abuse.

Definition and prevalence of CSA

In addition to the definition of CSA mentioned above, most authors include in their definition the use of a child for sexual stimulation and gratification of a perpetrator or another person who is significantly older than the child (usually five or more years) (Carr, 1999; Cohen & Mannarino, 2000; Hartman & Burgess, 1989; Ruggiero; McLeer & Dixon, 2000). The sexual activity may involve sexual penetration (oral, vaginal or anal), sexual touching or non-contact sexual acts (i.e. exhibitionism and voyeurism) (Berliner & Elliot, 1996).

The prevalence of CSA is difficult to estimate due to inherent problems in the research in this area: the first is related to the secrecy that surrounds families where CSA occurs and the reluctance of families to report it (Hartman & Burgess, 1989; Wyatt et al., 1999). Frequently, children are not able to report the abuse not only because they are being coerced by the perpetrator, but also because they do not fully understand what they have been through. Another problem is that authors differ in the criteria they use to identify CSA. Some authors exclude cases where inappropriate touching and exhibitionism only occurred while others would include these cases (Carr, 1999). A final difficulty in the study of the prevalence of CSA is the relationship between incidence studies and retrospective studies. The first refers to the number of cases of CSA identified at a
particular time and the second involves asking a sample of people if they ever suffered CSA (Gillham, 1994).

Due to the factors presented above prevalence rates in different studies vary between 2 to 30 per cent in males and 4 to 60 per cent in females (Smith & Bentovim, 1994, cited in Carr, 1999). In relation to abusers, less than 20 per cent are female (Carr, 1999). Intrafamilial abuse (when the perpetrator is part of the child’s family unit) varies from 30 to 75 per cent of all cases and it tends to be over-represented in clinical samples (Carr, 1999; Gillham, 1994; Berliner & Elliot, 1996). Girls are more commonly abused by somebody related to them (fathers, step-fathers or siblings) while boys suffer more extrafamilial abuse (teachers, baby-sitters, friends of the family) (Carr, 1999) and abuse perpetrated by women (Berliner & Elliot, 1996). Cases where CSA was perpetrated by a stranger correspond to 8 to 10 per cent of all cases and 40 per cent of cases involve abusers who were extrafamilial but known to the child (Hartman & Burgess, 1989).

Epidemiology studies should form a basis from which to develop models of CSA. However, it is important to take into account that the methodological difficulties presented above will also be present when attempting to investigate CSA in terms of its underlying mechanisms.

Consequences of CSA

There are short and long-term effects of CSA which can vary significantly from child to child (Berliner & Elliot, 1996). Short-term effects can be both physical and behavioural. Physical symptoms include pain, soreness, swelling or bleeding of genital areas, oral infections, soiling and wetting (Hanks, Hobbs & Wynne, 1988). Behaviour and psychological problems include aggressive and sexualised behaviour, running away from home, poor school achievement, low self-esteem and high levels of depression and anxiety (Ruggiero, McLeer & Dixon, 2000). Carr (1999) states that three quarters of children will
exhibit no behaviour problems 18 months after the cessation of abuse. One quarter of children will develop more severe behaviour problems and one fifth will continue to present with clinically significant problems which persist into adulthood (Carr, 1999). Long-term effects which can persist into adulthood include mood disturbances, interpersonal problems, sexual dysfunctions (Jehu, 1988), substance abuse and eating disorders (Vogeltanz et al., 1999). There are some differences between women and men in relation to symptomatology with men reported to exhibit more externalising behaviours, such as aggression while women tend to cope by internalising their experiences, exhibiting more symptoms of anxiety and depression (Berliner & Elliot, 1996).

There are some characteristics of CSA which appear to be related to increased child psychopathology after abuse (Ruggiero, McLeer & Dixon, 2000). These include: more frequent and longer duration of abuse, abuse which involved penetration and violence, closer perpetrator-victim relationship, higher number of offenders, and child-reported appraisal of threat. Parental support after disclosure is associated with higher level of child functioning (Ruggiero, McLeer & Dixon, 2000).

Some authors have attempted to describe the psychological mechanisms underlying children’s reactions to CSA (Browne & Finkelhor, 1986, cited in Carr, 1999; Summit, 1983, cited in Furniss, 1991). Browne and Finkelhor (1986, cited in Carr, 1999) propose a model encompassing different characteristics of CSA which originate different sets of symptoms. In their traumagenic dynamics formulation they describe four distinct dynamics of CSA which account for the symptoms presented by children who were abused. These four dynamics are identified as: traumatic sexualisation, stigmatisation, betrayal and powerlessness. The traumatic sexualisation dynamic is the process by which sexual activities children cannot fully comprehend become associated with rewards, attention and care and/or negative and threatening experiences. This leads to an excessive salience of sexual experiences which in turn leads to confusion regarding sexual norms and identity and consequent oversexualised behaviour or sexual dysfunctions. The dynamic of
stigmatisation involves the child being blamed for the abuse either by the perpetrator and/or family members when the abuse is disclosed. The child might then develop negative ideas about the self which can be expressed through self-harm, drug abuse and suicide. The CSA dynamics of betrayal, when the expectation that protection will be provided by adults is not met, leads to a basic sense of mistrust in relation to others which gives rise to interpersonal difficulties and intense feelings of sadness and anger. The last characteristic proposed by the authors is the dynamic of powerlessness which corresponds to the inability of the child to stop the abuse. This gives the child a sense of ineffectiveness and of being incapable of changing circumstances around him/her. This can lead to depression, anxiety and somatic complaints.

This model takes into account and offers explanations for the effects of CSA observed in children, adolescents and adults. It also attempts to explain the cognitive processes which mediate the emergence of symptoms, such as negative cognitions associated with the self, others and the world. Although this model has not been researched directly in terms of what it predicts, it seems to be supported by research with clinical samples which indicate that adults who were sexually abused as children can have negative cognitions relating to self-blame, low self-esteem, negative self-attributes, ineffectiveness, helplessness, and a perception of life as hopeless or dangerous (Jehu, 1988; Berliner & Elliot, 1996). In a study by Jehu (1988), 51 women who were victims of CSA and who were referred to a Sexual Dysfunction Clinic, were given the Belief Inventory (Jehu, 1988) which assessed their beliefs regarding themselves and the abuse. It was found that a high percentage of women (above 70%) held unrealistic and distorted beliefs about themselves and their experiences (for example, women scored high on items such as “I am worthless and bad” and “I am inferior to other people because I did not have normal experiences”). Although this study provides some support for the model presented above, it has some limitations in relation to the sample since it consisted of a small specific clinical sample (i.e. women referred to a Sexual Dysfunction Clinic). Furthermore, the measure used was insufficiently studied in relation to its psychometric properties.
The model presented above therefore, appears to be useful for generating formulation hypotheses and intervention plans when treatment is required. However, more research is needed to understand the extent to which this model applies to different populations (children as well as adults) and the extent to which cognitive variables mediate the emergence of psychopathology in victims of CSA.

More recently, two studies have linked the effects of CSA to attachment theory (Liem & Boudewyn, 1999; Shapiro & Levendosky, 1999). Attachment theory (Bowlby, 1979 cited in Buchanan, 1996) proposes that the early experience between a child and caregivers forms a prototype to later relationships. From his/her initial experiences with others, the child develops internal working models of him/herself and others, and develops sets of expectations about future relationships. It is hypothesised that the quality of attachment will influence the way in which an individual can adapt to extreme situations (such as CSA) without developing psychological problems (Shapiro & Levendosky, 1999). In one study, eighty adolescent girls were interviewed in relation to sexual abuse and attachment histories (Shapiro & Levendosky, 1999). It was found that a secure attachment was negatively correlated with the presence of psychological distress in girls who had been sexually abused. It appears therefore, that the presence of a secure attachment relationship can constitute a protective factor in terms of reducing the probability of development of psychological problems as a consequence of CSA. Although these are still preliminary findings and a replication of these results is needed, they provide an interesting avenue for future research. However, the role of the quality of attachment in CSA remains unclear. Other authors have suggested that poor attachment relationships can act as risk factors for the occurrence of CSA (Liem & Boudewyn, 1999). It was hypothesised that if children have internal working models of self as bad or unworthy and see others as abusive and hostile as a consequence of poor attachment relationships, they would be less likely to consider abusive experiences as outside the normal realm of experiences (Liem & Boudewyn, 1999). This would have the consequence of increasing the likelihood of abuse.
by preventing the child from using available coping mechanisms and support. Some evidence, from a retrospective study (Liem & Boudewyn, 1999) has shown that the frequency of maltreatment and loss before the age of 5, predicted the frequency of CSA. These two studies seem to suggest that attachment theory could be a useful model to understand CSA. If a clear link is made between attachment and the risk and effects of CSA, it will provide evidence to develop treatment programmes focusing on strengthening relationships between abused children and attachment figures (such as a non-abusing parent).

Other authors studied the long term-consequences of CSA in relation to the parenting abilities of women who had been sexually abused (Alexander, Teti & Anderson, 2000; Zuravin, Fonatanella, 1999). It was found that the children of CSA survivors had a higher risk of being exposed to several types of maltreatment (Zuravin, Fonatanella, 1999). One study (Spieker et al., 1996 cited in Alexander, Teti & Anderson, 2000) found that mothers with a CSA history were five times more likely than non-abused mothers to have Child Protection Services contacts. These findings seem to support a transgenerational model of abuse, which hypothesises that abuse can occur in families through generations. It appears, however, that this process is not limited to sexual abuse, but can occur in relation to physical abuse and neglect, thus pointing to the interaction between different types of abuse.

The above section presented data relating to the consequences of child abuse and models which attempt to explain specific effects of CSA. In the next section research on male sexual abusers will be presented as well as hypotheses regarding the processes which lead an individual to abuse a child.
Perpetrators of CSA

Since the phenomenon of CSA started to be studied there has been an attempt to identify specific personality characteristics of abusers which would allow predictions of future abuse to be made and would provide a basis for the development of intervention plans for abusers (Murphy & Smith, 1996; Sanderson, 1990). However, the research has failed to provide conclusive evidence due to methodological weaknesses of most studies related to the use of non-standardised measures and the use of inadequate control groups (Murphy & Smith, 1996). A recent study (Gudjonsson & Sigurdsson, 2000) compared violent offenders and rapists with child molesters. They found that child molesters had higher scores on measures of social desirability, they tended to assault relatives and friends, they were rarely intoxicated when committing the offence and they had a strong internal need to confess to the police. This might indicate that there are some differences between sex offenders against children and other types of offenders which could provide guidelines for intervention. However, it would be important to carry out more research in this area in order to conclude on the reliability and validity of these findings.

In their review of the literature, Murphy and Smith (1996) present research which addresses the level of cognitive distortions offenders present with in relation to the abuse. The cognitive distortions studied are related to the excuses, minimisation and rationalisation that many offenders exhibit in relation to their abusive behaviour. The level of distortion present is related to the willingness to take responsibility for the behaviour and the level of empathy to the victim. Pollock and Hashmall (1991, cited in Murphy & Smith, 1996) developed a syntax describing the level of denial of the offender based on the analysis of statements from records of 250 child molesters. The syntax moves from a denial of fact (where the abuser denies the occurrence of any incident) to the denial of self-determination (where the abuser admits to have committed a criminal act, and acknowledges that it was wrong but presents extenuating factors which diminish his responsibility). In this syntax there are several intermediate stages between these two
extremes. Although this model provides a useful framework to understand the rationalisations perpetrators might exhibit, it is unfortunate that it has not been empirically evaluated. The study of cognitive factors related to the abuse would be important not only to differentiate different types of abusers and risk of re-offending but also to inform the development of intervention plans for this population.

The theories and research presented above can provide some guidelines for the development of treatment programmes for offenders. The first conclusion that can be made is that sex offenders against children constitute a heterogeneous group. The implication of this finding is that any intervention should include an extensive and broad assessment of each individual's characteristics and needs (Murphy & Smith, 1996). It is likely that no unique intervention package will apply to all offenders. It is also important for clinicians to be aware that no measure of recidivism has proven effective and decisions regarding levels of supervision of offenders need to be carefully made (Murphy & Smith, 1996).

More recently, research has shown that most offenders start their abusing patterns in adolescence and that a significant proportion of convicted offenders belong to this age group (Dobash; Carnie & Waterhouse, 1993; Glasgow et al., 1994; Murphy & Smith, 1996; Worling & Curwen, 2000). This fact indicates that treatment programmes specifically designed for this group would be important in order to decrease recidivism rates.

Another aspect studied has been the incidence of CSA histories among perpetrators. Fehrenbach and his colleagues (1986, cited in Corby, 1993) found that 19% of male adolescent abusers had been abused themselves. Another study with 13 female child perpetrators (aged between 4 and 12) found that all had been severely sexually abused over long periods of time (Johnson, 1989, cited in Corby, 1993). Although the samples of these studies were not sufficiently large to permit generalisations, these findings seem to
suggest that CSA can be a risk factor for becoming an abuser. They also provide some evidence to support transgenerational models of abuse which hypothesise that abuse can be perpetuated through generations of abused individuals (Buchanan, 1996).

In the remaining part of this essay two models proposed to explain the occurrence of CSA will be described and critically evaluated in relation to current literature and clinical application. The first model is the family systems model where CSA is conceptualised in the context of family relationships and patterns of interaction. The second model is the Four Preconditions model proposed by Finkelhor (1984) and which encompasses individual, family and social/cultural factors in the conceptualisation of CSA. These models were chosen due to their wide use both in research and in clinical practice.

Family systems models

In family systems models, sexual abuse is seen as a symptom of overall family maladjustment (Sanderson, 1990). Furniss (1991) proposes two distinct patterns of family functioning in CSA: one where the abuse serves a conflict-avoidance function (the organised family) and the other where the abuse operates as a conflict-regulating mechanism (the disorganised family).

In the organised family (Furniss, 1991), fathers are immature and strongly dependent on their wives for emotional care and at the same time they are sexually demanding towards their partners. The mothers in these families tend to be moralistic towards sexuality and are very competent in providing practical care for their children. The child in organised families experiences both parents as not fulfilling emotional needs. Children comply with the abuse for fear of punishment and of not being believed if they disclose to the non-abusing parent. In these families there is a discrepancy between the family’s self-image, which is presented to the outside world as well functioning and observing strict moral
family values, and the reality of the quality of family relationships. The family colludes in denying the existence of abuse in order to avoid an open conflict between the parents in relation to their sexual relationship and between the non-abusing parent and the child in relation to the lack of provision of emotional needs (Furniss, 1991).

The disorganised family is described by Furniss (1991) as having inadequate intergenerational boundaries in all levels of family functioning. Frequently, one child takes the role of caretaker for both parents and siblings. The father in these families is more openly controlling and can be physically violent whereas the mother is more permissive. The abuse is known at some level by family members and they collude in keeping it secret to the outside world. There is open marital conflict in these families and frequently more than one child is abused. In these families the abuse serves a function of conflict regulation by decreasing the level of marital conflict and preventing family break-up.

The family systems model presented above provides a framework to conceptualise CSA in the context of family relationships. It has been reported by researchers that family dysfunction is a risk factor for the occurrence of CSA (Bentovim, 1992; Berliner & Elliot, 1996; Carr, 1999; Crittenden, 1996; Glaser & Frosh, 1988) and this model is an attempt to take this fact into account and provide two alternative formulations for the types of dysfunction that might be found. Furthermore in changing the focus of the analysis away from individual pathology, this model provides an understanding of interactions between the different family members which allow the abuse to occur and continue. The interaction patterns identified can function as a basis for the development of intervention plans for these families (Glaser & Frosh, 1988). However, this model is limited to intrafamilial abuse and therefore ignores a significant proportion of cases of CSA where the perpetrator is not part of the family. A further criticism of this model is the absence of evidence for its accuracy in describing families where CSA occurs. It is unclear if the types of families described are specific or predictive of CSA (Glaser & Frosh, 1988). Authors have also criticised this model for the excessive responsibility put on the non-abusing
parent (usually the mother) in terms of not being capable of protecting the child from the abuse (Glaser & Frosh, 1988; Sanderson, 1990). There is also no link between this theory and the body of research on male sexual offenders. This is a clear limitation of the model since it ignores the processes which might lead a man to abuse.

In a review by Crittenden (1996), the results of research with families where CSA has occurred are summarised. It is noted in this review that most studies in this area are methodologically weak and consequently results are contradictory. Frequently, the numbers of families studied are small preventing a sound statistical analysis of the data, the samples used are usually not representative of the population (e.g. clinical samples, students) and the measures used lack construct validity. At present only general conclusions can be drawn from research: Families of abused children frequently present with other problems such as parental divorce, violence, psychiatric problems and substance abuse (Berliner & Elliot, 1996) and this seems to indicate that family dysfunction is associated with CSA. Furthermore, there is some evidence that poor maternal functioning and maternal unavailability is a risk factor for sexual abuse (Berliner & Elliot, 1996; Crittenden, 1996). This evidence seems to partially support the model proposed by Furniss (1991) regarding the role of mothers in CSA, however it is not clear how frequently this is the case and if this is specific to CSA families.

The main goal of family therapy in cases of CSA is to ensure that abuse will not re-occur by developing a protective and supporting living environment for the child (Carr, 1999). Other aims of family therapy are to establish the facts of the abuse as a shared family reality, to ensure that the abusing parent takes responsibility for the abuse, to address parental responsibility for general care, to create a close and protective relationship between the non-abusing parent and the child and to address marital difficulties between the parents (Furniss, 1991). These aims follow the theoretical model proposed above closely, however, the limitations mentioned above apply to clinical practice. It is also important to stress the importance of working jointly with other agencies in the
management of these families and to ensure that the child's welfare is kept at the forefront of any intervention. It would also be important to develop interventions for families of children who suffered extrafamilial abuse. Berliner and Elliot (1996) point to the fact that CSA will always have great impact not only on the victim but on the family as a whole and this could be addressed through family therapy.

In the section above CSA was introduced in the context of family relationships. However, it is widely acknowledged that this is a multi-causal phenomenon and that individual, family and socio-cultural processes are involved (Bentovim, 1992; Finkelhor, 1984; Glaser & Frosh, 1988; Glasgow, 1993; Hanks & Stratton, 1988; Sanderson, 1990). Finkelhor (1984) has developed a model of CSA which takes into account these different levels of influence. This model will be presented below.

The Four Preconditions Model

The four preconditions model proposed by Finkelhor (1984) groups all the factors that were proposed as contributing to CSA into four preconditions that need to be met before abuse occurs. The first precondition is that the offender needs to have some motivation to abuse a child sexually, secondly, he needs to overcome internal inhibitions against acting on those motivations, thirdly, the offender needs to overcome external factors that prevent him from committing the abuse and fourth, the abuser has to overcome the child's resistance to the abuse. Each of the preconditions is met through the operation of both individual and socio-cultural factors. The factors presented by the author are research and theory based and for each case of CSA some of these factors will be present and others will not.

The first precondition states that for abuse to occur some level of motivation, on the part of the abuser, to engage in sexual activities with a child must be present. The source of this motivation has three components: emotional congruence (the abuse satisfies an
emotional need), sexual arousal (the child is a source of sexual gratification) and blockage (the abuser does not have other sources of gratification or these are less satisfying). At a social level, the emphasis of male sexuality on youth and submissiveness of sexual partners and the tendency of men to eroticise affectionate relationships might contribute to the abuse (Finkelhor, 1984). According to the author, pornography might also play a role in the conditioning of sexual arousal to children.

Precondition two is the assumption that for the abuse to occur, the internal inhibitions of the offender, which stem from social norms and taboos, need to be overcome. Alcohol abuse, acute mental illness and failure to incorporate incest inhibitions in the family might contribute to this disinhibition. Again, child pornography might play a role in facilitating the disinhibition of the abuser. The socially accepted norm that males have rights over their children and an inability on the part of males to identify with the needs of children might contribute to the occurrence of the abuse (Finkelhor, 1984).

Precondition three addresses the idea that for abuse to occur the potential sources of protection of the child are not present or are neutralised. These sources include non-abusing members of the family, friends, teachers, etc. This precondition addresses the often described inability on the part of mothers to protect their children from being abused. At a social level factors such as the level of dependence of women on their male counterparts might contribute to a decreased effectiveness on the part of mothers to protect children. The widely accepted view that the family unit should not be interfered with by outsiders can make it difficult for other potentially protective agents to act on their suspicions of abuse (Finkelhor, 1984).

Precondition four encompasses child factors which can make him/her more vulnerable to abuse. Risk factors which can make children less able to resist abuse are anything that makes a child feel unsupported, needy and insecure. This might make a child less prone to disclose abusive situations and this characteristic can often be sensed by the abuser. A
disability or lack of family support are contributing factors to the child's sense of insecurity. This precondition, although important in explaining abuse, does not apply to all situations of abuse, especially the ones where violence or the use of force are present. In those circumstances the child is unable to resist the abuse (Finkelhor, 1984).

The model proposed by Finkelhor (1984) has the advantage of encompassing different aspects of CSA which tend to be investigated separately in research. It takes into account factors related to the abuser, the child and other family members, friends, etc. It also attempts to include both individual factors and socio-cultural factors which might influence the occurrence of the abuse. Finkelhor (1984) also argues that the model can be expanded to include new findings coming from research in that different factors can be added to each of the four preconditions. The model can also provide a framework for treatment, since it indicates which areas have to be addressed in order to prevent abuse from re-occurring. Unfortunately, this model has not been empirically tested and therefore it remains as an heuristic framework to guide prevention and treatment of CSA (Sanderson, 1990). It is also important to point out that this model provides a useful tool to develop preventative intervention programmes but has less relevance in terms of assessing the effects of CSA and ways of helping children and their families to overcome these.

**Conclusion**

The review presented has focused solely on CSA, and other types of abuse, such as physical abuse and neglect were not addressed. It is important to take into consideration the fact that in some occasions sexual abuse can occur in conjunction with other types of abuse (Ney; Fung & Wickett, 1994). Models which take this evidence into account would be useful for these cases and research in this area is clearly needed.
The models presented above provide frameworks for the understanding of CSA in terms of its effects, the factors that lead individuals to abuse, its relation to family dynamics and the factors that contribute to its occurrence. However, these models need to be used with caution since they tend to be based more on clinical practice than well established research evidence. The reasons for this were presented above and are related to inherent characteristics of CSA, such as secrecy and limited access to wide samples.

In relation to treatment, some approaches were presented in relation to interventions with children, families and perpetrators. The impact and role of different agencies (law enforcement agencies, statutory child welfare agencies and child health agencies) which intervene in cases of CSA was not addressed (Carr, 1999 & Furniss, 1991). This is however, an important factor to consider when developing treatment plans.
References


research on the causes and consequences of child abuse and neglect (pp. 95-128). Cambridge: Cambridge University Press.


Depression is an inevitable part of the ageing process and requires understanding but not treatment. Discuss.

Older Adults Essay
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Introduction

Human societies changed immensely throughout the 20th century due to scientific and technological advances. Perhaps one of the most significant changes has been the increase in life expectancy as a result of the new developments in medicine. This has led to a steady increase of the world’s population of people over the age of 65. Although this change was welcome since it allowed people to live longer and healthier, it also brought considerable new challenges such as the need to understand the ageing process in order to provide adequate social, physical and mental care to increasing numbers of older people.

Clinical Psychology has contributed to the study of ageing by providing models which attempt to describe the different life stages across the life cycle (e.g. Erikson’s psychosocial theory of development (Erikson, 1980 cited in Boyd; McKiernan & Waller, 2000)) and by studying the psychological problems which might develop in old age. One of the areas which has received great interest has been the study of depression in old age. Several authors have published studies of depression in old age in relation to its prevalence, aetiology and clinical features (Karel, 1997; Katona, 1994). Much interest has been given to the differences between depression in the elderly and depression in younger adults and its association with the ageing process (Boyd; McKiernan & Waller, 2000; Gatz; Kasl-Godley & Karel, 1996).

In Western societies, old age has tended to be viewed as a period of decline both in relation to physical strength and mental abilities. Old age is perceived as an unproductive stage and as such it tends to be undervalued by society as a whole (Butler, 1974). It is no surprise therefore that symptoms of depression in old age are often misattributed to “normal ageing”, not requiring treatment (Harman & Reynolds, 2000). This essay will present evidence from research which will hopefully clarify this view. It will begin with a presentation of epidemiology and aetiology studies of depression in old age followed by a discussion of its clinical features. Some data will also be presented in relation to the
recognition and treatment effectiveness of depression for this age group. Finally, a model of depression in old age which attempted to integrate evidence from research will be presented.

**Prevalence of depression in older adults**

Epidemiological studies of depression in old age vary widely in their estimates of the prevalence of this disorder due to a number of methodological difficulties. One of these difficulties is the sampling procedure used in different studies (Katona, 1994). Some studies use hospital based samples while others use community samples (Katona, 1994). While both methods are valid, the interpretation of results and respective prevalence estimates need to take into account the representativeness of the samples used. A further difficulty reported by many authors is related to the criteria used to define depression (Dick & Gallagher-Thompson, 1996; Gatz; Kals-Godley & Karel, 1996; Katona, 1994). Some authors use the diagnostic criteria for depression as set out in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III) and 3rd Edition revised (DSM-IIIR) (American Psychiatric Association (APA), 1980, 1987)\(^1\) while other authors consider this definition to be imprecise in relation to older adults since they consider that the presentation of depression in old age is qualitatively different from depression in younger adults (Dick & Gallagher-Thompson, 1996; Katona, 1994). This aspect will be discussed in more detail below in the section presenting the clinical features of depression. A further limitation is related to the tools used to measure depression. It has been recognised that many scales which measure depression (such as the Beck Depression Inventory, Beck, 1978) contain many items which refer to somatic complaints which might be present in many elderly people due to real physical illnesses (Davies & Collerton, 1997; Katona, 1994). This characteristic of depression scales might lead to misdiagnosis. Furthermore, many older people suffer from severe disabilities (such as dementia, deafness

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\(^1\) Note that most of the epidemiological studies reviewed were carried out before the more recent DSM-IV (APA, 1994) was published. However, many of the criticisms of the previous editions still apply to DSM-IV since there is still no separate category for depression in old age.
of blindness) which makes the assessment of depression extremely difficult if not impossible (Katona, 1994). Katona (1994) also refers a further limitation of epidemiological studies which is related to the high rate of elderly people which refuse to participate in such studies.

A recent review (Karel, 1997) distinguished between prevalence rates of major depression using DSM-III criteria and rates of significant depressive symptomatology requiring treatment but which did not fulfil DSM-III criteria. The author reports data from a cross-sectional study with community residents of five American cities and shows prevalence rates of major depression to be 0.7% (Regier, et al., 1984 cited in Karel, 1997). In this study the prevalence of major depression was the lowest for adults over 65 years old and highest among adults aged between 25 and 44.

The above results seem to contradict the idea that depression is part of the ageing process. However, it is important to note that these results might have been influenced by a cohort effect. In fact, other authors report that generations of adults born after World War II present higher depression prevalence rates than adults born earlier in the 20th century (Gatz; Kals-Godley & Karel, 1996). Furthermore, this study did not include institutionalised elderly people and this might have contributed to the low rates found (Karel, 1997).

Other studies attempted to examine the prevalence of depressive symptomatology which did not fulfil DSM criteria but was considered to be severe enough to require some form of treatment. Most of these studies used rating scales or diagnostic interviews and used criteria based on cut-off points above which depressive symptoms were considered significant (Karel, 1997; Katona, 1994). The presence of depressive symptomatology varied between 8% and 17.5% in community samples in recent epidemiological studies (Katona, 1994; Karel, 1997). The variation in prevalence rates was related to the
methodological limitations presented above such as the use of different measurement tools.

It appears that the percentage of older adults suffering from depressive symptoms is relatively high and this has led many authors to consider depression one of the main problems faced by elderly people (Geerlings; Beekman; Deeg & Tilburg, 2000; Harman & Reynolds, 2000). However, although the prevalence rates for depressive symptoms are much higher than the rates for major depressive episode presented above, they still seem to suggest that many older adults do not suffer from depression and only a relative minority seems to suffer from significant depressive symptomatology.

It has been recognised by authors in this field that people living in residential settings tend to exhibit higher rates of depression than community samples (and this is the case for both major depression and depressive symptomatology). Katona (1994) presents data from several studies which indicate that prevalence rates of depression in residential settings varied from 19.1% to 44% for depressive symptoms and tended to be around 9% in relation to major depressive episode according to DSM-III criteria. The reason for the difference between community and residential settings samples might be related to the higher level of physical disability found in the latter. This will be discussed further in the aetiology and risk factors section.

All of the studies presented above consisted of cross-sectional surveys which only allow estimates to be made of the percentage of people depressed at any one time. It would be useful however, to be able to establish estimates for the number of people who would be likely to suffer from depression at some point in old age. To achieve this aim, longitudinal studies would have to be carried out. One recent study followed a group of depressed and non-depressed elderly people over a period of three years (Geerlings et al., 2000). The participants were assessed at eight different points in time (every five months). The authors found that 27% of people not depressed at the first assessment developed
depressive symptomatology later. Of this group most people experienced only a short-lived episode of depression with 57% recovering from it within five months. Of the group of people who were depressed at the beginning of the study, 29% recovered from depression and 36.7% exhibited a changeable course of depression. This was an interesting study which might indicate that a significant proportion of older people might develop depressive symptomatology at some point in their lives, but these might be short-lived and therefore, not apparent in most surveys. More longitudinal studies are needed in order to ascertain the percentage of older people who are likely to develop depression.

The above presentation summarised the results from several studies of the prevalence of depression in old age. Although it is clear that older adults suffer less from major depressive episodes as they are defined for a younger adult population, most researchers agree that when more appropriate ways of measurement for this population are used, these differences disappear. It appears therefore, that a significant part of older people suffer from depressive symptomatology at some point in their lives. In order to clarify the link between depression and ageing, it would be important to understand the above results by discussing specific etiologic and risk factors associated with the development of depression in old age. This will be addressed in the next section.

**Aetiology and risk factors**

In this section different factors associated with depression will be presented and discussed. In the interest of clarity they will be divided into demographic and physical health and social factors. However, it is important to note that in most situations, several of these factors interact to give rise to depression.

**Demographic factors**

Within a population of people aged 65 years old or more, there are inconsistent results in relation to the association between age and depression. Some studies found differences
between the old-old and the young-old with the latter exhibiting lower rates of depression (Gatz; Kals-Godley & Karel, 1996; Karel, 1997; Katona, 1994). However, the same authors report that when other factors such as the level of physical disability are controlled the prevalence rates are equivalent across different age groups.

In relation to sex, it has been reported that older women tend to present with higher rates of depression than older men (Katona, 1994; Krause, 1986). Some authors have suggested that this difference is explained by an increased impact on women of stressful life events such as marital conflict or financial strain (Katona, 1994; Krause, 1986). However, there is insufficient evidence for this at present and other authors have found that the impact of physical ill health is equivalent for both men and women (Husaini et al., 1991 cited in Katona, 1994). Other authors found that the difference in prevalence rates between men and women dissipated for people aged 80 years old or more (Wallace & O’Hara, 1992 cited in Gatz; Kals-Godley & Karel, 1996). This is probably due to the impact of physical disability in older adults as was discussed above.

In relation to race, most studies found no difference between African Americans and White Americans prevalence rates of depression in older adults (Blazer et al., 1998; Karel, 1997). There is a very limited amount of evidence in relation to Hispanic communities suggesting that this population might present with higher prevalence rates of depressive symptomatology (Frerichs, Aneshensel & Clark, 1981 cited in Karel, 1997). From this data it is clear that more studies are needed to establish the relationship between ethnicity and depression in old age.

**Physical health and social factors**

Physical ill health and disability are the strongest risk factors for developing depression in old age (Geerlings et al., 2000; Jorm, 1995; Karel, 1997; Katona, 1994). This is the case not only for the older adult population but across all age ranges (Karel, 1997). However, since there is a sharp increase of the likelihood of suffering from a disabling physical illness
in old age, this factor stands as the main predictor of depression for elderly people (Karel, 1997). This evidence also explains the higher prevalence of depressive symptomatology in residential or hospital settings since there is also a higher rate of physical illness compared to community samples (Karel, 1997; Katona, 1994).

In an interesting study which followed a group of non-depressed older adults and a group of depressed elderly over a period of three years, it was found that physical illness was a strong predictor of both the onset and the persistence of depression (Geerlings et al., 2000). However, when the course of depression was analysed more specifically, it was found that physical illness was not correlated with short-episodes of depression (less than five months) and was also not associated with depression which followed a fluctuating course (when scores on depression scales fluctuated around the cut-off point). The authors suggest that short episodes of depression might be more related to environmental factors and that personality variables might explain fluctuating courses of depression. This study was important since it helped to clarify the relationship between physical health and depression. It appears that there is not a direct relationship between the two, but rather, that physical illness tends to be a risk factor for the onset and persistence of chronic depression. It would be important to replicate these findings since this study had a relatively high attrition rate (24.2% for the depressed group) and no information was given in relation to treatment for depression given in between measurements (it is possible that the different depression course types defined by the authors were more related to treatment variables than the other studied variables).

Another factor which has been studied in relation to depression in the elderly has been bereavement. The relation between bereavement and depression remains unclear since it is difficult to distinguish between a normal reaction to loss and depressive symptomatology. This is true especially in relation to the elderly where DSM criteria might not be applicable. Some studies have found that depressed older people tend to report more experiences of bereavement than non-depressed people (Karel, 1997). However, other
studies have reported that bereavement accounts for relatively little variance when other factors are taken into account such as physical ill health (Kennedy et al., 1989 cited in Karel, 1994). It also appears that the severity of the bereavement reaction (a high level of depressive symptoms after the loss) is the strongest predictor of long-term depression (Jorm, 1995). This initial reaction appears to be related to the person’s previous history of depression (Katona, 1994).

One further social factor which has received some attention in this area has been the study of social support and its relation to depression. Generally it has been found that lack of social support is predictive of subsequent development of depression (Katona, 1994; Jorm, 1995). However, it has also been reported that the perceived quality of social support is more important than social support per se (Karel, 1997) and that negative social relationships are predictive of depression (Jorm, 1994). Karel (1997) reported that social networks tend to remain stable throughout adulthood. This indicates that although social support is related to depression in old age, it is not related to the ageing process.

Other social factors thought to be related to depression are having to care for a disabled partner. Caregivers have been found to exhibit higher rates of depression than non-caregivers (Jorm, 1995; Karel, 1997; Katona, 1994). Other life changes such as retirement and financial strain have not been found to increase depression rates (Karel, 1997; Katona, 1994).

In summary it appears that health status is the most well established predictive factor of depression in old age. Since there is an increased likelihood of suffering from a serious physical illness with ageing, it could be inferred that depression is to be expected in old age. However, it is important to note that the rates of depression among physical ill people although significant (30%, Kennedy et al., 1989 cited in Karel, 1994), are not universal. Furthermore, not all elderly people suffer from disabling physical illnesses (95% of older people live in the community, Butler, 1974).
As it was reported above, most studies of the epidemiology of depression in old age use different criteria from those set out in DSM. This is the case because it was found that when these criteria were used, very low percentages of depression were found but many people who appeared to be suffering from severe depressive symptomatology requiring some form of treatment were excluded. It appeared therefore, that depression in old age presented differently from depression in younger adults. This will be discussed in the next section.

Clinical features and diagnosis of depression

Several authors have reported that depression in old age presents itself differently from depression in younger adults (Fielden, 1992; Levy-Cushman; McBride & Abeles, 1999; Shapiro; Roberts & Beck, 1999). Although there are individual differences in how people report symptoms of depression, it appears that older people generally are less likely to report dysphoric mood (Karel, 1997), self-blame and guilt (Shapiro; Roberts & Beck, 1999). Furthermore, depressed older adults report less suicidal ideation than younger adults (Shapiro; Roberts & Beck, 1999).

Depression in old age seems to be characterised by feelings of hopelessness, worthlessness and a lack of interest in the world (Levy-Cushman, McBride & Abeles, 1999). There also appear to be more somatic complaints (such as appetite loss, fatigue, insomnia and back pain) in depressed older adults than in younger adults (Shapiro; Roberts & Beck, 1999).

There also appear to be differences in the sub-types of depression defined for younger and older adults. The usual distinction between endogenous and non-endogenous depression seems to be less useful when applied to older adults (Katona, 1994). This is the case because it appears that the majority of depressed older people (83 %) are given a diagnosis of endogenous depression (Burvill; Hall; Stampfer & Emmerson, 1989). Also,
this diagnosis does not appear to relate to demographic or clinical characteristics of patients (Gallagher-Thompson, 1992 cited in Katona, 1994). The utility in terms of guidance for treatment and prognosis that the distinction between endogenous and non-endogenous depression has for younger adults does not seem to apply to older adults.

Some authors suggested that a distinction between early-onset depression (depression occurring before the age of 60) and late-onset depression is more useful in providing guidelines for treatment in this population (Burvill, 1989; Katona, 1994). Karel (1997) reported that in late-onset depression, people experience more apathy and loss of interest in everyday activities when compared with early-onset depression. Furthermore, there is some suggestion that early-onset depression is more related to genetic vulnerabilities whereas late-onset depression is more associated with physical illness and dementia (Boyd; McKiernan & Waller, 2000). In terms of prognosis, it has been reported that early-onset depression is associated with quicker recovery whereas late-onset depression has a poorer prognosis with longer episodes of depression and a higher risk of death (Boyd; McKiernan & Waller, 2000).

Other authors distinguished between what they called a “depressive syndrome” and a “depletion syndrome” (Newmann; Engel; & Jensen, 1991). The first is characterised by guilt, self-blame and early morning awakening and the “depletion syndrome” seems to present with loss of interest in life, feelings of irritation, social withdrawal, sense of hopelessness and loss of appetite. Although this distinction appears to be useful in identifying clusters of symptoms which seem to co-occur, more studies are needed to replicate these findings and ascertain the usefulness of this categorisation in terms of treatment and prognosis.

One aspect which has been studied in relation to depression in old age has been its relationship with cognitive decline. A category of “pseudodementia” has frequently been used in the literature to describe a mainly depressive condition which is accompanied with
cognitive decline (such as language and memory deficits) (Katona, 1994; Lishman, 1988). In this situation the person presents with psychomotor retardation, withdrawal of interest from the environment, faulty orientation and deficits in recent memory (Lishman, 1988). This group of symptoms is also present in cases of dementia and therefore, the differential diagnosis is sometimes difficult. However, contrary to cases of dementia, the cognitive deficits tend to subside once the depression has been treated (Katona, 1994). However, it has been reported that most people who present with this type of depression tend to develop dementia at a later stage (Kral & Emery, 1989 cited in Katona, 1994).

Depression can also co-occur with a dementing process (Ancill, 1993; Fielden, 1992). Again, the distinction between depression and dementia is difficult to ascertain due to the similarities in symptomatology of the two conditions. Karel (1997) suggests that depressive symptoms in the early stages of dementia might reflect an awareness on the part of the patient of cognitive decline. The author also reports that dysphoric mood might be more present in the early stages of dementia whereas low motivation presents in the later stages of the illness. Treatment of depression in cases of dementia can lead to improvements in mood and sometimes improvements in cognitive performance (Fielden, 1992; Karel, 1997).

In summary, the clinical features of depression in old age appear to be different from the presentation in younger adults and can also co-occur with problems typical of old age, such as dementia. These differences might reflect associations between depression and the ageing process itself and this would be an important area to study in the future. It is important to note that at present, these factors lead to difficulties recognising and diagnosing depression in old age and this raises questions in terms of availability of treatment for older people. This will be discussed in the following section.
It has been widely reported in the literature in this area that depression in older adults tends to be unrecognised by health practitioners (e.g. nurses, general practitioners (GPs), etc.) (Goodwin & Smyer, 1999; Katona; Freeling; Hinchcliffe; Blanchard & Wright, 1995). One study found that 8.1% of nursing home residents had an unrecognised major depressive episode (according to DSM-IIIR criteria) (Goodwin & Smyer, 1999). This occurs for several reasons. One factor which contributes to depression being overlooked is the fact that it is often associated with a physical illness and, as such, it tends to be seen as a normal reaction to a difficult situation that will subside as soon as there is some improvement of the physical condition (Goodwin & Smyer, 1999). As it was described above, older adults tend to report dysphoric mood less than younger adults and this might make the recognition of a depressive condition less likely (Freeling; Hinchcliffe; Blanchard & Wright, 1995). Another difficulty in the recognition of depression is the similarity in some cases between depressive symptoms and dementia (Ancill, 1989).

These difficulties in recognising depression in old age have led to studies being carried out about effective ways of improving the recognition of depression in order to ensure that older people receive treatment. Some studies have found that older adults who frequently attend their GP surgeries have higher rates of depression than community residents in general (Katona; Freeling; Hinchcliffe; Blanchard & Wright, 1995). This group of elderly people could therefore be identified as a high-risk group and methods of screening and assessing people should be developed. One author suggested that high risk groups, such as the physically ill and nursing home residents should be routinely screened for depression (Jorm, 1995).

One study examined the effectiveness of very short screening scales for depression with a sample of older people attending medical rehabilitation wards (Pomeroy; Clark & Philp, 2001). The authors found that very short scales (with four items only) appeared to be very
effective in detecting depression when compared with more widely used scales, such as the Geriatric Depression Scale (Yesavage et al., 1983 cited in Pomeroy, Clark & Philp, 2001) which consists of 30 items. Although these results need to be replicated in similar and different settings, they appear encouraging in terms of providing a quick way for routinely screening older people.

Another aspect which has been studied has been the provision of treatment for depression once it has been diagnosed. It has been suggested that GPs are reluctant to prescribe anti-depressive medication to physically frail people due to the side-effects associated with this type of medication (Katona; Freeling; Hinchcliffe; Blanchard & Wright, 1995). Also, one study found that one in three GPs are unfamiliar with the psychological therapies available for depression (Collins; Katona & Orrell, 1997).

In terms of effectiveness of treatment for depression in late life, few studies have been carried out to date and the use of different outcome measures and different inclusion criteria makes comparison of results difficult. Furthermore, a substantial part of published articles on psychological therapies with depressed older adults consist of case studies which do not permit generalisation of results (see for example, Hinrichsen, 1999; Knight, 1992). Two reviews examining studies which used Cognitive Behavioural Therapy, Behavioural Therapy, Reminiscence Therapy and Psychodynamic Therapy concluded that all treatment modalities are effective in the treatment of depression when compared with no-treatment conditions (Davies & Collerton, 1997; Scogin & McElreath, 1994). The authors also indicated that at present no conclusions can be drawn in relation to the most effective treatment modality due to lack of sufficient numbers of well controlled studies. In terms of cost-effectiveness, Davies and Collerton (1997) concluded that psychotherapy, counselling or emotional support significantly reduce medical costs for older people.

In relation to treatment issues, it appears that health practitioners are not effective at recognising depression in old age and even when a diagnosis is given, treatment might not
become available. This might be due to a perception that depression is a normal part of ageing and that it does not require treatment. However, it is clear at present that, although depression can be associated with the processes of ageing, it is not experienced by a large majority of old people. Also, it has been shown that treatment of depression (pharmacological or psychological) can be effective in reducing distress and therefore it should be used when appropriate.

The evidence presented above clarifies some of the associations between depression and ageing, however, it does not clarify the nature of this relationship. Some authors have attempted to integrate this information into models of ageing and depression which would allow for hypothesis and predictions to be made and tested. These models will be briefly presented in the next section.

Models of ageing and depression

One model which has been used in relation to depression in old age has been the life span developmental diathesis-stress perspective (Gatz; Kasl-Godley & Karel, 1996). This is a two dimensional model with one dimension being the individual’s level of vulnerability (in this case vulnerability to depression) or diathesis, which is influenced by genetic predispositions, acquired biological vulnerabilities, and psychological factors (such as attributional style). The other dimension in the model is stress (i.e. negative life events) such as bereavement or unemployment. These two dimensions, diathesis and stress, both contribute to the likelihood of someone developing depression. The authors propose that by considering age and cohort differences in terms of these two dimensions, one could explain the differences found in relation to prevalence, aetiology and presentation of depression at different life stages (Gatz; Kasl-Godley & Karel, 1996). They suggest that the patterns of interaction between diathesis and stress factors which contribute to the development of depression earlier in life are different from the diathesis and stress factors in operation later in life.
One study offered some support to this model by analysing genetic and environmental influences in the presence of depressive symptoms in a group of twins (Gatz; Pedersen; Plomin; Nesselroade & McClearn, 1992). It was found that genetic influences played a greater part in the development of depressive symptomatology in old age, especially in relation to somatic complaints and psychomotor retardation. Furthermore, unique life experiences were more influential for older adults than for people under the age of 60. These results seem to support the model by providing some evidence that different influences operate at different life stages, however, this was a cross-sectional study and a cohort effect cannot be excluded. Furthermore, the sample used was a non-clinical sample and further studies with clinically depressed elderly are needed in order to generalise these results.

The model presented above is useful in generating hypotheses and possible avenues for research on the relationship between depression and age. However, more studies would be needed to understand the different factors (biological, psychological and environmental) which influence the development of depressive symptoms in old age. This would also contribute to the development of preventative and treatment programmes specifically designed to meet the needs of elderly people.

It is also important to mention Erikson’s psychosocial theory of development (Erikson, 1980 cited in Boyd; McKiernan & Waller, 2000). According to this model, each life stage has a specific task which needs to be carried out in order to successfully develop. According to the author, the specific task of old age is to review one’s life and to achieve a sense of coherence and wholeness in the face of death. One hypothesis put forward by the author is that the non-resolution of this task can give rise to depression.

Although this model has been very influential in the study of human development, it does not offer clear predictions in terms of the factors which contribute to the development of
depression in old age (Boyd; McKiernan & Waller, 2000). Therefore, it has limited utility for the understanding of depression.

Conclusion

This essay presented an overview on studies of late-life depression and pretended to clarify the relationship between depression and age. From the studies of prevalence of depression in old age, it was clear that this condition is not an inevitable part of the ageing process, although it stands as one of the main mental health problems affecting older people.

It can also be concluded that some of the risk factors associated with depression for this age group are associated with changes which are typical of old age (such as physical health decline and bereavement). The clinical features of depression in the elderly are also different from younger adults and this might be associated with changes related to ageing. However, the nature of this relationship is not clear at present.

In relation to treatment it is clear from the literature that health practitioners need to be educated in relation to depression in old age, both in terms of recognising and treating it. More studies in this area would be welcome in terms of establishing the most effective modalities of treatment, as it has been established for younger adults. It is likely that changes to the usual models of treatment would have to be made to meet the needs of this population. At this point, it can be concluded that treatment of depression is effective and should be made available to older people when needed.
References


Psychoanalytic family therapy in adolescence: A critical analysis

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Family therapy has been an influential approach in the psychotherapeutic field since the 1950s (Nichols & Schwartz, 1995). At this time it was recognised that many psychological disorders which were previously seen as intrapsychic problems, were in fact strongly influenced by the interpersonal patterns of the families of origin of the identified patients (Nichols & Schwartz, 1995). Although this understanding involved a major shift in the way these disorders were conceptualised and treated (mainly through the application of systems theories), there was also an attempt to adapt established individual approaches, such as psychoanalytic, behavioural and humanistic therapies, to this new way of treating psychological disorders. Within the psychoanalytic literature several authors (Box, 1978; Graham, 1998; Sharff, 1989a; Skynner, 1987; Slipp, 1993; Stierlin, 1977) developed ways of working with families which made use of concepts, such as unconscious, transference and countertransference, used in traditional individual therapy.

It is interesting to note that this psychoanalytic framework was developed mostly in relation to the work with families with children in the adolescence stage of development. Several authors point to the observation that the specific issues of autonomy, separation and sexuality which are particularly relevant at this stage (Carr, 1999) are likely to bring up anxiety in the family linked to unconscious conflicts related to these issues (Box, 1994).

The present essay is an attempt to summarise and to critically evaluate the literature in the field of psychoanalytic family therapy in adolescence. The first section will present a brief description of some important developmental issues in adolescence and their understanding in psychoanalytic terms. The second section will give a description of the psychoanalytic approach to family therapy, making reference to the main theoretical concepts used, including group analytic views and the concepts of projective
Adolescence

Adolescence is regarded as a period of crucial importance for the development of different aspects of personality into a more coherent and stable sense of self (Waddell, 1998). The entry of children into adolescence is marked by the arrival of puberty with its extraordinarily rapid physical and emotional changes. In broad terms adolescence can be defined as the child’s adaptation to these changes through the gradual development of an identity and of more autonomy from the family of origin (Waddell, 1998). One of the implications of this is that a realignment of parent-child relationship needs to take place to allow the child to pursue independence and problems to undertake this task on the part of the family can lead to psychological difficulties (Carr, 1999).

In psychoanalytic terms the period of adolescence involves the re-working of old infantile conflicts (Waddell, 1998). Some of these involve the move from what is called the paranoid-schizoid position to a depressive position (Klein, 1955) which is characteristic of very early infancy. The paranoid-schizoid position is characterised by a state of internal disorganisation where different parts of the self and the object (the internal representation of a significant person) cannot be integrated and “bad” or threatening parts are split off and projected outside the self in an attempt to maintain the good internal representations unspoilt. In adolescence this is observed as a tendency to “act-out” conflictual feelings rather than reflect and resolve them internally. Thought is thus replaced by action and aspects of the self which are felt to be disruptive are attributed to others through the mechanism of projection (Waddell, 1998). Waddell (1998) points out that this process, if used in moderation can be a positive way of self-exploration if the parts of the self which are projected are subsequently re-introjected. The author considers that the mechanism of
projection may stem from a mixture of anxiety and curiosity about parts of the self which cannot yet be integrated into a more coherent whole. Projecting these parts onto others may facilitate their observation and working through with subsequent reintrojection. These projections can be directed to members of the family but also to members of the adolescent’s group of friends which at early adolescence is of extreme importance. This paranoid-schizoid position is also demonstrated in the tendency to shift from extremes of hate and love, not only towards others but also towards the self, with an inability to acknowledge that they are one and the same person (Waddell, 1998).

The adolescent therefore, needs to move from this paranoid-schizoid position to a depressive position where good and bad parts of the object and the self can be seen as parts of the same person. This involves a capacity to experience guilt and responsibility for the damage done through one’s projections but also a capacity for gratitude and sensitivity to others. There is a move from a self-centred position to a position of concern and care for others (Waddell, 1998).

The development of an identity in the adolescent also involves the establishment of a stable sexual identity and the development of long-lasting relationships outside the family. This negotiation can bring up oedipal issues experienced earlier in life such as the desire for the parent of the opposite sex and the jealousy and hatred for the parent of the same sex. The fact that the fantasies associated with the oedipal scene can now become reality through the development of sexual potency contribute to the confusion and guilt associated with this process. Waddell (1998) suggests that the need of the adolescent to distance the self from the family might also be related to the anxieties associated with the oedipal situation.

Other authors make more direct connections between the tasks of adolescence and the shifts which occur within families (Dartington, 1994; Stierlin, 1977). Dartington (1994) introduces the concept of the adolescent as an outsider. The author explains this concept
as someone who is part of a social group (in this case the family) but who adopts a position on the fringe of that group. The role of the outsider is different from that of the outcast who is on the outside of the group. The outsider is seen as part of the group and also as performing some function for the group. During adolescence it is important to temporarily adopt an outsider role so that the rules, behaviours and values which have been previously accepted without question are now evaluated allowing the adolescent to develop his or her own values. This movement however can create tension in the family if it is seen as a manifestation of rejection of the family and as a threat to the cohesion of the family structure (Dartington, 1994).

**Psychoanalytic Family Therapy**

The field of psychoanalytic family therapy is not a unified one and in some aspects, mirrors the differences observed in psychoanalytic individual therapy. For example, American authors tended to develop their ideas from what was called ego-psychology (Scharff, 1989a; Stierlin, 1977), whereas British authors (Box, 1978, 1994; Graham, 1998) based their work on the developments from object-relations theories introduced by Klein (1955), Bion (1961) and others. In this section some of the concepts which appear to be shared by the different approaches will be described.

The development of psychoanalytic ways of working with families incorporated concepts taken from different sources. One of the influences frequently mentioned in the literature is the work of Bion (1961) with analytic groups. This is presented next followed by the description of the mechanism of projective identification introduced by Klein (1955) and its use in family therapy. The concept of family myth as used by Byng-Hall (1973) is also described. Finally the therapeutic technique used in psychoanalytic family therapy is briefly presented.
Family Therapy and Group Analysis

One of the main ideas used in family therapy taken from the psychoanalytic work with groups is that the group (in this case the family) is seen as a single complete psychic entity as distinguished from an aggregate of individuals (Bion, 1961; Sharff, 1989a). This implies that each individual has a particular function and role within the family which contributes to the whole group.

Bion (1961) defined the work group as the activity of the group which is directed towards the completion of a task. This activity is grounded in reality and conscious mental activity and attempts to move the group towards a shared goal. Bion (1961) went on to distinguish this type of activity from what he called basic assumptions which relate to unconscious emotional drives within the group. These are at times chaotic and interfere with the work group but they also provide, to the extent that they are shared by the group members, a sense of cohesion to the group.

These ideas of group as a unified entity and of unconscious drives influencing and shaping the behaviour of the different members of the group have been incorporated into psychoanalytic family therapy. However, it is also acknowledged that family groups are very different from therapeutic groups of strangers (Behr, 1988). The main difference between the two types of groups is the common history and continuing relationships of families which in the case of stranger groups are limited to the therapeutic experience. This fact has a strong influence on how the therapist is seen by families. Contrary to stranger groups, the therapist joins an established group and is therefore an outsider to this group. Furthermore, the family is likely to come into therapy at a time of crisis which will again influence the way the therapist is seen. It is therefore likely that the family will either experience the therapist as someone extremely powerful who can provide solutions or as someone who threatens the cohesion of the group and therefore needs to be expelled from the group (Behr, 1988). The implication of this is that the therapist needs to be
extremely aware of countertransference issues which might indicate the way in which the family unconsciously perceives him or her, to attempt to correct these views into more realistic ones.

Behr (1988) uses the concepts of mirroring and resonance used in analytic groups to explain how the therapist can contribute to change within the family. Through mirroring the therapist simply reflects back what he/she observes in the room, thus articulating aspects of the functioning of the family which had not been previously acknowledged. The process of resonance requires the therapist to join in the same style of communication as the family by using similar expressions which can then resonate within the group and be picked up by one member who will expand on the topic. These techniques appear to stem from a view that the therapist should adopt a position of facilitator of communication within the family.

Another major difference between stranger groups and family groups is that in stranger groups the focus of the work is in the development of a transference reaction between the individual and the group (based on past family experiences) which can be worked through and changed into more realistic ways of relating to others. In family groups however, the relationships between family members are the basis with which transferential reactions are developed in the first place (Stierlin, 1977). In other words, the inappropriate ways of relating which are transferred into future relationships have their basis within the family. This mechanism is explained by authors as stemming essentially from a process of projective identification between family members. This will be expanded below.

**Projective Identification in Families**

The concept of projective identification was introduced by Klein (1955) to explain a process which has its origin in the first three or four months of life when the baby is in the paranoid-schizoid position. At this stage, as it was mentioned earlier, the good and bad parts of the internalised object cannot be integrated and parts of this object are split off.
and projected outside the self. In this position the baby experiences extremes of emotions of either pleasure or anxiety and does not have the capacity to integrate the two. The only mechanism available to the baby to deal with these extremes is to get rid of these anxieties through splitting and projection. Furthermore, the baby projects these parts of his/her emotional experience into another person (usually the mother). This process changes the perception the baby has of the object (for example, by seeing the mother as threatening and bad) and in a reciprocal way alters the image of the self (for example, as a victim, helpless baby) (Zinner & Shapiro, 1972). Klein (1955) also points out that this mechanism is used not only to project bad or negative parts of the self but also good parts of the self and this would be the basis for the creation of empathy. It is important to note that this mechanism is not only in operation in the young baby but also in adults. For example, in the case of empathic understanding one may attribute to the other one's own feelings in an attempt to understand the other and have a basis for communication (Waddell, 1994). Likewise, projective identification may operate when unwanted parts of the self are projected into others.

The defence mechanism of projective identification is central to the development of psychoanalytic theories of family functioning because it provides a way to understand interpersonal processes based on intrapersonal defence mechanisms. One way in which therapists attempt to explain interpersonal patterns observed in the family is by attending to unconscious intrapersonal conflicts of the family members which are played out in the family through the process of projective identification. Zinner and Shapiro (1972) put forward the idea that within families the mechanism of projective identification may lead to lasting structural changes in the personality of the recipient of projections. This can be easily understood if one thinks that the personality of a child is not stable but in a state of constant development and therefore open to the projections which may come from the exterior (in this case the parents or siblings). An example of this given by Waddell (1994) is the family with two children in which one child is seen as attractive, successful and popular and the other as the difficult one, bad-tempered, unsuccessful. In this case it is as
if the good idealised parts of the parents’ self are projected into one child and all the bad qualities of the self are projected into the other child. There is therefore a total split between the good and bad parts of the self. It is frequent to observe that in these families the children actually play out the roles attributed to them with one child being successful at school for example, and the other becoming a delinquent.

This process of projective identification is present from the start of family life. The work of Dicks (1963) provided some understanding of the manner in which the mechanism of projective identification is active in relation to partner choice. The author postulated that marital choice is motivated by a desire to find an object who will reinforce and complement unconscious fantasies stemming from earlier past relationships within the family of origin. Dicks (1963) suggested that each partner longs for someone who will fit with unconscious fantasies of resolution of internal conflicts while at the same time, and paradoxically, finding someone who will also prevent the working through of these conflicts (therefore maintaining the status quo). When children are born, they too will play a part in this process by becoming recipients of these fantasies (Zinner & Shapiro, 1972). The young child due to his/her instinctual needs of closeness and protection is engaged in this process and colludes with the projections received from the parents, which will therefore shape the development of the young child’s personality (Zinner & Shapiro, 1972). The child can then be seen as the hated or longed part of the parent’s self (Sharff, 1989b).

Zinner and Shapiro (1972) elaborated on the mechanism of projective identification to explain its operation in relation to the development of a child’s personality. They introduced the concept of delineation to define the behaviours of the parents which communicate to the child their image of him or her (their unconscious projections). The authors suggest that these delineations are determined by parental defensive mechanisms and they interfere with a realistic perception of the child’s attributes. They are therefore unconscious processes and the parents are strongly motivated to sustain these perceptions.
of the child (in order to keep anxiety at bay) even when evidence of the contrary is presented. The authors suggested that the child is likely to also identify with the parents’ perceptions of him/her and develop similar images of the self, therefore perpetuating the cycle and maintaining the family dynamic untouched. However, it is likely that these projections become a problem when children reach adolescence (Zinner & Shapiro, 1972). At this stage a major re-structuring within the family needs to take place to allow the adolescent to become independent and develop a sexual identity. This task can be made difficult by the implicit attempts of the family to maintain the status quo which previously offered some resolution to unconscious conflicts.

It is clear from the above formulation that each member of the family can project different parts of the self or internal object into different members within the family. The way in which these different defensive projections as well as the more conscious views are integrated to provide a coherent narrative for the family has been denominated the family myth (Byng-Hall, 1973). This concept will be expanded below.

The Family Myth

The concept of the family myth was introduced by Ferreira (1963) as the pattern of mutually agreed, but distorted, roles which family members adopt as a defensive posture and which are not challenged from within the family. One of the ideas put forward in this definition is that family myths are narratives shared by the different family members regarding each member’s role. However, these narratives are either distorted versions of a person or as Byng-Hall (1973) suggested, represent only a segment of that person’s behaviour. Furthermore, the myth is not challenged from within the family and therefore has a degree of permanence. Byng-Hall (1973) suggested that the function of the myth is to hyde from awareness unconscious intrapsychic conflicts defended against within the family, thus maintaining the family’s sense of cohesion and stability. The myth is therefore the manner in which the family presents itself to the outside world as well as the way it sees itself. However, to an external observer the myth appears to distort or cover
up other aspects of the functioning of the family which are associated with high levels of anxiety (Box, 1979).

A simple example of this may be the family in which the mother tends to be warm and submissive and the father strict and authoritarian with a son who is close to mother and has a distant relationship with father. There may be a myth that the family is a very happy and close one until the son, as he reaches adolescence starts exhibiting delinquent behaviour. The family may present as very concerned about this and identifying the son’s behaviour as the only problem within the family. However, with close observation one may come to the conclusion that the mother encourages the delinquent behaviour in subtle ways like for example, colluding with the son in not informing father about some of these delinquent behaviours. It may then be hypothesised that the mother is projecting to the son a part of herself who is rebellious and angry towards the authority of the father. This may have perhaps originated in her own past relationships in which her own father was strict and authoritarian. It can then be seen that the family myth of a close family with mother warm and submissive may be defending against her own anger with her husband and the fragility of their relationship. The tension in the couple is therefore acted out by the son, thus keeping the real source of tension outside awareness.

Technique

The main goal of therapy, as with individual therapy, is to bring to awareness unconscious processes within the family as a way of working through or resolving internal conflicts, thus, rendering the acting out of these conflicts in the family dispensable. In their conceptualisation, most authors (Box, 1998; Byng-Hall, 1973) see the relationship between the parental couple as central to the understanding of the family myth and of the projective identifications observed. It is assumed that conflicts in the parents’ own families of origin are enacted in some form (Box, 1998). The way in which the concepts presented above are used in family work has similarities with the principles used in psychoanalytic individual work. Box (1978) presents three guiding principle for
this: a) the setting of the work needs to change as little as possible so as not to confound
changes occurring within the family; b) the sessions are opportunities for the family
members to test out fears associated with internalised objects against the reality of the
therapeutic environment as it unfolds and c) the therapist uses his/her own feelings as
clues to the family’s state of mind in the session. In relation to this point, it is usually the
case that there are two therapists and the countertransference between the two therapists
as well as between them and the family needs to be attended to. This point is especially
important since the therapists, as a new system joining the family system, may become
the recipient of projective identifications from the family members and this can give clues
as to the anxieties which are being defended against (Box, 1998).

Box (1978) mentions that one of the difficulties of having sessions with families is the
amount and the complexity of the material presented. The therapists should attempt to
attend to the whole significance of what is being said and avoid focusing on little pieces
of information which may distract from the overall picture (Skynner, 1987). Another
characteristic of this approach is the lack of structure within the sessions. It is important
to let the feelings present within the family be expressed as freely as possible so as to
allow the therapists to understand the mechanisms in operation as well as to provide the
family with an experience of containment where difficult feelings can be understood and
owned (Box, 1978, 1998; Copley, 1994). Box (1978) reports that the objective is to be
“working at the point of maximum anxiety” (p. 126), so that it can be experienced in the
here and now in safety of the session and therefore be relieved.

Critical Analysis

One of the main criticisms which has been put forward in relation to psychoanalytic
thinking (both for individual and family therapy) is the lack of studies evaluating both the
validity of the theories put forward to explain psychic processes as well the effectiveness
of the approach (Dare, 1998). In relation to the first point, it can be said that most of the
concepts and theories developed are based on clinical observations. Thus, an inductive process of arriving at theories is utilised. Although this process has the advantage of remaining closely linked with clinical material which provides a rich source of material for analysis, it is insufficient since it does not allow for hypothesis testing of the theories described. Research has often been seen in the field (especially quantitative research) as a reductionist practice where rich clinical material is lost (Gurman & Kniskern, 1978; Sprenkle & Bischoff, 1995). Recently, however, new methodologies have been developed which allow for both inductive and deductive approaches to be used as well as quantitative and qualitative methods which maintain a close link to clinical practices (Pinsof & Wynne, 2000; Safran, 1990; Sprenkle & Bischoff, 1995; Smith; Flowers & Osborn, 1997). It would be important therefore, for psychoanalytic practice to take these new developments in research methodologies into account and perhaps adapt some of them to allow for a more rigorous evaluation of its theories.

The lack of studies evaluating psychoanalytic theories of family therapy is also reflected in the evaluation of its effectiveness. Many authors in the family therapy field (including systems theories) have brought attention to the need for more research in relation to the effectiveness of family therapy (Carr, 2000; Dare, 1998; Sprenkle & Bischoff, 1995). Although, it has been concluded that family therapy approaches are more effective than no-treatment conditions, the differences in effectiveness between different approaches to family therapy have yet to be established (Carr, 2000; Sprenkle & Bischoff, 1995). A review carried by Gurman, Kniskern and Pinsof (1986) provides estimates of the effectiveness of different approaches to family therapy. The authors considered that the effectiveness of psychoanalytic approaches was uncertain for conduct, psychosomatic and mixed disorders and divorce adjustment and that there was no evidence for its effectiveness in relation to schizophrenia, substance abuse, affective disorders, anxiety disorders and juvenile delinquency. Whereas some of the other approaches to family therapy, such as cognitive behavioural, structural and strategic have produced outcome
research since then (Carr, 2000), psychoanalytic approaches appear to have remained largely untested.

Another aspect which has not received much attention on the part of family therapists in this area is the effect of social changes of the family in the second half of the twentieth century. Most formulations presented appear to relate to a traditional view of the family with two parents and the children. It does not explain in which way the unconscious processes described operate in families with single parents or in families with step parents and step siblings. An interesting exception to this has been the work of Dartington (1998), who presents views on adolescent development in small families (mainly single-parent families).

The way in which the dynamic between the parental couple is seen as the main source of tension in the family, appears to follow a linear way of thinking. This may give rise to a perception of attributing blame to some members of the family which can make the engagement in the therapeutic process difficult (Hayley, 1980). Furthermore, this view may also lead to conceptualisations which view the adolescent child in the family as a passive recipient of the parents' projections. The way in which the parents' projections interact with the children's own projections and behaviours is not made clear in this approach (although temperamental issues are taken into account in explaining why one particular child may receive certain projections instead of another). However, the fact that the impact of different generations of the family is taken into account is an advantage of this approach since it allows for a wider understanding of the family dynamics.

Hayley (1980) also points out that this approach tends to focus on the negative aspects of the relationships between the different members of the family, thus precluding the instillation of hope and the using of resources from within the family.

Conclusion
The above essay presented a brief description of the concepts and technique used in psychoanalytic family therapy in adolescence. It was not intended to be a comprehensive review and should be seen as providing a basic understanding of the main concepts used in this approach, such as the use of analytic interpretations of group functioning, the concept of projective identification and its use in family therapy and the concept of family myth. The main goal of this approach is, as in individual therapy, to bring awareness to the family of the unconscious processes guiding behaviour. This process of gaining insight takes place in the safety of the therapeutic encounter, allowing for the expression and working through of deep rooted feelings. It is expected that the experiencing of these feelings will lead to more realistic appraisals of the different family members allowing their development to continue. In the case of adolescence, this means allowing the young person to gain more autonomy and independence and develop a sense of personal identity separate from the parents, with the ultimate aim of establishing long lasting relationships outside the family. Most authors (Box, 1998) emphasise the importance of countertransference in the sessions since this will give information about the particular projections which are coming from the family to the therapists.

A brief critical analysis of the approach was also included. The approach has the advantage of being drawn directly from clinical practice, which allows for a deep understanding of the concepts as they are used clinically. Furthermore, it includes in its conceptualisation a transgenerational view of current problems which provides an understanding of the manner in which certain problems are repeated in consecutive generations of the same family. Another strength of the approach, and in relation to adolescence, is that it takes into account the stage of development of the child in the family and its effect in the family dynamics. A last comment on the strengths of this approach is in relation to the position of the therapist which is seen as establishing a relationship with the family, thus becoming part of the system. The subjectivity of the
therapist position is therefore acknowledged and is incorporated in the explanation of the mechanisms of change by the use of countertransference and its interpretation.

Several limitations of this approach were also discussed, mainly, the lack of well controlled research in the area in relation to both the validity of the theoretical model and the clinical effectiveness of the approach. Furthermore, there appears to be an absence of integration of the recent social changes of the structure of the family (such as single parent families). It was also noted that there is a linear view of the origin of problems from the parents to the children and this may have implications for the way in which parents may be made to feel blamed for the problems presented. The role of the adolescent in the generation and maintenance of problems appears to receive less emphasis. This view focuses mainly on the negative side of the relationships within the family, making it less explicit the way in which resources in the family can be used for change.

The psychoanalytic approach to the work with families has remained an influential approach to psychotherapeutic practice. Although initially it was not widely accepted in the field of family therapy (more specifically systems approaches), several authors (Bentovim, 1998; Flaskas, 1992; Lamer, 2000; McFadyen, 1997) have recently made attempts to integrate the different views.
References


Box, S. (1994). Space for thinking in families. In S. Box (Eds.), *Crisis at adolescence: Object relations therapy with the family* (pp. 3-11). Northvale, NJ: Jason Aronson Inc.


Copley, B. (1994). Introducing families to family work. In S. Box (Eds.), *Crisis at adolescence: Object relations therapy with the family* (pp. 51-65). Northvale, NJ: Jason Aronson Inc.


Sharff, J. S. (1989a). The development of object relations family therapy ideas. *In J. S. Sharff (Eds.), Foundations of object relations family therapy* (pp. 3-10). Northvale, NJ: Jason Aronson Inc.


Waddell, M. (1994). The family and its dynamics. In S. Box (Eds.), *Crisis at adolescence: Object relations therapy within the family* (pp. 31-47). Northvale, NJ: Jason Aronson Inc.


CLINICAL DOSSIER

CORE ADULT MENTAL HEALTH PLACEMENT

CORE PEOPLE WITH LEARNING DISABILITIES PLACEMENT

CORE CHILDREN, ADOLESCENTS AND FAMILIES PLACEMENT

CORE OLDER ADULTS PLACEMENT

SPECIALIST ONE-YEAR PLACEMENT IN PSYCHOANALYTIC THERAPY FOR ADOLESCENTS
CORE ADULT MENTAL HEALTH PLACEMENT

PLACEMENT DETAILS

Dates: 13th October 1999 - 26th March 2000

Supervisor: Shaheen Shibli (Consultant Clinical Psychologist)

NIHS Trust: Surrey Oaklands NHS Trust

Base: Banstead Community Mental Health Team, Strathmore House, The Drive, Brighton Road, Banstead, SM7 1DE

Summary of clinical experience

The placement provided valuable experience in working with a range of presenting problems within a community mental health team (CMHT). The trainee developed assessment and intervention skills, using a cognitive-behavioural approach. Experience was gained in the use of psychometric assessment tools, assessment interviewing, cognitive-behavioural intervention with a range of difficulties and neuropsychological assessment. The trainee also co-run a group (with a Community Psychiatric Nurse) for clients with phobic anxiety using a cognitive-behavioural approach. Individual assessment and intervention were carried out with a range of presenting problems including obsessive-compulsive disorder, agoraphobia, specific phobias, generalised anxiety disorder, post-traumatic stress disorder, bereavement, depression, delusional disorder, sexual identity problems, relationship problems and memory problems. Assessment tools used during the placement included BDI, BAI, GHQ, PDS, Fear questionnaire, Activity checklist for obsessional symptoms, WAIS-III and AMIPB.
Meetings, seminars, visits and research

The trainee had the opportunity to observe other professionals (own supervisor, consultant psychiatrist and neuropsychologist) carrying out clinical assessments and interventions. The trainee attended several clinical and business meetings in the context of the CMHT and the psychology department in the Trust. Two presentations on the group work carried out during the placement were given to the psychology department and the CMHT respectively. The trainee visited an acute in-patient unit and attended a one-day workshop on the use of WAIS-III and WMS-III.

The service related research project included in this portfolio and entitled “A pilot study on the care programme approach: User’s perspectives” was carried out in the service.
SUMMARY OF ADULT MENTAL HEALTH CASE REPORT

Cognitive behavioural intervention in a case of delusional disorder

Presenting Problem
Mr. Blake was referred by the Consultant Psychiatrist in the CMHT for a cognitive-behavioural intervention for delusional ideation. Mr. Blake was 53 years-old and was diagnosed as suffering from a delusional disorder 5 years previously when he had been made redundant from his job. He had been admitted to hospital twice during this period. Mr. Blake complained of olfactory hallucinations which he called ‘the fumes’ and which he believed were the result of his wife trying to poison him. At the time of the referral he was taking anti-psychotic medication. He also complained of feeling generally low and tense.

Assessment
Assessment was carried out through interview, standardised measures, activity diaries and through consultation of the client’s notes. The assessment was guided by cognitive approaches to psychosis and focused on the experiences of olfactory hallucinations and delusions experienced by Mr. Blake. The BDI and BAI were also used to assess the presence of depression and/or anxiety.

Formulation
The psychotic illness Mr. Blake presented with was conceptualised as a multifactorial problem in which biological, psychological and social factors played a role. Within this perspective a vulnerability-stress model was used and the outset of Mr. Blake’s illness was seen as the result of an interaction of biological and genetic vulnerabilities with stressful environmental events (in this case his redundancy from his job). The maintenance of the disorder was hypothesised to be the result of the deterioration of his social network following his first psychotic episode and also other stressful events, such as moving houses. It was also hypothesised that his delusional system led to his
withdrawal from social interactions which probably reinforced his beliefs that others were against him by preventing him from receiving feedback. Furthermore, he occasionally behaved in an aggressive manner which led others to avoid him reinforcing his delusional beliefs.

**Intervention**

The intervention followed a cognitive behavioural approach for psychosis. It started with developing a new individualised model of psychosis in collaboration with the client integrating the ideas from a vulnerability-stress model. The next stage involved addressing specific delusional beliefs and finding evidence for and against the client’s beliefs as well as developing alternative explanations for this evidence. Some work on dysfunctional beliefs was also carried out as well as addressing relationship difficulties between the client and his wife which seemed to be accentuating the problem. In the last stages of therapy a relapse prevention plan was developed with the client.

**Outcome**

After 13 sessions Mr. Blake showed more flexibility in relation to his delusional ideation and was able to consider alternative explanations for his experiences. He reported beneficial changes in his relationship with his wife. His scores on the BDI and the BAI reduced slightly (this minor change was as expected since his scores on these measures were low during the assessment stage).
PLACEMENT DETAILS

Dates: 13th April 2000 - 29th September 2000

Supervisor: Dr. Gill Koheecalle (Consultant Clinical Psychologist)

NIIS Trust: South West London Community NHS Trust

Base: Merton and Sutton Community Team for People with Learning Disabilities, Birches House, 1 Birches Close, Cricket Green, Mitcham CR4 4LB

Summary of clinical experience

The placement provided valuable experience in working with a range of presenting problems within a community team for people with learning disabilities. The trainee developed assessment and intervention skills, using mainly cognitive, behavioural and neuropsychological approaches to children and adults with mild, moderate and severe learning disabilities. Experience was gained in providing consultation to staff in residential and day centre facilities as well as to family members of people with learning disabilities. Clinical work with clients and services was varied and included challenging and self-injurious behaviour, transition and change to different care settings, bereavement, assessment of dementia, learning disability status and ability to consent. Assessment methods used during the placement included WAIS-III, WISC-R, Leiter, BPVS-II, WMS-R, assessment of dementia and autism and direct observations.

Meetings, seminars, visits and research

The trainee had the opportunity to observe other professionals (own supervisor, and community nurse) carrying out clinical assessments and interventions. The trainee
attended several clinical and business meetings in the context of the community team and
the psychology department in the Trust. The trainee visited day centres for people with
learning and multiple disabilities as well as schools for children with mild and multiple
and/or severe disabilities. The trainee also visited a local supported living team, the local
Mencap charity, an NHS unit for people with dual diagnosis and an employment and
rehabilitation service for people with disabilities.
SUMMARY OF PEOPLE WITH LEARNING DISABILITIES CASE REPORT

**Behavioural intervention targeting the eating habits of an autistic child**

Presenting Problem
Joseph was referred to the community team by his classroom teacher. At the time of referral Joseph was 4 years and 9 months old and had been diagnosed with autism at the age of 2 and a half years. Joseph’s mother reported that she was finding it very difficult to keep Joseph at the dinner table during mealtimes and when she tried he would show challenging behaviour (such as jumping and screaming). She also complained that he ate a very restricted range of foods.

Assessment
Assessment was carried out through interviews with Joseph’s mother and school teacher, naturalistic observations of Joseph’s behaviour at mealtimes both at school and at home and a descriptive measure of autistic features. The assessment was carried out in order to identify and describe and carry out a functional analysis of the target behaviour. The choice of assessing Joseph in two settings was made in order to establish if the behaviour was consistent across situations and to obtain more reliable data.

Formulation
A behavioural formulation based on the functional analysis carried out in the assessment stage was developed in relation to Joseph’s refusal to sit at the table at mealtimes and food selectivity at home. This formulation including precipitant factors (e.g. termination of the use of physical restraint), maintaining factors (e.g. positive reinforcement through access to favourite foods) and perseverating factors (e.g. inconsistency of response to Joseph’s attempts to leave the table) and was integrated with vulnerability factors associated with autism (e.g. lack of generalisation of learned skills).

Intervention
A behavioural approach was selected for implementation since this approach made it possible to promote learning without the use of verbal language. Ethical considerations were taken into account when developing the intervention plan since Joseph did not have the ability to consent to treatment. The intervention plan consisted of instructing Joseph’s mother on behavioural principles and involved the removal of primary reinforcers outside mealtimes, the removal of primary and secondary reinforcers contingent to Joseph’s attempts to leave the dinner table, and reinforcement in the form of social attention at regular intervals when Joseph sat at the dinner table. In relation to food selectivity, Joseph’s mother presented him with his favourite foods in conjunction with new foods (stimulus fading) and Joseph would be consistently reinforced each time he tried a new food. Also, his access to food was restricted outside mealtimes and predetermined snacks.

**Outcome**

An improvement was observed and reported by Joseph’s mother in relation to his behaviour at mealtimes. He was able to sit down at mealtimes until the end of his meal, he was seen eating different types of food and his communication skills improved (he learned to ask for food when he wanted to eat outside mealtimes).
CORE CHILDREN, ADOLESCENTS AND FAMILIES PLACEMENT

PLACEMENT DETAILS

Dates: 11th October 2000 - 23rd March 2001

Supervisor: Maggie Minter (Clinical Psychologist)

NIH Trust: Oxleas NHS Trust

Base: Bexley and Greenwich Child and Adolescent Mental Health Service, Memorial Hospital, West Theatre, Shooters Hill, London SE18 3RZ

Summary of clinical experience

The placement provided rich experience in working with a range of presenting problems within a child and adolescent mental health service (CAMHS). The trainee developed assessment and intervention skills, using cognitive-behavioural, systemic and psychoanalytic approaches. Experience was gained in the use of psychometric assessment tools, assessment interviewing with children and families and neuropsychological assessment. The range of presentations worked with included separation anxiety, adjustment to divorce, behaviour problems in school and at home, anxiety and phobias, obsessional behaviour, conduct disorder and school refusal. The trainee also had the opportunity to observe the supervisor working with families where children had suffered sexual abuse and worked jointly with a psychiatrist in a case of physical abuse. There was also the opportunity to be supervised by a psychodynamic psychotherapist in relation to two individual assessments and intervention. Assessment tools used during the placement included WISC-III, WORD, WIPPSI, BAS, FSSC-R and Conners’ rating scales for parents and teachers. Skills of providing written and verbal feedback to children, their parents and teachers were developed.
Meetings, seminars, visits and research

The trainee had the opportunity to observe other professionals (own supervisor, consultant psychiatrist, family therapists, social worker, paediatrician and health visitor) carrying out clinical assessments and interventions. The trainee attended weekly clinical and business meetings in the context of the CAMHS and meetings with the psychologists in the service. There was the opportunity to be an observer in 4 consultation meetings with social services in relation to looked after children with complex needs. Visits to a local primary school, a health centre, a special needs school, a social services family resource centre and the local child protection team were carried out. The trainee attended a workshop on family therapy and religion.
SUMMARY OF CHILDREN, ADOLESCENTS AND FAMILIES CASE REPORT

Systemic intervention for a family with an adolescent exhibiting aggressive and oppositional behaviour

Presenting Problem
Jake, a 14 year-old boy, was referred to the CAMHS by his GP following a meeting with Jake’s mother who expressed concerns regarding his behaviour. This request for help followed an incident when Jake hit his mother when she tried to correct him. Jake’s mother reported that his behaviour had begun to deteriorate 3 years previously when she divorced Jake’s father. She reported that he was also verbally and sometimes physically abusive towards his sister and that he had also been suspended from school due to his behavioural problems.

Assessment
Assessment was carried out through interview with the family, consultation of notes and contact with school and family crisis unit (where Jake had been seen previously). The assessment had the aim of collecting information in relation to the history of the problem, Jake’s developmental and educational history and family relations.

Formulation
The problem behaviour identified was described as aggressive and verbally abusive behaviour which occurred when Jake was contradicted and uncompliant behaviour (e.g. refusal to follow instruction or requests at home). The different factors affecting the behaviour were organised in 4 categories encompassing predisposing, precipitating, maintaining and protective factors. In each category personal and contextual factors (family, parental and social network factors) were identified. Factors such as the divorce of Jake’s parents, the beginning of new relationships by both of his parents and the birth of a half-brother were all conceptualised as influencing Jake’s behaviour. Also, the response given to his behaviour (i.e. attention) and the absence of more positive
interactions was also thought to be affecting the behaviour. Factors which were conceptualised as protective (in that they indicated a capacity for change on the part of the family) included Jake’s mother and her partner’s commitment to resolve the problem.

**Intervention**

As Jake’s behaviour seemed to be embedded in a particular family environment undergoing change, intervention involved the whole family. A solution-focused approach was used in which solutions to problems were generated by the family drawing upon its own resources. Intervention aimed to achieve minimal change that would impact on the family system as a whole through recursive patterns of interaction. The therapist helped the family to identify unique outcomes (instances where the behaviour was expected to occur but did not occur) and also develop new narratives about Jake (to replace others that described Jake’s oppositional behaviour as intrinsic and unchangeable) and/or amplify positive narratives already present. Externalisation techniques were also used to help the family perceive a greater sense of control over the problem.

**Outcome**

The family were seen for 4 sessions with 3 weeks interval between sessions. In the last session the family reported that the atmosphere at home was calmer and Jake expressed a greater sense of closeness with his family and control over his own behaviour. Jake’s step father expressed some concern in relation to the ability to maintain the change observed.
CORE OLDER ADULTS PLACEMENT

PLACEMENT DETAILS

Dates: 4th April 2001 - 21st September 2001

Supervisors: Dr. Sue Webb (Clinical Psychologist) and Dr. Farzad Shamsavari (Consultant Clinical Psychologist)

NIIS Trust: South West London and St. George's NHS Trust

Base: Department of Clinical Psychology, Elmside, 1 Oakhill, Surbiton, Surrey, KT6 6DU

Summary of clinical experience

The placement provided experience in working with older adults within the context of an outpatient psychology service and an inpatient unit for older adults with mental health problems. The trainee had the opportunity to learn and work with life span issues and to develop skills in working within a cognitive approach and in carrying out neuropsychological assessments. The trainee co-ran (with supervisor) a six-session group for older adults with anxiety problems. The range of problems worked with included depression, obsessive-compulsive disorder, anxiety, memory problems, paraphrenia, bereavement, effects of physical illness and schizophrenia. Assessment tools used included HAD, WAIS-R, WAIS-III, WMS-III, NART, AMIPB, GNT, TEA, CAMCOG, RBT and Maudsley Obsessive-Compulsions Inventory.

Meetings, seminars, visits and research

The trainee had the opportunity to observe other professionals (own supervisor, psychiatrist) carrying out clinical assessments and interventions. The trainee attended 2 multi-disciplinary meetings at community mental health team for older adults and 2 trust wide psychology for older adults departmental meetings. Opportunities to meet with
professionals working (such as head of local service for carers) in the area were provided and met with psychologist developing a service for support of people caring for older adults. Visited in-patient, day centres and residential settings for older adults (run by health authority or social services). The trainee attended an afternoon lecture on the therapeutic relationship and older adults and on half-day workshop on writing court reports.
SUMMARY OF OLDER ADULTS CASE REPORT

Neuropsychological assessment of a client with memory problems

Presenting Problem
Mrs. Richards, who was 64 years-old was referred by her GP to the out-patient psychology department due to persistent memory complaints. She was seen at the department two years previously due to the same complaints and a follow-up assessment was requested to establish if there had been any cognitive deterioration since the previous assessment and to determine if her difficulties had an organic or functional basis. Mrs. Richards reported that her difficulties were the same as before and consisted of feeling disorientated while driving, having difficulties finding words, and memory problems. She reported that since the last assessment she had become less motivated to do certain things. She also suffered from severe back pain.

Assessment
A neuropsychological assessment was carried out using a variety of assessment tools as well as through an interview. The assessment instruments were chosen taking into consideration the tools used in the previous assessment to allow comparisons to be made. The tools used in the assessment were subtests of the WAIS-R, AMIPB, TEA, GNT and the HAD and these provided information in relation to several areas of cognitive functioning such as general ability, memory and information processing, attention, language impairment, depression and anxiety.

Formulation
Mrs. Richards scores profile was not homogeneous and no clear pattern of strengths and difficulties emerged from the assessment. Although Mrs. Richards showed some deterioration in some areas of functioning, the results were mixed and did not indicate specific areas of deficit. There was no conclusive evidence for the presence of a degenerative organic process taking place. The results were consistent with a pattern of
depressive pseudodementia characterised by psychomotor retardation and withdrawal of interest from the environment. The possibility that Mrs. Richards was suffering from depression could be understood taking into account her current circumstances in that she had suffered several losses that she did not seemed to have processed adequately.

**Intervention and Outcome**

Verbal and written feedback regarding the results was provided to Mrs. Richards. It was suggested that she could discuss the possibility of taking anti-depressive medication with her GP. She was also offered a course of 6 sessions of cognitive therapy to address some of her concerns and process the various losses she suffered.
SPECIALIST ONE-YEAR PLACEMENT IN PSYCHOANALYTIC THERAPY FOR ADOLESCENTS

PLACEMENT DETAILS

Dates: 11th October 2001 - 20th September 2002

Supervisor: Linda Young (Consultant Clinical Psychologist)

NHS Trust: Tavistock and Portman NHS Trust

Base: Adolescent Department, Tavistock Centre, 120 Belsize Lane, London, NW3 5BA

Summary of clinical experience

This one-year placement provided extensive experience in working within a psychoanalytic approach with adolescents and their families. The trainee worked with adolescents with a variety of problems individually for short or longer term work. There was also the opportunity to work with parents in supporting their child’s therapy and with families. In all these different contexts the trainee had the opportunity to work jointly with other professionals. The amount of supervision received was extensive and provided by different professionals in the department, providing a rich experience of different styles of work. The trainee also had the opportunity to carry out assessments and one intervention with younger children in the Child and Family Department. The range of problems worked with included depression, anxiety, OCD, eating disorders, relationship difficulties, schizophrenia, behavioural problems and the consequences of domestic violence and neglect. In relation to assessment tools, the trainee developed skills in the use of projective techniques for children and adolescents, such as the CAT and the Object Relations Test.
Meetings, seminars, visits and research

The placement provided the opportunity to attend numerous workshops and seminars in subjects such as Psychoanalytic Family Therapy, Introduction to Psychoanalytic Theory and Projective Techniques for children and adolescents. Other workshops attended focused on the discussion of clinical material. The trainee attended a four-day conference on the study of group processes. There was the opportunity to give presentations on both theoretical learning and clinical case material at different settings. A presentation was also carried out for a group of Japanese students on the History of Clinical Psychology in Britain.
SUMMARY OF SPECIALIST PSYCHOANALYTIC THERAPY FOR ADOLESCENTS CASE REPORT

*Very brief psychodynamic consultation with a 19 year-old young man with relationship difficulties*

Presenting Problem
John contacted the administrator of the Young Persons Consultation Service (YPCS) and reported that he was seeking help because he had problems with relationships. He also reported that he was unemployed and that his mother was seriously ill (she had been diagnosed with Multiple Sclerosis 10 years previously and had recently suffered from severe paralysis). Due to this situation he had moved in with his father and step-mother.

Assessment
The YPCS is a self-referral service offering a 4 session consultation service for young people. Due to the brevity of contact with clients, a formal assessment stage was not clearly defined and the initial interview focused on the John's current concerns. Some background history was addressed when it was relevant to the understanding of the problem.

Formulation
John's presentation indicated a difficulty in resolving some of the developmental tasks of adolescence, especially in relation to the formation of a stable sense of self and separation from family life. These difficulties had been accentuated when his mother became seriously ill and he moved in with his father. It was hypothesised that John's difficulties stemmed from a difficulty in processing his parents' divorce, which became the focus of the work from the second session onwards. The concept of containment used in psychoanalytic literature was used to formulate John's difficulties. It was hypothesised that John's mother had been unable to contain John's anxieties in relation to the conflict between his parents witnessed by him. He also used a defence mechanism typical of
adolescence to cope with his anxieties (i.e. acting-out by leaving jobs and relationships when things became difficult, thus avoiding experiencing feelings of anxiety).

**Intervention**

John attended 3 or the 4 sessions offered. The intervention followed a psychoanalytic approach adapted to the particular characteristics of the service. The intervention focused on helping John to gain insight in relation to the impact his parents' divorce was having on his development and on thinking with him about the best ways to move forward. As in all psychoanalytic work the sessions were left as open as possible and the work focused on the material brought by the client. Another focus of the work was to allow John to seek further help to work through his emotional difficulties.

**Outcome**

In the fourth session John reported that he felt better with himself after attending the sessions at the YPCS, despite feeling at times more confused and anxious. John was receptive to the idea of requesting further help and he self-referred to a psychotherapeutic service for adolescents that would be able to offer him longer term support.
RESEARCH DOSSIER


LITERATURE REVIEW: “A review of recent literature on borderline personality disorder: Concept validity and treatment effectiveness”

MAJOR RESEARCH PROJECT: “The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis”
SERVICE RELATED RESEARCH PROJECT

A pilot study on the care programme approach:

Users’ perspectives

Year I PsychD in Clinical Psychology

University of Surrey

July 2000

Word Count: 2992
Abstract

The Care Programme Approach was introduced in 1991 to ensure that people suffering from a mental health problem and living in the community received appropriate care. Responding to government requirements to evaluate health services, the present study is a cross sectional survey which aims to collect users' views on their care. It evaluates the extent to which government recommendations for the CPA are being achieved. Setting: a Community Mental Health Team in a small town. Participants: 122 users on CPA levels 2 and 3 (requiring multidisciplinary input). Measures: A questionnaire was developed in consultation with representatives of each clinical profession in the service and users groups. It consisted of three sections addressing each component of the CPA (assessment, key worker, review meeting and care plan) and a final section with general questions about satisfaction with the service. Results: 34.1% of participants did not feel involved in the development of their initial care plan; 22.7% of respondents did not know who to contact if their key worker was not available and they needed help; 16.1% of participants felt their views were not listened to at the review meeting and 39.4% did not receive a copy of their care plan. 88.7% of participants rated the service as good or very good. Conclusions: The results point to areas which need to be addressed in order to meet government guidelines, in particular information about who to contact if the key worker is not available and developing systems to increase user involvement in their care.
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Introduction

The Care Programme Approach (CPA) was introduced by the Government in 1991 providing a framework to respond to the complex needs of people suffering from a mental illness living in the community (DoH, 1996). This approach was designed to minimise the risk of someone losing contact with psychiatric services by ensuring a thorough assessment of individual needs and adequate co-ordination between different agencies.

The CPA has four main components (DoH, 1995):
(i) A systematic assessment of the health and social needs of the client;
(ii) The allocation of a key worker to each client who has the responsibility of co-ordinating the care provided from different agencies;
(iii) The development of a care plan agreed between the members of the multidisciplinary team, service users and their carers; and
(iv) The regular review of care plan delivery and the client’s progress.

After it was first introduced, studies describing ways of using this approach in clinical settings were carried out (Broughton & Divall, 1994; Mathews, 1995) as well as evaluations on its effectiveness (Carpenter & Sbaraini, 1996; Perkins & Fisher, 1996; Shepherd; King; Tilbury & Fowler, 1995).

Shepherd et al. (1995) compared the individual needs identified in the care plan (level of functioning) with the amount of support received. They predicted that individuals with the lowest level of functioning would receive greater support which would indicate that the CPA was being effectively used in tailoring care to individual needs. The results showed that clients with lower levels of functioning received more support from key workers. Although these results seem to suggest that the CPA was effective in providing
greater levels of support for more vulnerable clients, the question remains whether this help was tailored to the specific needs of individual clients.

In another study Perkins and Fisher (1996) evaluated the extent to which staff and clients' views were reflected on the care plan developed. The results indicated that problems identified by clients were less likely to be included in care plans than staff's views.

Carpenter and Sbaraini (1996) evaluated the extent to which the CPA was effective in taking into account users' and carers' views when developing care programmes. As this study was carried out in the initial stages of the introduction of the CPA, the authors were able to compare clients who had received a care plan with those who had not. They found that clients who had a care plan were more involved in their care and better informed about their rights and services than clients with no formal care plan.

From the literature presented above it can be seen that some efforts have been made to evaluate the CPA; however studies are sparse and conclusions about its effectiveness remain tentative. Furthermore, different services use the CPA in different ways and conclusions from one service cannot be generalised to others. In a recent document (DoH, 1999, pp. 22-23) the Government stressed the importance of involving service users in mental health services by “developing research tools to assess their views on how services can best meet their needs” and by evaluating “service users satisfaction with CPA”.

In several published documents the Government presented some basic guidelines for the CPA which services should aim to fulfil (DoH, 1995; DoH, 1999):
- every client should have an initial needs assessment;
- each client should have a key worker and everyone involved in his/her care should know who the key worker is;
- a care plan should be agreed by everyone involved in the care including the client and relatives or carers;
- everyone involved should have a copy of the agreed care plan;
- review meetings should ideally occur every six months if the client’s situation is stable
- ensure that users have access to services around the clock.

The current study is a cross sectional survey that aims to collect the views of users of a Community Mental Health Team. It will address the extent to which government recommendations on the CPA are being met and satisfaction levels with care received.
Method

Setting:
The study took place in a Community Mental Health Team (CMHT) located in a small town serving a total population of 43,500 people. At the time of this study the CMHT had 11 clinical staff, a team manager and 3 administrative staff. Every week new referrals are discussed in the multidisciplinary team meeting and are allocated to one professional for assessment. According to the needs identified on assessment a key worker is allocated to each client and a decision is made regarding the CPA level the client requires (level 1 - low support needs and only one professional involved; level 2 - health and social care needs, requires multidisciplinary input; level 3 - complex needs, maximum support and frequent review required).

Sample:
The sample consisted of clients on CPA levels 2 and 3 who were on the CMHT caseload in the month of December 1999 (total of 122 clients). Clients on CPA level 1 were excluded since some of the components of the CPA do not apply to this group (such as multidisciplinary review meetings).

Procedures:
A questionnaire (see Appendix I) was developed in consultation with representatives of each profession in the team and local user groups. The input of users was considered important to avoid bias towards professionals’ views. The questionnaire was divided in three sections corresponding to the different components of the CPA (assessment, key worker, care plan and review) and a final section addressing general satisfaction with the service. The decision to divide the questionnaire into sections was based on the assumption that specific questions would elicit more meaningful and reliable responses (Stallard, 1996). Each of the first three sections contained questions related to government guidelines for the CPA (for example, “Do you know who your key worker
is?”) and questions assessing satisfaction with the relevant component of the CPA (for example, “How satisfied are you with how often you see your key worker”). The format of the questions was mainly closed with dichotomous (e.g. Yes/No) and likert scale answers. Each section also included open questions which gave participants an opportunity to express other views (for example, “Do you have any other comments about the role your key worker is taking in your care?”). A total of 32 questions was included. A final section covered demographic questions (i.e. sex, age, ethnic origin, time of contact with CMHT, reason for referral and hospitalisation).

The questionnaire and a cover letter (plus an addressed stamped envelope) were sent to all service users in the sample. A postal survey was the method chosen due to cost and time constraints. It was also thought that this was the best method to ensure anonymity and confidentiality of responses. The cover letter gave information about the aims of the survey and of its confidential, anonymous and voluntary nature (see Appendix II). Access to client details was obtained by consulting a database set up by the administrative staff in the CMHT. Three weeks after sending the questionnaire a reminder letter (see Appendix III) was sent. This letter was sent to all clients within the sample since it was not possible to identify participants who had already returned the questionnaire due to the confidential and anonymous nature of the project. It was also stressed that only the Trainee Psychologist on placement (temporarily working with the team and with no employment ties to the CMHT) would have access to the returned questionnaires.
Results

Of the 122 questionnaires sent, a total of 45 were returned (response rate of 37%). Descriptive statistics were used to analyse the quantitative data. The analysis of qualitative data was made through content analysis.

Demographic data
Sixty-two percent of the respondents were female, 7% were less than 25 years old, 29% were aged between 26 and 35 years, 18% between 36 and 45 years, 20% between 46 and 55 and 26% between 56 and 65 years. All participants described themselves as white. The fact that there were no participants from ethnic minority groups was not surprising as less than 3% of clients at the CMHT came from these backgrounds.

The majority of participants (75%) had been in contact with the CMHT for more than one year and had had an admission to an in-patient unit. These results were to be expected since the participants were all on CPA levels 2 or 3, thus having more complex needs and requiring more support from mental health services.

The demographic data obtained was similar to the initial sample in all of the above variables except with regard to the age range between 26 and 35 years old (in the initial sample, 19% of clients were in this age range compared with 29% of respondents).
Questionnaire

Section A - Assessment

A summary of the results is presented in Table 1.

Table 1. Assessment section

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentages (Frequencies)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important issues for client were discussed fully</td>
<td></td>
</tr>
<tr>
<td>Client was involved in initial care plan</td>
<td></td>
</tr>
<tr>
<td>Client’s opinions were taken into account</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>86.7% (39/45)</td>
</tr>
<tr>
<td></td>
<td>65.9% (27/41)</td>
</tr>
<tr>
<td></td>
<td>81.4% (35/43)</td>
</tr>
</tbody>
</table>

* figures exclude missing data (i.e. participants who did not answer particular questions)

In addition to these results, 65% (26/40) respondents were seen by someone from the CMHT within two weeks of the referral and 35% (14/40) waited for more than two weeks before they met with a member of the team.
Section B - Key worker

A summary of the results of this section is presented in Table 2.

Table 2. Key worker section

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentages (Frequencies)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client knows who their key worker is</td>
<td>88.9% (40/45)</td>
<td>11.1% (5/45)</td>
</tr>
<tr>
<td>Client had special requirements about key worker and these were taken into account</td>
<td>13.3% (6/45)</td>
<td>86.7% (39/45)</td>
</tr>
<tr>
<td>Client knows how to contact key worker</td>
<td>93% (40/43)</td>
<td>7% (3/43)</td>
</tr>
<tr>
<td>Client knows who to contact if key worker is not available</td>
<td>77.3% (34/44)</td>
<td>22.7% (10/44)</td>
</tr>
</tbody>
</table>

The majority of respondents (68.9%) identified a Community Psychiatric Nurse as their key worker followed by a Social Worker (17.8%). These results are similar to data from the initial sample.

In relation to the frequency of contact with the key worker, 75% (34/43) of respondents were satisfied with it, 11.1% (5/43) would like to see their key worker more often and 8.9% (4/43) would like to see less of their key worker.

Section C - Review meeting

A proportion of respondents (24.4% - 11 respondents) had not had a review meeting. Of these, seven clients (15.9%) had been in contact with the team for more than one year.
The following results only refer to respondents who had a review meeting prior to this study. A summary is presented in Table 3.

Table 3. Review meeting section

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentages (Frequencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Client was given information about review meeting</td>
<td>83.3% (25/30)</td>
</tr>
<tr>
<td>Client had a review meeting within six months of coming into contact with the service</td>
<td>76% (19/25)</td>
</tr>
<tr>
<td>Client was satisfied with number of people present at the meeting</td>
<td>81.2% (26/32)</td>
</tr>
<tr>
<td>Client was able to express views at the meeting</td>
<td>90.6% (29/32)</td>
</tr>
<tr>
<td>Client felt views were listened to at the meeting</td>
<td>83.9% (26/31)</td>
</tr>
<tr>
<td>Relatives or carers were involved in decisions about care plan</td>
<td>73.3% (22/30)</td>
</tr>
<tr>
<td>Client was given a copy of the care plan</td>
<td>60.6% (20/33)</td>
</tr>
</tbody>
</table>

With regard to the number of people present at the meeting, 12.5% (4/32) of respondents felt there were too many people and 6.3% (2/32) reported that there were not enough people at the meeting.
One client reported that relatives or carers had been involved in the care plan against their wishes and 2 participants reported that no relatives or carers were involved in their care plan although they wished there had been.

Out of 31 respondents, 25.8% (8) were very satisfied with the review outcome, 48.4% (15) were satisfied, 16.1% (5) were neither satisfied nor dissatisfied, 3.2% (1) were dissatisfied and 6.5% (2) were very dissatisfied.

Section D - General opinion

A summary of the results for this section is presented in Table 4.

Table 4. General satisfaction section

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentages (Frequencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Needs were met by care received at CMHT</td>
<td>83.3% (35/42)</td>
</tr>
<tr>
<td>If client had a complaint it would be listened to</td>
<td>75% (33/44)</td>
</tr>
<tr>
<td>If a friend needed similar help, client would recommend CMHT services</td>
<td>80% (36/45)</td>
</tr>
</tbody>
</table>

The quality of the service received was rated as very good by 36.4% (16/44) of participants, as good by 52.3% (23/44), as neither good nor bad by 4.5% (2/44), as poor by 4.4% (2/44) and as very poor by 2.3% (1/44) of participants.
Qualitative data

The mean response rate to the open questions of the questionnaire was 30% (15.5% to 51.5% range). The method of content analysis was used to extract units of meaning from the answers obtained and grouping them into descriptive categories (based on the method described by Miles & Huberman, 1994 and Pauli & Bray, 1998). This was done for each of the six questions (see Appendix IV).

To demonstrate the reliability of the coding, a second rater (BK) coded each of the statements. Inter-rater agreement was 97.6%.

In relation to the role of the key worker 7/14 participants commented on the help offered by their key worker and 4 people referred to the time and mode of contact with the key worker. Other comments were related to staff leaving the CMHT (2/14) and lack of skills of the key worker (2/14).

The themes emerging from statements on the most helpful component of the review meeting were the sense of support (5/19), being given the opportunity to discuss treatment alternatives (4/19), being able to express oneself (3/19), different professionals getting together (2/19), meeting with the doctor (3/19), and dissatisfaction with the meeting (2/19). The least helpful aspect of the meeting included feeling one’s views were not being taken into account (4/8), feeling pressured to accept treatment offered (2/8), not having enough time (1/8) and too many people present at the meeting (1/8).

Some themes referring to needs not met by care received referred to medical care, especially related to medication (4/14), not being taken into account by professionals (4/14), lack of information (2/14), no access to alternative treatments (2/14), lack of support (1/14) and requesting more experienced staff (1/14).
Suggestions for improvement of the CMHT had the highest response (23 statements) and the themes included reference to staff levels and organisational issues (7/23), frequency of contact with staff (6/23), training of staff (2/23), information provided (2/23), access to different treatments (1/23) and the physical conditions of the CMHT (1/23). Five participants felt that the CMHT did not need to be improved.
Discussion

The aim of this study was to collect users’ views on the care they receive at the CMHT in relation to the CPA. This aim was achieved and conclusions can be drawn from the data obtained. However, some limitations of the study need to be taken into account. The main limitation of this study was the relatively low response rate. Although it is within the expected rate for postal surveys in mental health settings (Ruggeri, 1994), it still raises questions about the representativeness of respondents and their views.

The fact that the questionnaire was developed specifically for this study has the disadvantage of not allowing comparisons with other studies and of it not being possible to ascertain its psychometric characteristics. However, the development of the questionnaire provided an opportunity to involve local users in the study and make it specific to the service and aims of the study.

CPA and government guidelines
In relation to assessment and development of the initial care plan, most participants reported that the issues that were important to them at the time of referral had been discussed fully. However, 34.4% of respondents did not feel involved in deciding what should be included in the initial care plan. This might be related to the fact that professionals tend to include in care plans the types of services they know they can provide, but this might give rise to unmet needs.

There were 11.1% of users who did not know who their key worker was, 7% did not know how to contact their key worker and 22.7% did not know who to contact if the key worker was not available. This contrasts with the Government recommendations regarding the role of the key worker.
In relation to the review meeting, the Government recommended that these should take place every six months. In this sample, 15.9% of respondents had been in contact with the team for more than one year and did not have a review meeting during that time. Furthermore, for 24% of clients who had had a review meeting, it took place more than six months after they came into contact with the service. With regard to the multidisciplinary care plan, 39.4% of users did not have a copy of their care plan.

**Satisfaction with services**

The results of this survey indicate that the majority of users is satisfied with the services they receive and this is consistent with other studies on user satisfaction (Ruggeri, 1994). However, 20% of respondents would not or did not know if they would refer a friend to the services. In an indirect way, this question might have been more sensitive to users who were not satisfied with the services at the CMHT. When asked more specifically about the review meeting, a smaller proportion of participants reported being satisfied or very satisfied. This is consistent with the idea that specific questions about care will provide more meaningful answers from users (Ruggeri, 1994 and Stallard, 1996).

The open questions also revealed some areas which would need further investigation. Specifically three main themes emerged in more than one of the sections: several participants mentioned not being taken into account or not being listened to by staff; another aspect mentioned was related to staff turnover; and a final aspect was the wish for more information regarding treatment. Interestingly, the positive comments emerging from these questions were complementary to the ones above: being listened to and receiving support and being given information and choice about treatment alternatives. This clearly indicates that these are valued aspects of care which should be taken into consideration by staff at the CMHT.
Implications for the service
In any service evaluation, the ultimate goal is to improve the service and assist in the achievement of stated objectives (Skaife, 1995). This study provides useful data which could inform future changes at the CMHT. Particularly, it might be appropriate to review the system of appointment cards which contains the CMHT's address and phone number and name of key worker. It might be useful to include in these, the telephone number of crisis services and information about who to contact if the key worker is not available. In terms of the review meeting, it was clear from this survey that users value being given information about treatments and being given the opportunity to express their concerns. It would be relevant to explore this aspect further in terms of what would be the most effective means of achieving this.

Conclusion

This survey was a pilot study on the views of users of a Community Mental Health Team on the Care Programme Approach. As a pilot study, it provided initial information about issues which should be further explored. These included ensuring that clients know who their key worker is and who to contact if they are not available, taking into account the client's views when developing care plans and where possible give information about treatments. The results presented above will be feedback to the team and further discussion will be encouraged.
References


Dear Anna,

Care Programme
Approach Audit 16th August 2000

I am writing to say thank you for presenting the result of your research. The Team are very grateful for the hard work that went into it.

We wish you all the best of luck for the future.

With kind regards,

Yours sincerely,

[Handwritten signature]

Senior Nurse Practitioner
Acting Community Manager
APPENDICES

Appendix I: Questionnaire

Appendix II: Cover Letter

Appendix III: Reminder Letter

Appendix IV: Qualitative Statements and Categories
Appendix I
Questionnaire
Questionnaire
Service users' views

Thank you very much for your help. The questions in this questionnaire can be answered by ticking the box next to the answer that applies to you.

Section A
When you first came into contact with the service, did you feel that the issues that were important to you at the time were discussed fully?
Yes [ ] No [ ]

How soon after you were referred did you meet with someone from the service?
Less than two days [ ] Within three weeks [ ]
Within one week [ ] Within one month [ ]
Within two weeks [ ] More than one month [ ]

How involved were you in deciding what was in your initial care plan?
As much as I wanted [ ] Not as much as I wanted [ ]

Did you feel your opinions were taken into account when developing your initial care plan?
Yes [ ] No [ ]

Section B
Do you know who your key worker is?
Yes [ ] No [ ]

If you answered Yes, how soon, after your first contact with the service, were you told who your key worker was?
Within one week [ ] Within one month [ ]
Within two weeks [ ] More than one month [ ]

Is your key worker?
a community psychiatric nurse [ ]
a social worker [ ]
a psychiatrist [ ]
an occupational therapist [ ]
a psychologist [ ]
other [ ] Please specify..............................................
I don’t know [ ]

Did you have any special requirements about who should be your key worker (for example in terms of gender, ethnicity or profession)?
Yes [ ] No [ ]
If you answered yes, were these requirements taken into account by the service?
Yes □ No □

Do you know how to contact your key worker?
Yes □ No □

Do you know who to contact if your key worker is not available and you need help?
Yes □ No □

How often do you normally see your key worker?
More than once a week □ Once a month □
Once a week □ Less than once a month □

How satisfied are you with how often you see your key worker?
I would like to see them more often □
I am satisfied with how often I see them □
I would like to see them less often □

Do you have any other comments about the role your key worker is taking in your care?
........................................................................................................................................
........................................................................................................................................

Section C
Have you had a review / care plan meeting?
Yes □ No □

If you answered No go to Section D

Were you given information about the review / care plan meeting?
Yes □ No □ I don’t know □

How soon after you came into contact with the service did you have a review / care plan meeting?
Within two weeks □ Within three months □
Within one month □ Within six months □
Within six weeks □ More than six months □

Were you satisfied with the number of people present at the meeting?
Yes □
No, there were too many people □
No, there were not enough people □

Were you able to express your views at the review meeting?
Yes □ No □
Did you feel your views were listened to in the review / care plan meeting?  
Yes 1  No 2

Was there any of your relatives or carers involved in decisions about your care plan?  
Yes, according to my wishes 1  
Yes, against my wishes 2  
No, although I wished there was 3  
No, according to my wishes 4

Were you given a copy of your care plan?  
Yes 1  No 2

How satisfied were you with the review outcome?  
Very satisfied 1  
Satisfied 2  
Neither satisfied nor dissatisfied 3  
Dissatisfied 4  
Very dissatisfied 5

What was the most helpful thing at the meeting? 
.............................................................................................................................................

What was the least helpful thing at the meeting? 
.............................................................................................................................................

Section D  
In your opinion, were your needs met by the care you received at the team?  
Yes 1  No 2

Could you tell us which of your needs were not met by the care you received at the CMHT? ............................................................................................................

How would you rate the quality of the service you received?  
Very poor 5  
Poor 4  
Neither good nor bad 3  
Good 2  
Very good 1

If you had a complaint about the service, do you feel it would be listened to by someone in the team?  
Yes 1  No 2  I don't know 3
If a friend of yours needed similar help would you recommend the services at the CMHT?

Yes □  
No □  
I don’t know □

Can you tell us how you think the services at the CMHT could be improved?

..................................................................................................................................

Is there anything else you would like to tell us?
..................................................................................................................................

Section E - To better analyse the results it would be helpful if you could give us some information about yourself. We can reassure you that we will not be able to identify you through this and that this information will remain confidential.

Sex:  
Male □  
Female □

Age:
Less than 25 years □  
Between 26 and 35 years □  
Between 36 and 45 years □  
Between 46 and 55 years □  
Between 56 and 65 years □  
More than 65 years □

Ethnic origin:  
White British □  
White Other □  
Black Caribbean □  
Black African □  
Black Other □  
Indian □  
Pakistani □  
Bangladeshi □  
Chinese □  
Other □

How long have you been in contact with the team?
Less than three months □  
Between three and six months □  
Between six months and one year □  
Between one and two years □  
Between two and five years □  
More than five years □

Why were you referred to the CMHT?

..................................................................................................................................

Have you ever been in hospital because of this problem?

Yes □  
No □

Thank you very much for your help.
Appendix II
Cover Letter
Dear ..

One of the best ways to improve the services we offer at the Community Mental Health Team is to hear the opinions of those in our care. To do this we are asking people who were or are in contact with the Team for their opinions.

It would be of great help if you could complete the questionnaire enclosed. We also enclose a pre-paid envelope for you to return it to us.

We are sending the same questionnaire to everyone who was seen by two or more members of the Team and who were on our list of clients during recent months.

Your feedback is anonymous and confidential and none of the people involved in your care will have access to it. In fact, we do not want you to put your name in the questionnaire.

Although we hope you will return the questionnaire, your participation is voluntary. If you choose not to return it, the care you receive at the Team will in no way be affected.

Once we analyse the results, they will be discussed by the team and will help to plan our future services.

If you have any further questions do not hesitate to contact me at the telephone number or address below.

I would be most grateful if you could return the questionnaire by 17 March 2000.

Thank you very much for your assistance.

Yours sincerely

Trainee Clinical Psychologist
Appendix III
Reminder Letter
9th March 2000

Dear [Name],

A couple of weeks ago we sent you a letter. In that letter we invited you to tell us what you thought about the services you received at Community Mental Health Team. Quite a lot of the people we wrote to completed the questionnaire, but we hoped we could hear from everyone. We believe your opinion is important. If you have already replied, please accept our apologies and you can ignore this letter.

It would be of great help if you could complete the questionnaire. If you feel you would like some help with it you can ask a friend, relative or carer.

Your feedback is anonymous and confidential and none of the people involved in your care will have access to it.

Although we hope you will return the questionnaire, your participation is voluntary. If you chose not to return it, the care you receive at Community Mental Health Team will in no way be affected.

If you have any further questions do not hesitate to contact me at the telephone number or address below.

Thank you very much for your assistance.

Yours sincerely

[Name of the Trainee Clinical Psychologist]
Appendix IV
Qualitative Statements and Categories
Question: Do you have any other comments about the role your key worker is taking in your care?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Statements</th>
</tr>
</thead>
</table>
| Help offered     | - Doing their best  
                   - I found her very easy to talk to and she was very caring.  
                   - I am satisfied with the service I receive.  
                   - Has supplied help and support for me - the whole family for which we are extremely grateful.  
                   - Arranging me to get back into the community.  
                   - Excellent supportive relationship and without whom I probably would not have coped.  
                   - He is very helpful over entitlements and generally. |
| Lack of skills   | - Not able to give much help. I think it is the wrong skills.  
                   - Doesn’t listen to basic social or problems in society. |
| Time and mode of contact | - When I’ve not been well enough to keep an appointment no one has rung me to see how I am.  
                          - Sometimes she phones which is fine - instead of visiting.  
                          - Don’t see CPN enough when do need to see her.  
                          - She’s either away or too busy, no structure to visits. |
| Staff leaving    | - Some staff leaving.  
                   - She has since left you and put me in touch with another counsellor (out worker) who has also been very helpful. |
Question: What was the most helpful thing at the meeting?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Statements</th>
</tr>
</thead>
</table>
| Meeting with the Doctor     | - To speak to the Doctor who was reassuring and told me that the anti-depressants I was on were not addictive.  
                                - Seeing the doctor.  
                                - That I had my doctor. |
| Discussing treatment       | - Monitoring the correct medication level and given the choice of alternative medication.  
                                - Help me in drugs.  
                                - Selecting how often to meet.  
                                - Offered help with other issues. |
| People involved in care    | - Every one involved in my care getting together, we all knew what was going on.  
                                - The fact that I knew everyone there (I had met them all before, nobody was unfamiliar). |
| Getting together           |                                                                                |
| Dissatisfied with meeting  | - Outcome unsatisfactory but new developments now satisfied new care.  
                                - Last time I felt dissatisfied in the meeting. |
| Being able to express      | - My views were listened to.  
                                - Talking about my problems.  
                                - To be able to express myself fully as regards my mental health problem. |
| oneself                    |                                                                                |
| Support                    | - Key worker for making me feel much more confident.  
                                - Reassurance.  
                                - Sense of support.  
                                - Reassurance. |
Question: What was the least helpful thing at the meeting?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not being taken into account.</td>
<td>- You are supposed to be intelligent but really you are considered stupid.</td>
</tr>
<tr>
<td></td>
<td>- Not being listened to.</td>
</tr>
<tr>
<td></td>
<td>- Doctor was totally disinterested with my physical condition but did his best to help my husband and I.</td>
</tr>
<tr>
<td></td>
<td>- Once meeting ended all decisions were changed without consulting me!</td>
</tr>
<tr>
<td>Pressure to accept treatment offered</td>
<td>- Feeling pressured into accepting the consultant's views.</td>
</tr>
<tr>
<td></td>
<td>- I kept to my side on his suggestion - my husband didn't.</td>
</tr>
<tr>
<td>Not enough time.</td>
<td>- On certain aspects not highlighted because of short time scale.</td>
</tr>
<tr>
<td>Number of people present</td>
<td>- Maybe too many people.</td>
</tr>
</tbody>
</table>
Question: Could you tell us which of your needs were not met by the care you received at the CMHT?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>- Should have been in hospital sooner.</td>
</tr>
<tr>
<td></td>
<td>- Medicine not reviewed often enough.</td>
</tr>
<tr>
<td></td>
<td>- Feel I could have been prescribed present medication and dosage some time ago.</td>
</tr>
<tr>
<td></td>
<td>- Drugs causing problems.</td>
</tr>
<tr>
<td>Lack of information</td>
<td>- Not sufficiently clear why I have to stay under section 117.</td>
</tr>
<tr>
<td></td>
<td>- Would liked to have known about newer medication with less side effects at an earlier stage.</td>
</tr>
<tr>
<td>Access to different types of treatment</td>
<td>- Better advice in forming relationships with people e.g. getting a partner.</td>
</tr>
<tr>
<td></td>
<td>- Need for more in-depth psychotherapeutic-type counselling.</td>
</tr>
<tr>
<td>Not being taken into account</td>
<td>- Working together with my CPN.</td>
</tr>
<tr>
<td></td>
<td>- Lack of social freedom.</td>
</tr>
<tr>
<td></td>
<td>- Did not feel I was being heard when discussing problems.</td>
</tr>
<tr>
<td></td>
<td>- As mentioned I transferred from the Doctor. After last meeting I mentioned my pain following a car accident when he eventually asked CPN how I was. He did not know I had a back problem which I think you would agree proves my point.</td>
</tr>
<tr>
<td>Lack of support</td>
<td>- Not enough support.</td>
</tr>
<tr>
<td>Experience of staff</td>
<td>- I repeatedly had to see a trainee psychiatrist. Whereas I feel I should have seen someone with more experience at least on alternate visits. Because, as soon as I saw the consultant my medication was changed and my illness improved much quicker.</td>
</tr>
</tbody>
</table>
Question: Can you tell us how you think the services at the CMHT could be improved?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff levels and organisational issues</td>
<td>- Obtain a full complement of staff instead of overlapping and stretching staff levels as a result.</td>
</tr>
<tr>
<td></td>
<td>- Less staff changes.</td>
</tr>
<tr>
<td></td>
<td>- Get more staff so the work load is better so improving care to clients.</td>
</tr>
<tr>
<td></td>
<td>- CPNs should liaise more with each other so that if they are away it is clear who a client may otherwise contact in an emergency.</td>
</tr>
<tr>
<td></td>
<td>- I think that users should be allowed to see another consultant if they do not feel that Doctor is of help.</td>
</tr>
<tr>
<td></td>
<td>- Continuity of same psychiatrist.</td>
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<td></td>
<td>- More support if your CPN is off especially long-term.</td>
</tr>
<tr>
<td>Training</td>
<td>- Use properly trained staff.</td>
</tr>
<tr>
<td></td>
<td>- Staff to be trained in being attentive to clients and improve listening skills.</td>
</tr>
<tr>
<td>Frequency of contact</td>
<td>- More effort on part of key worker to keep in touch.</td>
</tr>
<tr>
<td></td>
<td>- See me more.</td>
</tr>
<tr>
<td></td>
<td>- Less intensive care for people classed as difficult.</td>
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<td></td>
<td>- More time more regularly should be allotted regarding appointments with a psychiatrist to ascertain the true root problem of the patient.</td>
</tr>
<tr>
<td></td>
<td>- As said earlier every patient should get to see the consultant at least once a month.</td>
</tr>
<tr>
<td>More information</td>
<td>- By making section 117 reviews clearer.</td>
</tr>
<tr>
<td></td>
<td>- Come and explain more</td>
</tr>
<tr>
<td>Access to different treatments</td>
<td>- I would like to be referred to a sleep therapist.</td>
</tr>
<tr>
<td>Physical conditions</td>
<td>- I think the waiting room should be separated from the phone/reception desk as confidential info can be heard by anyone waiting when discussion goes on at the desk or on the phone.</td>
</tr>
</tbody>
</table>
| No improvement      | - I am very happy with all the services I have received.  
                       - No need for improvement.  
                       - Cannot be improved.  
                       - Stay the same.  
                       - Very happy with treatment. Doctor very helpful with care. |
**Question:** Is there anything else you would like to tell us?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational issues at CMHT</td>
<td>- Continuous recruitment at various levels to CMHT as need arises - all staff.</td>
</tr>
<tr>
<td>Treatment</td>
<td>- I have just come out of hospital and still need help.</td>
</tr>
<tr>
<td></td>
<td>- You have left medicines too long without review.</td>
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<tr>
<td></td>
<td>- I was left for too long just seeing a trainee.</td>
</tr>
<tr>
<td>Information</td>
<td>- Explain in detail how the drugs work to improve illness.</td>
</tr>
<tr>
<td>Gratitude</td>
<td>- Thank you for your on-going support and treatment.</td>
</tr>
<tr>
<td>Dissatisfaction</td>
<td>- At the moment this system sucks!</td>
</tr>
</tbody>
</table>
A review of recent literature on borderline personality disorder: concept validity and treatment effectiveness

Literature Review

Year II PsychD in Clinical Psychology

University of Surrey

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Word Count: 4991
Introduction

Over the last 20 years much interest has been given to the area of personality disorders (PDs) both in terms of research and clinical practice. This interest followed the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychological Association (APA), 1980) where PDs were placed separately (axis II) from other psychiatric diagnoses. Over the last 10 years this interest has also been apparent in the media and political arenas. Questions have been raised about the dangers people with PDs might pose to the public in general and whether or not society has the right to detain people with these diagnoses on this basis. Other questions discussed have been the treatability of these disorders and the resources which should be made available for their management and treatment (Campling, 1998; Marlowe & Sugarman, 1997)

Within the different categories of PDs, the literature on borderline personality disorder (BPD) has shown the most significant rate of growth since the DSM-III publication (Blashfield & Intoccia, 2000). One reason for this might have been the recognition of the burden this disorder poses to mental health services. In DSM-IV the estimated prevalence of this disorder among out-patient mental health services is 10%, and 20% among in-patient services. Furthermore, it is estimated that 30-60% of all patients with a diagnosis of PD have BPD and that patients with this disorder tend to exhibit high levels of use of mental health services (APA, 1994).

Despite this interest, the study of BPD has been characterised by controversy. One aspect of this debate has been the definition of the disorder itself (Parnas, 1994; Simosen, 1994; Zimmerman & Mattia, 1999). Since the borderline construct was first introduced by Stern (1938, cited in Gunderson, 1994) it has undergone many changes and at present its description and assessment are still a matter of discussion. Furthermore, many authors
have criticised the way in which this diagnosis is used in clinical practice, where it is often given to ‘difficult’ clients (Higgit & Fonagy, 1993).

Another area of interest has been the development and evaluation of different treatment models for BPD. Due to its complexity and difficulty in treatment, this disorder has stimulated the development of different treatment approaches which attempt to address the limitations of more established models (for example, Bateman, 1995; Linehan, 1993; and Ryle, 1997).

These two areas of research, concept validity and treatment effectiveness, will be addressed in turn in the following review. In the first section the concept of BPD will be described and issues related to co-morbidity of this disorder with other diagnoses, level of homogeneity within this diagnostic category, and problems in the reliable assessment of this disorder, will be addressed.

The second section will present a brief review of studies on treatment effectiveness for BPD. Although the different treatment models to be addressed are linked to specific theoretical formulations related to causal and maintaining factors of the disorder, these will not be described in detail due to the lack of empirical verification and to space limitations.

The studies addressed in this review were selected in terms of their present relevance in the field and their recency. Therefore, some older studies were reviewed if they continue to be cited in different publications today. Also, in the sections on assessment of BPD, and treatment effectiveness, readers are referred to previous reviews (Bateman & Fonagy, 2000; Perry, 1992; Stone, 1993; Zimmerman, 1994) for a more comprehensive analysis of the literature.
Validity of BPD Concept

Definition
The term personality disorder is defined in DSM-IV (APA, 1994) as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control” (p. 630). This pattern is inflexible; leads to clinically significant distress; is stable and of long duration; and is not better accounted for by another mental disorder, medical condition or use of substances. Within this broad definition there are several specific diagnoses of which one is borderline personality disorder.

The term borderline was first used by Stern (1938, cited in Gunderson, 1994) to describe patients who could not be fitted into either psychotic or neurotic organisations as understood within psychoanalytic theory and who persistently pushed the boundaries of therapy. Since then, Kernberg and other psychoanalytic authors (Clarkin, Yecomans & Kernberg, 1999) have described the term borderline personality organisation as a concept to describe a group of patients who exhibit: 1) identity diffusion, 2) primitive defence mechanisms such as splitting and 3) maintenance of reality testing. The term borderline indicates that this concept shares characteristics of both psychotic (first two points) and neurotic structures (the maintenance of reality testing). This concept, according to the authors, encompasses several diagnostic categories as defined in DSM-IV such as schizoid personality disorder, borderline personality disorder and paranoid personality disorder, for example. This definition thus refers more to a specific theoretical understanding used to guide psychoanalytic practice, than to a diagnostic category.
From DSM-III onwards (APA, 1980, 1987, 1994) efforts were made to operationalise the criteria for the diagnosis of BPD (as well as other personality disorders) to allow for more reliable diagnosis. In DSM-IV, BPD is defined as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (APA, 1994, p. 654) (see Appendix for full criteria).

Although much progress has been made since the first definitions of BPD were put forward, there are still several problems associated with the validity of the above definition. Some of these problems relate to the definition of PDs in general whereas others are specific to the BPD category. One of the problems discussed in the literature is the low specificity (high level of co-morbidity) of the categories presented in the DSM manuals. Another relates to the heterogeneity of people diagnosed with BPD and a further, more practical problem relates to the characteristics of the assessment tools used to diagnose PDs. These three areas will be discussed below.

Co-morbidity of BPD with other axis I and axis II disorders

One of the criticisms that has been directed toward the criteria for PDs in the DSM manuals is the fact that, to increase objectivity and reliability, the criteria have been defined in behavioural terms which are thought to be the result of rigid ways of thinking and perceiving the world (Marlowe & Sugarman, 1997). These behavioural characteristics are actually symptoms which are present in many of the affective disorders which are part of axis I of the manual (Bank & Silk, 2001; Parnas, 1994). For example, in relation to BPD, the criteria of impulsivity (Criteria 4, see Appendix) can be characterised by substance abuse and this can also be classified under axis I substance misuse diagnosis. This fact can make differential diagnosis difficult and lead to a high level of co-morbidity in people diagnosed with BPD.
In a recent study, McGlashan, Grilo, Skodol, Gunderson, Shea et al., (2000), assessed the diagnostic co-occurrence of axis I and axis II diagnosis in four groups of patients diagnosed with a PD (schizotypical, borderline, avoidant and obsessive-compulsive). They found that the group of patients diagnosed with BPD showed a high level of co-morbidity for major depression (70.9%), post-traumatic-stress disorder (46.9%), alcohol abuse (52%) and drug abuse (53.1%). This study had the limitation of assigning patients to each group who met the criteria for more than one of the four groups of PDs, which makes the within-group homogeneity questionable. However, it clearly indicates that there is considerable co-morbidity for BPD and other axis I diagnoses which has also been reported by other authors (Bank & Silk, 2001; Links et al., 1995; Zanarini, Frankenburg, Dubo, Sickel, Trikha et al., 1998). Three explanations can be offered to account for this observation: a) BPD is related to other axis I disorders making BPD diagnosed individuals more vulnerable to these disorders; b) axis I and axis II disorders are independent and coexist in certain individuals; or c) the current definition and assessment methods of BPD are inadequate and do not allow for sufficient discrimination from other disorders. The above questions continue to be investigated in current literature (Bank & Silk, 2001; Berelowitz & Tarnopolsky, 1993; McGlashan et al., 2000; Westen & Shedler, 1999).

In addition to the above discussion, individuals meeting the criteria for BPD also exhibit a high level of co-morbidity with other PDs. In the above study by McGlashan et al. (2000), BPD co-occurred significantly with antisocial and dependent personality disorders. The methodology of the study did not allow for the interpretation of co-morbidity levels between the four groups of PDs studied (since individuals were assigned to each group by severity of disorder which meant that an individual in the BPD group could also meet the criteria for avoidant PD). In another study (Dolan, Evans & Norton, 1995), it was found that 86% of patients referred to a specialist service for PDs met the criteria for BPD and presented with a mean number of 6 PD diagnoses. In a comparison group of undergraduate students the mean number of diagnoses was 3.4. This study had
several limitations, such as the use of a self-report measure, which tends to overdiagnose PDs in comparison with other methods (Zimmerman, 1994). Although both studies had some limitations, they indicate that there is a considerable level of co-morbidity between BPD and other PDs and this has implications for the validity of this diagnosis since it does not allow for sufficient discrimination with other disorders.

The problem of co-morbidity poses problems both to research and clinical practice. In terms of research it will be difficult to find 'pure' examples of this diagnosis in order to evaluate treatment effectiveness. It also makes it difficult to decide which problem or disorder to address first in clinical practice if an individual diagnosed with BPD presents with a number of other axis I and II disorders. Several authors have recently argued that the solution to this problem could be to switch from a categorical diagnostic system to a dimensional one, as it has been the case in the study of personality (Bank & Silk, 2001; Maffei & Fossati, 1999; Westen & Shedler, 1999). This new system would allow for more flexibility in diagnosing personality pathology by allowing clinicians to position clients within a continuum of certain personality traits instead of just stating a certain diagnosis as being present or absent. However, the research on personality and personality pathology is still insufficient (many models have been proposed but no single one has proved to be superior to others in describing basic personality traits) to allow for this system to be implemented (Maffei & Fossati, 1999).

**Homogeneity of BPD category**

Several authors have suggested that there might be more than one category of borderline patients and some have criticised the DSM manuals for not accounting for the variability of borderline presentations (for example, Whewell, Ryman, Bonanno & Heather, 2000). In DSM-IV, only five out of a total of nine diagnostic criteria need to be met for a BPD diagnosis to be made. This in effect leads to a vast number of possible combinations of presentation which could vary a great deal from each other. It would therefore be
interesting to investigate whether there are specific clusters of symptoms which tend to co-occur indicating possible sub-types of BPD.

In one study the scores of 288 patients diagnosed with BPD on a self-report questionnaire were analysed (Whewell et al., 2000). Through factor analysis, the authors identified two criteria which appeared to represent the core of borderline symptomatology: unstable relationships and identity confusion. They also identified two groups of symptoms which appeared to co-occur within this category: one comprising impulsive/addictive behaviour, suicidal/self-harm behaviour and fear of abandonment which the authors called calm-internalising factor and another comprising the criteria of moodiness and anger which the authors named mood-externalising factor. Although this study presented some interesting results, it also suffered from several limitations such as the use of a self-report questionnaire (see section on assessment methods for PDs below). Also, the loadings on each factor differed for men and women, making it difficult to make generalisations about the findings.

In another study, the results of a structured diagnostic interview for PDs of 564 patients admitted into an in-patient unit were analysed (Maffei & Fossati, 1999). As with the previous study the authors found that the criteria of unstable relationships and identity disturbance provided the best diagnostic accuracy for BPD. Through factor analysis of the results of 100 of the patients diagnosed with BPD, the authors did not find clear groupings of criteria to form sub-types for this disorder, contrary to the previous study. However, it is important to note that the two studies used different assessment methods which might have influenced the results (see next section on agreement between different assessment methods).

From the previous studies, it appears that the two criteria which present as the core features of BPD and which provide the best level of accuracy for diagnosis are the
presence of unstable relationships and identity disturbance. There is no conclusive evidence at present that this category can be divided into sub-types.

Assessment of BPD
Since the publication of DSM-III, several instruments have been developed to assess PDs (see Perry (1992) for a review). Although, most of the instruments developed were based on the diagnostic criteria set out in the DSM manuals, it has been found that the agreement between different diagnostic methods is poor with a median kappa value of 0.25 (the accepted kappa value for fair to good agreement is 0.40 and above (Shrout, Spitzer & Fleiss, 1987)) (Perry, 1992). In his review, Perry (1992) concluded that semi-structured interviews in general held higher levels of agreement than self-report measures with the latter ones tending to overdiagnose PDs. Zimmerman (1994) suggested that self-report measures are highly subjective and can be influenced by the individual’s state rather than identifying long-standing personality characteristics.

The above findings refer to the assessment of PDs in general. In relation to BPD, one study evaluated the validity of a self-report questionnaire for this disorder (Marlowe, O’Neill-Byrne, Lowe-Ponsford & Watson, 1996). The authors calculated the agreement values between the Borderline Syndrome Index (BSI) (Conte et al, 1980, cited in Marlowe et al., 1996), a self-report measure, and the Personality Assessment Schedule (PAS) (Tyrer, 1988 cited in Marlowe et al., 1996), a semi-structured interview, of 50 patients referred to an out-patient department. The authors found a poor level of agreement between the two instruments for the identification of BPD (kappa = 0.12). Furthermore they found that the BSI levels were significantly correlated with the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) and with the Symptom Checklist-90 (Derogatis, 1983). The authors concluded that the BSI was not an effective measure in identifying BPD cases and that it seemed to be influenced by the state of the individual. However, it is important to note that the validity of the PAS was
not reported in this study and the poor agreement between the two instruments might have been due to limitations of this measure in addition to problems with the BSI.

From the evidence presented above it appears that at present, assessment tools for the diagnosis of PDs are still rudimentary and more research is needed to identify efficient diagnostic tools and to refine the existing measures. It has also been found that the methods used to diagnose PDs in research differ from the methods used in clinical practice which tend to be based more on clinical judgement from unstructured interviews rather than standardised tools (Westen, 1997; Zimmerman & Mattia, 1999). In one interesting survey, Westen (1997) found that clinicians tended to rely more on the narratives and behaviour of patients during interviews to diagnose PDs rather than on direct questioning (which is usually utilised in semi-structured interviews for PDs). The author also found that clinicians found direct questioning in relation to the presence or absence of certain symptoms or traits more useful in diagnosing axis I disorders.

Westen (1997) argued that the current research methods for assessing axis II disorders, which were developed in the same manner as instruments for axis I disorders, might not be appropriate for the assessment of maladaptive personality patterns. However, it is also possible that clinicians' tendency to rely less on structured assessment methods for PDs was due to lack of time or access to these methods or that they prioritised diagnoses of axis I disorders which might be more relevant for immediate treatment. This latter hypothesis seems to be supported by one study where it was found that when clinicians had access to a semi-structured interview for BPD, they tended to make more diagnoses for this disorder than when they only relied on unstructured clinical interviews in their assessments (Zimmerman & Mattia, 1999).

From the above findings it is clear that more research is needed to develop valid assessment tools for PDs. In a recent study (Westen & Shedler, 1999), a new method was used to assess PDs, in which clinicians grouped descriptive statements of personality
traits according to how well each described a particular client (on a scale from 0, not applicable to client, to 7, highly descriptive of client). In this study the authors compared the responses of 797 clinicians relating to 530 real clients and 237 hypothetical prototypical clients corresponding to each of the PD categories in DSM-IV. In relation to BPD, they found a high level of agreement between the descriptions of real clients diagnosed with BPD and the prototypical descriptions given by clinicians. However, they found that the characteristics rated by clinicians as best descriptors of BPD clients differed from the diagnostic criteria set out in DSM-IV (for example, clinicians described BPD clients with statements such as “tends to feel unhappy, depressed or despondent” and “tends to feel he/she is inadequate, inferior, or a failure” (p. 265)). The authors of this study suggested that this different assessment method for BPD could be used to refine the criteria in future editions of the DSM manual since it allows for a more accurate description of what clinicians consider to be important descriptive criteria for the different disorders. This study was interesting in that, contrary to other studies, it developed an instrument which did not rely solely on the diagnostic criteria set out in DSM-IV, but used data from research on personality as well. This is an important aspect since the DSM criteria have been a matter of controversy in the literature as to their validity in describing. As the authors suggested, it will be important to replicate the findings of this study and continue to evaluate the psychometric properties of this new instrument. It will also be important to adapt this method for use in clinical practice since it is very time consuming.

Despite the controversy relating to the definition and assessment of BPD, it is acknowledged by most clinicians that clients with this diagnosis pose a serious burden to mental health resources and several efforts have been made to develop effective treatment models for this disorder. These will be briefly discussed in the next section.

Treatment Effectiveness
In the last 20 years, several efforts have been made to develop and evaluate treatment approaches for BPD. However, it is clear from the literature presented above that studies have been fraught with difficulties. Starting from the fact that the simple definition of this disorder is a matter of discussion, with multiple definitions used (APA, 1994; WHO, 1992; Clarkin, Yeomans & Kernberg, 1999, for example), it is difficult to compare studies which use different definitions. Furthermore, the problem of co-morbidity makes it difficult to find 'pure' cases of this disorder and this might confound any outcome results achieved. Also the lack of valid research tools makes the establishment of baseline and outcome data questionable. Different authors tend to address different aspects of this disorder in their treatment approaches, evaluating outcome in different ways, making the comparison between studies and treatment models difficult (e.g. some studies use symptomatic recovery as a measure of change (Ryle & Golinkina, 2000), while others use behavioural measures such as self-harm and suicide attempts (Linehan, Heard & Armstrong, 1993)).

Despite the above problems, some studies have been published reporting on treatment effectiveness for BPD. Several models have been developed in the treatment of BPD, from cognitive-behavioural models (Linehan, 1993) to models based on psychoanalytic theory (Bateman, 1995) and integrative models, such as cognitive analytic therapy (Ryle, 1997). Some models rely on in-patient treatment (Rosser, Birch, Bond, Denford & Schachter, 1987), whereas others use other approaches such as day-hospital (Bateman, 1995) and out-patient services (Ryle & Golynkina, 2000). In this section several studies will be reviewed relating to the above models.

In a review by Bateman and Fonagy (2000), the authors present some factors which appear to be relevant in achieving moderate success in the treatment of PDs. Some factors identified were that treatment protocols need to be well structured; provide strategies to enhance compliance; have a clear focus; be theoretically coherent to both therapist and
client; be long-term; be well integrated with other services; and encourage an active posture on the part of the therapist.

In a review of long-term outcome for PDs, Stone (1993) reports that 20 to 30 years after first admission to hospital outcome for BPD is generally favourable with two thirds of patients being clinically well. The majority of these patients, however, exhibited some residual mild symptoms with only 20% being asymptomatic. From the samples analysed around 8% of patients committed suicide. Factors which were associated with suicide were alcohol abuse, chaotic impulsivity and a history of physical or sexual abuse. Factors associated with chronic impairment were history of physical and/or sexual abuse and concomitant schizotypal and/or antisocial features. These results point to important characteristics of patients which can guide on the development of treatment plans (for example, it might be relevant to allocate more resources for patients with a history of abuse since this factor seems to be related to outcome). However, from the studies reviewed by Stone, it is difficult to ascertain which factors contributed to outcome since many non-controlled variables could have influenced these results (such as treatment received after first admission). Also, these studies do not provide clear guides in relation to effective components for treatment. They should therefore be seen as providing information of the course of BPD (Bateman & Fonagy, 2000), rather than long-term follow-ups of specific treatment approaches.

Two recent studies examined outcome and factors affecting early termination of treatment in a cohort of patients admitted to an in-patient unit (Chiesa & Fonagy, 2000; Chiesa, Drahorad & Longo, 2000). Although these studies did not include a control group and therefore need to be interpreted with caution, they presented some interesting results. The first study examined 12 month outcome on two groups of patients with PDs admitted to a psychotherapeutic in-patient unit. One group participated in a one-stage programme which consisted of 11 to 16 months of in-patient treatment whereas the other group went through a two-stage model of treatment which consisted of six month in-patient treatment
followed by 12 to 18 months out-patient treatment. The results showed that patients on both groups improved significantly 12 months after admission, however, the two-stage treatment showed significantly better results on measures of social and psychological adjustment. This latter result was more evident in patients with BPD. In their discussion of the findings the authors considered that this finding might be related to the intense separation anxiety often observed in these patients which makes the longer admission followed by an abrupt discharge of the one-stage model more difficult to cope with. It is important to note that patients were not randomly allocated to each group and this might have introduced a bias in the study. Nevertheless, these results seem to indicate that a relatively short admission in a psychotherapeutic unit followed by support in the community can produce good results for patients with BPD. These results refer to outcome after treatment and data referring to follow-up assessments would be important to establish the level of maintenance of gains.

It is also important to note that the drop-out rate for the two groups in the above study was high (47%) and 4% of clients (all from the one-stage group) committed suicide. One study (Chiesa, Drahorad & Longo, 2000), presented data regarding 42 patients (32%) who abandoned treatment within the first 14 weeks. It was found that participants in less skilled employment presented with higher drop-out rates. It was also found that BPD clients' drop-out rate was significantly lower than non-BPD clients and that this was more evident in relation to the two-stage treatment model. These results appear to provide more evidence for the view that a two-stage treatment model is appropriate for BPD clients.

In relation to out-patient treatment, Bateman and Fonagy (1999) found that a partial-hospitalisation programme involving long-term psychoanalytically oriented therapy was superior to general psychiatric services. This was a well-controlled study which randomly allocated patients to groups and evaluated a number of areas, such as symptomatology, length of hospital stay, suicide attempts, self-harm and social adjustment. The partial hospitalisation programme was superior in all measures. Furthermore, no patients
committed suicide and only 12% of patients dropped out of the programme. These results are encouraging and seem to indicate that it is possible to use out-patient services to treat BPD clients. However, the study had the limitation of involving a small number of clients in each group (19). There is also no data at present regarding follow-up and this would be important to assess maintenance of gains.

All of the above studies used psychoanalytic models of therapy. Another model used in the treatment of BPD is dialectical behaviour therapy (DBT) which is based on cognitive and behavioural approaches (Linehan, 1993). In a randomised controlled trial which compared DBT with treatment as usual in a group of women, it was found that after a year of DBT treatment clients showed a reduction in severity of suicide attempts and number and length of hospital admissions (Linehan, Armstrong, Suarez, Allmon & Heard, 1991). Although there were significant differences in these variables between the two groups after treatment in favour of DBT, these were not apparent at one year follow-up (Linehan, Heard & Armstrong, 1993). Also there were no differences between the groups on measures of depression and anxiety after treatment. The results from this study are not clear and might be due to differences in the treatment received by the control group which was not controlled for.

Another recent study evaluated treatment effectiveness on a group of 27 BPD patients receiving out-patient cognitive analytic therapy (Ryle & Golynkina, 2000). This was a naturalistic study with no control group, therefore, results need to be interpreted with caution. The authors found that participants had significantly improved in all measures of symptomatology and interpersonal functioning following treatment. At 18 months follow-up, the gains were maintained in relation to clinical symptoms but not in relation to interpersonal functioning. Fourteen patients no longer met the diagnostic criteria for BPD following treatment. According to this criteria, the sample was divided into two groups ("improved" vs. "unimproved") and they were compared in relation to variables associated with outcome. It was found that unemployment, self-cutting, alcohol abuse and
severity of BPD features were associated with poorer outcome. This study appears to provide evidence for the effectiveness of out-patient treatment for BPD clients. The study had some limitations such as the use of only one measure for the identification of BPD clients (it is usually recommended the use of at least two measures due to the low level of agreement between different measures) and the choice of outcome measures: although the authors presented data on employment, further treatment and other clinical features (such as self-harm) they did not present pre-post comparisons on these measures.

The main conclusion that can be drawn from the studies presented above, is that more randomised controlled trials are needed to establish the most effective treatment for BPD. It would be important to compare in-patient specialist treatment with out-patient approaches since the latter would probably be more cost-effective, if equivalence of results were found. Also, it could be important to establish if some patients would benefit more from one type of treatment over another. The results from studies using out-patient approaches appear to indicate that it is possible to use them effectively in the treatment of BPD (especially in relation to the partial hospitalisation programme used in the study by Bateman and Fonagy (1999)). However, the results from different studies differ quite considerably and it is difficult to compare them due to the different assessment methods used.

Conclusion

This review presented literature related to the validity of the BPD concept and to the effectiveness of treatment for this disorder. Although much progress has been made since DSM-III (APA, 1980) was published, the debate surrounding these issues continues. The problem of co-morbidity of BPD with other axis I and axis II diagnoses poses problems both to research and practice. It appears that this problem can be related to the definition of BPD in DSM-IV (APA, 1994) and research should attempt to address this issue by providing alternatives to the current classification which would lead to a useful evolution
of the concept. The study by Westen & Shedler (1999) has made a valuable contribution in this area. Furthermore, the assessment methods for BPD available at present do not appear to stand as valid, and more attention needs to be paid to this issue in future research. It is likely that both areas of research can benefit from each other, in that the development of assessment tools can lead to a refinement of the category and an understanding of the specific characteristics of this disorder might contribute to the development of more rigorous assessment methods.

In terms of treatment for BPD, the results presented are encouraging in that some models have been developed which appear to achieve good results. The finding that out-patient treatment might be effective is particularly encouraging. However, in most of the studies reviewed, the rate of early termination and suicide is still considerable for all models and this problem needs to be addressed. It will be relevant to ascertain if certain clients with specific characteristics will benefit from one type of treatment over another. It appears that research has yet to address the effective ingredients of treatment for this group of clients.

These results have several implications for clinical practice. From the survey by Westen (1997), it appears that there is a considerable gap between research and practice and attempts to breach this gap would be important. Furthermore, treatment models for this disorder appear to be very specialised and it is unclear how many patients have access to these services. It is likely that the majority of clients are seen within general psychiatric services. It would therefore be important to explore the ways in which general psychiatry can make use of the findings of research and adapt them to its context.
References


APPENDIX

DSM-IV Diagnostic Criteria for Borderline Personality Disorder

(APA, 1994, p. 654)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms
The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis

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ABSTRACT

A wealth of literature has been produced in the last decade in relation to the conceptualisation and treatment of borderline personality disorder. However, no studies have addressed the experiences of psychologists working with this client group in community settings. The present study attempted to address this limitation in the literature. The aims of the study were: to explore psychologists' understanding of BPD; to explore psychologists’ subjective experiences of working with clients with BPD; to identify treatment strategies employed by psychologists; and to identify themes which are likely to influence the establishment and maintenance of a good therapeutic alliance. The participants were 11 clinical psychologists working in Community Mental Health Teams who had experience of working with clients with BPD. A semi-structured interview schedule was developed and participants were interviewed face-to-face regarding their experiences of working with this client group. The interviews were transcribed verbatim and analysed according to the principles of interpretative phenomenological analysis. Three superordinate themes were identified in the analysis: conceptualisation of BPD; reflexivity; and complexity of relationships. Psychologists reported on the importance of relationships within the system of care both in relation to conceptualisation and treatment of BPD. The theme of reflexivity encompassed ideas regarding clients’ difficulty in using a reflective capacity as well as professionals' difficulty in maintaining this capacity whilst working with clients. The importance of establishing and maintaining a good therapeutic relationship with this group of clients was stressed by all participants and strategies to achieve this were suggested.
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INTRODUCTION

The last decade has seen an increased recognition amongst mental health professionals of the challenge that personality disorders, and borderline personality disorder (BPD) in particular, pose in terms of the provision of mental health services (Holmes, 1999; O'Brien, 1998). BPD has been identified as the most common personality disorder in clinical settings, with a prevalence of 10% in out-patient mental health services and 20% in in-patient services (American Psychiatric Association (APA), 1994; 2001). It is also generally accepted that clients with this diagnosis tend to exhibit high levels of use of mental health services (APA, 1994).

The definition of BPD given in the Fourth Edition of the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (APA, 1994) includes the more general definition of personality disorder as an ‘enduring pattern of inner experience and behaviour that deviates markedly form the expectations of the individual’s culture, is pervasive and inflexible’ (p.629). The essential feature of BPD as presented in the manual is ‘a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts’ (p.650). Nine criteria are then offered for the establishment of an accurate diagnosis (see Appendix I for full criteria).

Despite this apparent clarity, the definitions of this disorder and its use in clinical practice have been a matter of continuing debate. Of particular note clinically are the high levels of co-morbidity between this diagnosis and other DSM axis I and II diagnoses, the high level of heterogeneity of people diagnosed with BPD and the inadequacy of most measures used for the diagnosis of this disorder (for a full discussion of these issues see Mendes (2001), this portfolio). These issues have had an impact on the way the diagnosis of BPD is used in clinical practice with some authors suggesting that it tends to be given to ‘difficult patients’ (Higgitt & Fonagy, 1993). This has led some clinicians to consider
that the diagnosis has created a climate of stigmatisation of clients with this disorder who present with complex difficulties, instead of representing a guide for management and treatment (O'Brien, 1998).

In relation to the psychological treatment of BPD, different models have been proposed with some, although sparse, clinical validation (Bateman & Fonagy, 1999; Chiesa & Fonagy, 2000; Chiesa, Drahorad & Longo, 2000; Linehan, Heard & Armstrong, 1993; Ryle & Golynkina, 2000; for a review see Mendes (2001), this portfolio). Due to the complexities of this disorder, most authors have adapted and developed new models from the more traditional approaches such as psychoanalytic and cognitive-behavioural, in order to respond to the multiple needs of clients. Most models tend therefore to be highly specialised approaches, which call for additional service resources. For example, therapeutic community models are residential inpatient units which draw on both individual and group approaches (Norton, 1992); and dialectical behavioural therapy, developed from a cognitive-behavioural tradition also involves both individual and group treatment (Linehan, 1993a). The specialisation of the treatment models raises questions as to the ability of general mental health services to provide adequate treatment for this group of clients, where the resources and specialist knowledge might not be available. However, it remains the case that most clients with BPD are seen within non-specialist psychiatric settings (Bateman & Fonagy, 1999).

Despite the variety of models developed for the treatment of this disorder, and the differences between them, they all stress the central importance of the therapeutic relationship (Bateman, 1997). It is recognised that one of the key features of clients with this diagnosis is a pattern of unstable relationships, which is likely to affect their ability to establish a working alliance with therapists. Since there is a well-established relationship between the quality of the therapeutic relationship and positive therapeutic outcome
Given the likelihood that Clinical Psychologists working in general adult mental health services will be faced with working directly with this client group, in contexts that tend to have limited specialist resources for this population group (Kerr, 1999), this study sets out to explore the experiences these clinicians face in working with clients diagnosed with BPD. Firstly it would be useful to explore the views clinicians have of the diagnosis and the key features they look for when working with this group of clients, given the controversies that exist regarding the concepts of BPD within the research field. Secondly, it would be important to assess the strategies used by psychologists working in general settings when working with these clients. And lastly, it would be relevant to explore the subjective experiences that psychologists associate with this work, since this is likely to impact on the willingness and ability of the clinicians to establish a good therapeutic alliance. The following study proposes to address these three topics.

In what follows, the main approaches that have been proposed for the understanding and treatment of BPD will be reviewed. Three different theoretical models will be discussed, focusing initially on the psychoanalytic tradition, specifically the approach developed by Kernberg (Kernberg, Selzer, Koenigsberg, Carr & Appelbaum, 1989). This model was chosen because of its influence on the psychoanalytic literature in this area and because it includes both a conceptualisation of the disorder and a specific treatment model. This will be followed by the approaches developed from a cognitive-behavioural tradition, with a focus on Dialectical Behavioural Therapy (Linehan, 1993a). This model was chosen because it has been subjected to several outcome studies and is suitable to use on an outpatient basis, making it relevant for use in the context of Community Mental Health Teams (CMHTs). Finally, more integrative approaches will be described with a specific

1 Note: In this report the terms therapeutic relationship, therapeutic alliance and working alliance will be used interchangeably, although it is recognised that some authors tend to differentiate between these concepts (Bordin, 1979)
focus on Cognitive Analytic Therapy (Ryle, 1997). This model, although developed fairly recently, has already been the subject of outcome studies and has been used in the context of a CMHT (Kerr, 1999).

In each section, attention will be given to the conceptualisations of this disorder by each model, its approach to treatment and the more specific issue of the management of the therapeutic relationship (for a review of recent outcome studies on the effectiveness of these different models in treating BPD see Mendes (2001), this portfolio).

The last section of this introduction will address the observations made in relation to the way BPD clients relate to staff in in-patient units. This was considered to be relevant to the current study since it can be hypothesised that many of the patterns of relating observed in this setting may also be present in community services. Three studies which addressed the work with clients with BPD in community settings will then be reviewed.

Psychoanalytic Approaches
Stem (1938) first used the term ‘borderline’ to indicate a group of patients who did not appear to fit clearly into either psychotic or neurotic personality organisations as understood within the theoretical models of the time (Gunderson, 1994; Kernberg et al., 1989). Since then, Kernberg developed a psychoanalytic model for the understanding and treatment of borderline patients and has been one of the most influential authors in this area (Higgitt & Fonagy, 1993).

According to Kernberg, the criteria for BPD presented in the DSM manuals is too narrow due to its overlap with other personality disorders, and it does not provide a clear link to aetiology, treatment and prognosis of the disorder (Kernberg et al., 1989). Instead the author proposes the use of a broader concept known as *borderline personality organisation* based on three criteria: the presence of identity diffusion which refers to the lack of integration of the concept of the self and significant others; primitive defensive
operations, such as splitting, primitive idealisation and projective identification; and some capacity for reality testing (which refers to the ability to differentiate the self and intrapsychic processes from non-self and external stimuli) (Kernberg et al., 1989). This definition covers other personality disorder diagnoses such as histrionic, narcissistic and schizoid personalities.

Kernberg and colleagues (1989) propose that this borderline personality organisation also encompasses secondary structural characteristics, such as ego weakness (for example lack of impulse control and anxiety tolerance), superego pathology (for example, immature value systems) and chaotic object relations. This model is based on a structural view of personality and considers that the origin of disturbance is internal conflict with intense aggressive and destructive impulses being inadequately managed by a weak ego structure (Higgitt & Fonagy, 1993). Kernberg (1999) sees the presence of identity diffusion and the use of primitive defence mechanisms, such as splitting, as creating internalised part-object relationships where all-good and all-bad representations and affect are kept separate. In this conceptualisation good and bad aspects of the self and others need to be kept separate in order to protect the positive images from being overwhelmed by the negative and destructive ones (Higgitt & Fonagy, 1993). This contrasts with the more mature neurotic organisation where object representations integrate both good and bad aspects of the self and others.

According to Kernberg (1999), the aim of psychotherapeutic treatment is to integrate the split off and dissociated part-objects into total object relationships as they emerge in the transference relationship. As this process evolves, the accompanying intense affects become more modulated with increased capacity for affect control and a heightened capacity for empathy towards both self and others.

In terms of therapeutic technique, the usual tools of psychoanalysis, such as interpretation, transference analysis and neutrality are also used here (Kernberg, 1999;
Kernberg et al., 1989). However, interpretation and transference analysis tend to relate the experiences within the session with outside current experiences of the patient, in contrast with traditional individual psychoanalytic approaches, which link in-session material with past experiences (to avoid regression on the part of the client which could be destructive and lead to psychotic states). Also, it is acknowledged that the potential for acting-out\(^2\) destructive impulses may at times demand that the therapist temporarily abandon the position of neutrality.

In relation to the therapeutic relationship, Kernberg and colleagues (1989) stress the importance of attending to countertransference issues in the therapy due to the intense and powerful emotional reactions which are likely to arise for the therapist in relation to the use of primitive defences by patients (such as idealisation or devaluation). The authors see the recognition and management of countertransference reactions as important not only to allow the therapist to maintain a position of neutrality, but also because they offer useful information about the patient's defences and conflicts.

The model of BPD and its treatment presented above remains influential within the psychoanalytic literature, however, there has been some discussion regarding the position the therapist should adopt with this group of clients. Whereas Kernberg and colleagues (1989) view the role of the therapist as providing interpretations for the resolution of conflict and integration, other authors suggest that the therapist should adopt a more supportive posture to allow the primitive processes present within the clients to mature and develop (Adler, 2000). This alternative approach, developed from the ideas of Kohut (1971), emphasises the profound inadequacy of the child's early environment, which leads to a deficiency in the capacity to achieve a sense of cohesion in the self (Higgitt & Fonagy, 1993). The aim of therapy within this approach is to provide a sufficiently supportive and containing environment to allow the client to develop more mature ways of relating to the self and others (Adler, 2000).

\(^2\) Acting out refers to acts or behaviours which are a substitute for remembering and reporting verbally. It implies a regression to a pre-verbal level of functioning (Bateman & Holmes, 1995).
In the models presented above, the disturbance observed in BPD is seen as a consequence of largely unconscious processes and one of the aims of therapy is to bring these to awareness, focusing therefore on intrapsychic processes. It is postulated that this type of work will then allow for more adequate patterns of relating to self and others to emerge. Despite their influence, the models presented above were developed from clinical observation and have not been more systematically tested (as is the case with other psychoanalytic literature). Other authors focus more specifically on overt behaviour and conscious cognitions and try to substitute them with more adaptive patterns of thinking and behaving (Linehan, 1993a; Safran & McMain, 1992; Young & Lindemann, 1992). These models were mainly developed from a cognitive-behavioural tradition and will be presented bellow.

Cognitive-Behavioural Approaches

The most influential author in this area is Linehan (1993a) who developed a theoretical and therapeutic model of BPD known as Dialectical Behavioural Therapy (DBT). Several outcome studies (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan et al., 1993) have been carried out in relation to this model with some positive results, namely the considerable reduction of parasuicidal and self-harm behaviours in women with BPD (see Mendes (2001), this volume, for critical analysis of these studies).

According to this model the central feature of BPD is the presence of emotion dysregulation which is defined as the combination of an oversensitive and overreactive emotional system with an inability to modulate emotions and actions associated with them (Linehan, 1993b). The author postulates that this dysregulation is the result of both biological (i.e. emotional vulnerability) and environmental factors and the interaction between the two during development.
Great emphasis is given to the role of an *invalidating environment* in the aetiology of BPD. This is described as erratic and inappropriate responses on the part of caregivers to private experiences (e.g. beliefs, thoughts, feelings, sensations) of the child (Linehan, 1993b). According to this model, caregivers can either be insensitive to these experiences or react to them in extreme ways (for example, with criticism, physical or sexual abuse). The environment around the child also emphasises the control of emotional expressiveness and internal painful experiences may be trivialised or attributed to negative traits. It is hypothesised that the presence of this invalidating environment contributes to a failure on the part of the child to develop a mechanism of correctly labelling, tolerating and regulating emotions. It also leads the individual to learn to be over-alert to any clues in the environment, which indicate how they should react, and also to either the repression of emotions or their expression in extreme fashion (Linehan, 1993a).

The symptoms of BPD are seen as manifestations of this basic deficiency of emotion dysregulation. For example, parasuicidal behaviour and self-harm are conceptualised as maladaptive attempts to cope with overwhelming emotion. The unstable sense of identity observed in clients with BPD is also seen as a result of unpredictable and chaotic responses from the environment in relation to the individual which preclude the emergence of a continuous and stable sense of self (Linehan, 1993b).

The treatment model proposed by the author (Linehan, 1993b) shares many characteristics with more traditional cognitive-behavioural approaches such as the emphasis on on-going assessment and collection of data regarding target behaviours, definition of specific treatment goals, and a development of a collaborative therapeutic relationship. Strategies such as problem solving, skills training, exposure and cognitive modification are also used here. However, the author also stresses the differences between DBT and other cognitive-behavioural models with the main difference being the specific focus on the therapeutic relationship. Thus, it is considered essential that the
The emphasis on the relationship is an important shift from more traditional cognitive approaches, where the relationship was seen as the basis for the therapeutic work but it was not usually addressed directly in therapy. Linehan's approach seems therefore to move toward an incorporation and adaptation of the psychoanalytic concepts of transference and countertransference through the use of the term therapy interfering behaviours (Linehan, 1993b). However, the presence of unconscious processes is still not addressed and only overt and conscious behaviours and cognitions on the part of therapist and client are focused upon.

It is interesting to note in the literature that other authors (Lockwood, 1992; Safran & McMain, 1992; Young & Lindemann, 1992) who developed cognitive-behavioural models for the treatment of personality disorders reached similar conclusions in relation to the importance of the therapeutic relationship. For example, Safran and McMain (1992) refer to the rigidity of interpersonal schemas (i.e. unconditional beliefs about self in relation to others) in personality disorders which tend to trigger in others the expected responses of the individual (e.g. if a person has a belief that others will be rejecting, he/she will behave in such a way that will lead others to a rejecting position). The authors stress the importance of being aware of this process within the therapeutic relationship so as to avoid being pulled into these ways of relating. They stress the importance of the

therapist adopts an accepting and validating posture in relation to the client and that any behaviours which interfere with the therapeutic process (coming from either the client or therapist) are addressed when they arise. These behaviours are called therapy interfering behaviours and can include the consumption of drugs or alcohol before therapy sessions, violent behaviours within the sessions or a refusal to pursue the target goals mutually agreed at the beginning of therapy. In relation to the therapist, Linehan (1993b) recommends that he/she should adopt an irreverent posture which challenges some of the beliefs of the client but at the same time shows acceptance and validates the client's current emotional and cognitive responses.
therapeutic relationship as a forum where the client can experience a different type of relationship, which will serve to disconfirm the client's dysfunctional interpersonal schemas.

These ideas are similar to the psychoanalytic concept of corrective emotional experience proposed by Alexander and French (1946 cited in Bateman & Holmes, 1995) who stressed the importance of the therapeutic relationship (as opposed to interpretation) as central to the healing process. It is also concordant with the views of Adler (2000) presented above. Safran & McMain (1992) go further to suggest that the therapists should be particularly self-aware and that they should use their own emotional reactions to the clients as a source of information about the interpersonal schemas being played out at a particular moment. Again, this idea seems to be similar to the importance given in psychoanalytic thinking to countertransference issues when intervening with borderline personality disordered clients (Kernberg, et al., 1989).

It therefore appears that cognitive-behavioural models have begun to move towards integrating some concepts from earlier psychoanalytic thinking into the practice of CBT with people diagnosed as personality disordered, especially with regards to the therapeutic relationship. However, many of the cognitive-behavioural assumptions about therapy (for example, the idea of intervening at the level of beliefs and behaviour) remain the same.

**Integrative Approaches-CAT**

Other authors (Millon, 1999; Ryle, 1997) have attempted to integrate ideas from different traditions to create a whole new model of therapy for BPD and personality disorders in general. A good example of this movement is the model proposed by Ryle (1997) known as Cognitive Analytic Therapy (CAT) which integrates ideas from both cognitive and psychoanalytic approaches. One of the ideas proposed in this model is that observed behaviour is part of a procedural sequence model, which encompasses mental processes
(beliefs, intentions, appraisal, etc.), action, evaluation of consequences and confirmation or revision of aims or means. One central type of procedure concerns the maintenance of close relationships with significant others. The model hypothesises that these procedures evolve into established patterns as a result of early experiences of relationships with caregivers. These patterns are called reciprocal role procedures and not only guide the individual's actions in relation to others but are also part of the way a person views and manages their self (Ryle, 1997). The definition of role includes behaviours, expectations of how the person and others will react, affects and memories. In normal circumstances people possess numerous reciprocal role procedures, which will be activated according to the environment at any given time. It is also assumed that people are usually able to make smooth transitions between different role procedures.

According to the author (Ryle, 1997), clients with BPD can show abrupt (instead of smooth) changes of opposing reciprocal roles or even switch to different role procedures altogether. These are known in the model as dissociated self-states. The author postulates that the rapid changes in mood and patterns of thinking frequently observed in clients with BPD are manifestations of switches to different self-states. The dissociation of the different role procedures or self-states is seen to be the result of early trauma and deprivation. It is hypothesised that these early negative experiences affect the individual at three levels: they restrict and distort the development of an adaptive repertoire of role procedures; they disrupt the process of linking the different role procedures; and they disrupt the development of a capacity for self-reflection.

In CAT the therapist attempts to help the client initiate a process of integration of the different self-states through a process of reformulation whereby the therapist shares with the client a descriptive model of their different self-states and their interrelationships. The reformulation also attempts to engage the client in a self-reflective process through the continuous and collaborative analysis and adjustment of the presented self-states model. It is stressed by the author that the therapist should avoid playing out a reciprocal role...
procedure which the client elicits and should maintain a reflective and observant posture to identify the roles being acted at any given time.

This model presents an idea similar to the psychoanalytic approaches in that there is a conceptualisation of BPD as being characterised by dissociated parts of the personality (Kernberg, 1999), which need to be integrated in therapy. Furthermore, cognitive-behavioural ideas are also used, especially in relation to the adoption on the part of the therapist of a collaborative relationship in which shared models of functioning are developed. As with other models, the need for the therapist to be particularly self-aware when working with this group of clients is stressed.

Although quite different from each other in relation to the conceptualisation of BPD, the models presented above also share some similarities. For example, most models stress the importance of the inadequacy of the clients’ early relationships as aetiological factors for the disorder. This particular aspect has received some support in the literature in studies which linked abuse, loss and traumatic early experiences, such as the witnessing of violence, with BPD (Liotti, Pasquini & The Italian Group for the Study of Dissociation, 2000; Murray, 1993). Authors also stress the importance of attending to the therapeutic relationship. However, it can be observed that most models for the treatment of BPD are fairly specialised. It would therefore be interesting to investigate the way in which they are used in general community mental health services (if at all).

One of the common factors of all models is the importance of the therapeutic relationship in the treatment of BPD. In the next section studies addressing the development of relationships between professional carers and clients in therapeutic contexts will be briefly presented.
Therapeutic Relationship and BPD

In this section, some descriptions from the literature will be provided in relation to the specific types of relationships that are observed between clients and their professional carers, mainly in in-patient units. Some of the dynamics described here may have direct relevance for community teams where more than one member of staff may be involved with a client diagnosed with BPD.

In a classic paper by Main (1957), the author describes a particular type of relationship, which is established between some clients and nurses on mental health in-patient wards. Although the author does not refer specifically to the diagnosis of BPD, it is now recognised that many of the descriptions provided are observed within this client group (Kerr, 1999). Main (1957) was interested in observing the sources of stress and strain for individual nurses in an in-patient unit. He found that a group of patients who proved difficult to help and who were usually discharged without having improved, despite great efforts on the part of the nurses, were at the root of many of the observed professional 'burn-outs'. With further investigation, Main found that all of these patients elicited specific kinds of responses from professionals, beginning from the source of referral to discharge. Referrers and nurses alike tended to feel that the patient was 'special' in some way and needed and deserved great amounts of care, which would usually not be provided to other patients. There was also a sense that all other professionals had mistreated the patient in some way and only the chosen staff member could provide the understanding that the patient required. The patient also presented with a history of being 'passed-on' from service to service with no apparent progress being made. In the hospital the nurses experienced the client as being more and more demanding and the primary nurse would tend to provide more and more care, sometimes well beyond their usual obligations. Initially there was usually a neglect of the severity of symptoms presented, such as serious self-harm, but finally the seriousness of the disorder would lead the professionals involved to see them as untreatable. Within the staff group, one nurse seemed to be chosen by the patient to become the person who could actually provide the
care needed. This nurse was often left feeling that other nurses were not good enough to care for this patient. This led to difficulties in communication between the nurses and sometimes to conflict.

Since the above paper was published many authors have described similar difficult patterns of relating with particular groups of clients, especially in relation to in-patient treatment (Bateman, 1998; Breeze & Repper, 1998; Gabbard, 1989a; Norton & Dolan, 1995; O'Brien, 1998; Watts & Morgan, 1994). A review by O’Brien (1998) presented the range of nurses’ responses frequently observed in relation to clients with BPD. The author mentions feelings of hopelessness and incompetence on the part of the nurses in relation to the lack of progress of clients and either a sense of flattery (due to their patients’ preference for them with a subsequent loss of objectivity) or a posture of distance (with a subsequent failure to provide empathic responses). Reactions of frustration and anger, but also fear were also reported in relation to incidents of self-harm.

Watts and Morgan (1994) report on the feelings of hate which can be triggered in professional carers through working with borderline clients. They report that clients can provoke hate by being verbally abusive, being silent or missing appointments. To deal with this countertransference of hate, professionals may respond with malice or aversion, which may lead to premature discharges. The authors claim that although malice is deleterious for the client, it at least maintains a contact with the client, whereas aversion may lead to despair on the part of the client with consequent extreme self-injurious or violent behaviours.

Another aspect discussed in the literature is the idea that BPD clients are difficult to treat and as such challenge the self-image of staff as providers of help and instruments of cure and progress (Breeze & Repper, 1998). This aspect tends to leave staff with feelings of incompetence, frustration and anger, and guilt about not being able to help. This can in turn affect the way staff interact with patients.
In relation to hospital treatment, Gabbard (1989b) uses the concept of splitting to identify the processes observed in the staff caring for BPD clients. This concept is used to describe the highly polarised positions that different groups of staff tend to adopt in relation to a particular client. The author conceptualises this observation as reflecting the internal splits within the client’s personality, which are then projected into different members of staff thus creating the potential for conflict within staff groups. The author points out that one common arrangement of this split is one in which the psychotherapist or the member of staff who has more individual contact with the client becomes an idealised figure to whom the client does not show the more aggressive and destructive sides. Conversely the ward staff are devalued and denigrated by the client. This set-up can lead to problems in communication and ultimately to conflict without the possibility of dialogue and compromise in relation to the client’s care.

One recent study by researchers in Sweden (Bergman & Eckerdal, 2000) used a qualitative methodology (grounded theory) to investigate staff’s perceptions of their work with BPD clients. They interviewed professionals working in either in or out-patient services and identified themes relating to the experiences of working with this client population. The participants reported a need for better co-ordination of different services and more flexibility and resources in their own services. There was also a focus on the need for supervision, especially from the psychology discipline. Participants also reported on a difficulty in remaining empathic with their clients and frequent feelings of incompetence. This study is useful in that it points to specific experiences of staff which might be important to identify in the work with BPD clients in order to develop effective models of treatment. For example, the need to help staff to empathise with clients and the need for the provision of support to staff (such as supervision). However, the study did not address the issue of management of risk with this client group which is likely to affect staff. Furthermore, the sample included members of different professions (nurses, physicians, social counsellors and psychologists) working in different contexts (in and
out-patient services) and it is not clear if there were any differences between the perceptions of different professionals.

An interesting study by Nehls (2000) interviewed 17 case managers of clients with BPD in a community setting. Participants were asked to describe a situation which they had experienced when working with clients with BPD. Through the qualitative analysis of the transcripts of the interviews, the author identified two main themes which were the monitoring of concern in relation to risk and monitoring boundaries. In relation to risk, there were themes related to the need to constantly monitor the level of risk, but also some level of doubt among participants about their ability to deal with risk and their need to share this responsibility with colleagues. In relation to the issue of boundaries, the author reported that participants showed concern about their level of involvement with the client. This is an interesting study which provides good insight into some of the experiences of community workers in caring for this client group. The study also points out the relevance of monitoring risk when working with clients with BPD on an out-patient basis and it would be interesting to verify if this is the case in other community services. However, the fact that the study focused on only one situation which stood out for the participants may have lead to a neglect of other or more general experiences of participants. It would have also been useful to know the professional background and training of the participants which may have influenced the way they experienced their clients.

The literature presented above represents a summary of the models available currently for the understanding and treatment of BPD and also of the issues that are likely to arise within the therapeutic relationship when intervening with these clients. It is important to note that much of the literature presented above is theoretical and more studies are required to evaluate the adequacy of the models presented in relation to the understanding and treatment of BPD. Furthermore, although there have been some positive advances in relation to the development of treatment models for BPD, they constitute fairly
specialised models and it is unclear the extent to which these models are used in general psychiatric community services due to the lack of studies in this area. In relation to the therapeutic relationship and the way staff experience clients with BPD, there is also a lack of studies addressing community services with the exception of the two studies mentioned above (Bergman & Eckerdal, 2000; Nehls, 2000). Furthermore, there have been no studies to date addressing the specific experiences of psychologists working in this area. This is a clear limitation since most of the models of BPD have arisen out of the psychological and psychotherapeutic literature (as was described above) and psychotherapy has been identified as an important part of the treatment of BPD (APA, 2001). The present study is an attempt to address these limitations in the literature.

**Aims of the Present Study**

In the following study, there is an attempt to address one aspect of care that has received little attention in the current research literature, the provision of mainstream psychological *community* services for clients with BPD. Although some clients have access to specialist in-patient or out-patient units, most clients are seen within general psychiatric services (Bateman & Fonagy, 1999). Also, although many clients are admitted into hospital at some point, this occurs mainly in response to crisis, such as serious self-harm or suicide attempts. Clients therefore tend to be seen by community teams. It would therefore be of interest to explore the experiences psychologists in CMHTs have of working with clients with BPD as well as their conceptualisation of this disorder.

The aims of the study are:

- To explore psychologists’ understanding of Borderline Personality Disorder;

- To explore psychologists’ subjective experiences of working with clients with Borderline Personality Disorder;
To identify treatment strategies employed by psychologists working with this client group;

To identify themes which are likely to influence the establishment and maintenance of a good therapeutic alliance with this client group.

In order to achieve the aims proposed above, a qualitative research method was chosen. In the last decade there has been a trend towards this type of methodology as opposed to quantitative methodologies due to the recognition of the limitations of the latter in relation to the study of human phenomenon. This was first acknowledged in relation to laboratory experiments which gave limited information about behaviour in naturalistic settings (Smith et al., 1995). Also, some authors argue that reducing phenomena to numbers misses important components of human experience, such as the importance of the use of language and the individualised nature of experience (Smith, Harre & Van Langenhove, 1995).

In relation to clinical practice, authors have pointed out the limitations of outcome studies, especially in relation to the links between research and practice (Guthrie, 2000; Safran, 1990). Some of these limitations are the homogeneity of samples selected for these studies which do not reflect the needs of clients seen in practice which usually present with an array of difficulties. Also, outcome studies need to control for the variations in therapists' skills and incorporate manualised therapy approaches which again do not reflect the more flexible approaches used in practice (Guthrie, 2000). Furthermore, the use of statistical methods obscures individual differences in both presentation and outcome (Safran, 1990). It has therefore been argued that there is a need to complement quantitative methods of research with qualitative methodologies in order to achieve a more accurate view of clinical experiences.
This is particularly the case in relation to BPD, since this group of patients poses particular difficulties in terms of using quantitative methods where there is an attempt to eliminate the effect of other variables than the one studied. It is recognised that BPD clients are a very heterogeneous group which may present difficulties when trying to select an homogeneous sample for study (APA, 2001). In relation to outcome studies BPD clients show high drop-out rates which reduce the validity and reliability of any results found (Perry, Banon & Ianni, 1999). Also, it is recognised that currently both the defining criteria and the assessment methods for BPD are inadequate (see Mendes (2001), this portfolio).

Due to the factors presented above and to the nature of the research questions of the current study, which are concerned with understanding and meaning of experiences of professionals working with clients with BPD, a qualitative methodology was considered to be the most appropriate choice.
METHOD

Ethical issues:
A research proposal for this study was submitted to a first Ethics Committee and approved on 20 August 2001 (see Appendix II). It was also submitted to a second separate Ethics Committee and approved on 6 November 2001 (see Appendix III).

Participants:
Participants were clinical psychologists working in CMHTs in urban and semi-urban areas in the South East of England who had experience of working with clients with BPD. Participants were recruited following two different procedures. A group of four psychologists were recruited after the researcher attended a departmental psychology meeting and gave a brief 10 minute presentation of the research project. This procedure was chosen to maximise the willingness of potential participants to contribute to the study. Psychologists present in the meeting were given an Information Sheet (see Appendix IV) and interested psychologists provided the researcher with contact telephone numbers. The potential participants were then contacted by the researcher no earlier than 48 hours after the presentation and enquired about their interest and availability to participate in the project. If interest was shown, times for interviews were arranged. All psychologists who met the inclusion criteria present at the meeting (4) agreed to take part in the study.

A second procedure was developed due to the different arrangements of psychology departments in relation to the nature and frequency of psychology meetings which precluded the presentation of the research project in that context. In order to widen the number of participants, the Register of Chartered Psychologists by The British Psychological Society (2000) was used to identify psychologists working in CMHTs in the chosen region. Psychologists were then sent a letter (see Appendix V) with a brief
summary of the project and a request for participation, as well as the information sheet for the project. The potential participants were contacted by telephone no earlier than a week after the initial letter was sent to enquire about their willingness and availability to participate in the project. If they expressed an interest a time was arranged to carry out the interview. This alternative procedure was submitted to the Advisory Committee on Ethics of the University of Surrey and approved by Chairman’s action on 20 November 2001 (see Appendix VI). A total of 7 out of 11 clinical psychologists were recruited through this procedure.

Data Collection:
Semi-structured face-to-face interviews were carried out with a total of 11 clinical psychologists working in the chosen area. The interviews involved general questions about participants’ experiences of working with clients with BPD. The questions centred around the three areas of interest: the first was psychologists’ conceptualisation of BPD with questions such as ‘what do you understand as BPD?’ and ‘what do you think are the core difficulties of clients with this disorder?’; the second area focused on psychologists’ subjective experiences of working with clients with BPD and questions included were ‘what is it like working with these clients?’, ‘what feelings or emotional reactions do you find yourself experiencing in relation to these clients?’ and ‘how would you describe the therapeutic relationship you establish with these clients?’; the third and final area of questioning related to the treatment strategies employed by psychologists working with this client group and included questions such as ‘what are for you the main goals of therapy when working with these clients and what do you think is the best way to achieve them? and ‘what do you think is helpful and what do you think is unhelpful when working with these clients?’ (see Appendix VII for full schedule). Specific examples were sought to illustrate psychologists’ views, but participants were asked to ensure that no identifying details of clients were given. A debriefing time was allocated at the end of the interview to address any issues which arose for the participant during the interview.
After an initial draft of the schedule was completed by the researcher, consultation with an experienced psychologist in the area of BPD was held to analyse the content of the interview schedule in terms of its structure and feedback from this consultation was incorporated. Following this consultation a pilot interview was undertaken with a psychologist working in a CMHT to assess the phrasing and adequacy of the questions. Minor changes to the schedule were carried out to reach the final version of the interview schedule (see Appendix VIII for an example of a full interview).

Each interview began with the signing of a consent form (see Appendix IX) and with general demographic questions which were recorded on a form (see Appendix X). The interviews were audio-taped and lasted between 45 minutes and one hour and a quarter. They were then transcribed verbatim for analysis. All identifying details were deleted or changed in order to keep the anonymity of participants and their clients. The audio-tapes were erased once the interviews had been transcribed (as was requested by the Advisory Committee on Ethics of the University of Surrey).

Data Analysis:
The data in the form of transcripts obtained from the interviews were analysed using Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Osborn, 1997). This method is informed by the philosophical approach of phenomenology in which there is an attempt to reach an understanding of the world as it is experienced by human beings in particular contexts at particular times without the influence of previous assumptions (Willig, 2001). Although there is a recognition of the impossibility of gaining direct access to people's experiences and thinking through their verbal accounts of those experiences, in IPA there is an assumption that meaningful interpretations can be made in relation to that thinking (Coyle & Rafalin, 2000). At the same time, there is also an acknowledgement that the exploration of people's accounts will also involve the researcher's own view of the world as well as the nature of the interaction between the
researcher and participants (Willig, 2001). Hence the interpretative nature of this methodology.

Due to the subjectivity of this process of analysis, some authors have suggested that the researcher should attempt to provide as clear an account as possible of their own values and assumptions in order to allow the reader to interpret the quality of the analysis and also to generate alternative interpretations of the data (Henwood & Pidgeon, 1992; Elliott, Fisher & Rennie, 1999). The researcher in this study is a white non-British female clinical psychology trainee in her final year of training. The researcher has mainly received training in cognitive-behavioural and psychoanalytic approaches to therapy. The interest in BPD came mainly from a primary interest in the study of the therapeutic relationship as central to the therapeutic process and the observation that most models of therapy for BPD also subscribed to this idea. There is also an interest in the importance of self-reflection in therapy as a vehicle for understanding of clients which again seems to be a feature of most therapeutic approaches to BPD. Furthermore, the researcher is interested in the movement towards integration of different therapeutic models which seems to have occurred in relation to BPD.

As with other qualitative methods, there is an emphasis on the systematic analysis of data. In IPA the researcher attempts to engage with the data through a series of steps to identify groups of themes within and across transcripts (Willig, 2001). As the approach is idiographic in nature, being more concerned about individual accounts rather than generalisability of data, there is a detailed analysis of each transcript with identification of themes before moving on to grouping themes from different accounts (Willig, 2001).

One of the criteria to evaluate the quality of this type of methodology is to present a detailed account of the analytic process (Henwood & Pidgeon, 1992). The process of analysis involved reading each transcript several times and making notes in the form of
summaries, questions, and descriptive labels, for example, about key statements in the text.

The importance of doing credibility checks by referring to others' interpretations of the data was recognised (Elliott et al., 1999). Therefore, one of the transcripts was read by five other researchers (two supervisors and three doctorate trainees familiar with IPA) and a discussion about key passages in the transcript, as well as possible thematic categories, was incorporated by the main researcher. In addition, the researcher's supervisor read one other transcript making notes of statements which appeared to be relevant and these were then also incorporated in the next stage of the analysis.

This initial stage was followed by clustering together some of these statements to form a number of thematic categories for each transcript. These were labelled in a way which attempted to capture the essence of what was represented in the text. In the third stage of this phase of the analysis, relationships between themes were established to provide some structure to the data. At this stage some themes which were not related to the topic under investigation were dropped. Finally, the clusters of themes identified were checked again against the original data to ensure a good level of correspondence between the interpretative themes and the data. At this stage examples, in the form of direct extracts from the text, were identified for each thematic category (see Appendix XI for an example of a table of themes identified for one transcript).

The second phase of the analysis involved systematically integrating the themes from the different individual transcripts to try to capture the quality of the participants' shared experience of working with clients with BPD. At this stage super-ordinate categories encompassing subordinate themes were identified and this process was concluded when all subordinate themes were either integrated or dropped from the analysis. Since the aim of the research was to provide a detailed account of participants experiences, quantification of data was eschewed. Care was taken to not only identify the
commonalities in experiences, but also the exceptions, when reports did not fit the themes identified for the majority of participants (see Appendix XII for the table of themes identified for all transcripts).

As was stated above the subjectivity of this type of methodology is taken into account. Therefore, the criteria used in quantitative research to evaluate studies (such as reliability) is not appropriate for this study, since they assume objectivity and distance on the part of the researcher. Some authors have suggested alternative ways to evaluate the quality of the analysis by grounding any interpretations in examples from the data (Elliott et al., 1999). Therefore, all themes in this report will be illustrated with direct quotes from the transcripts to allow the reader to assess the persuasiveness and plausibility of the interpretations made. In these quotations, empty brackets are used to indicate when material has been omitted and text in square brackets constitutes added material for clarification purposes.

The participants were given pseudonyms to facilitate the reading of the report. After a brief presentation of the demographic data of the psychologists interviewed, there will be a presentation of the themes identified in the analysis. Although there were specific questions the researcher had in mind when analysing the data, there was an attempt to abstain from imposing a pre-determined structure on the data. Therefore, the presentation of the themes does not follow the research questions rigidly, although references to these questions will be made throughout the text. Inevitably some of the themes identified related closely to the structure of the interview schedule.
ANALYSIS

Demographic Data
The majority of participants (7/11) were aged between 36 and 45 years, with two aged between 26 and 35 and two others between 46 and 55 years. Only one of the participants came from a non-white origin (Bangladeshi), and one other from a white, non-British origin. Three participants worked in CMHTs full-time and the remaining eight participants worked between two to four days a week in a CMHT. The psychologists working part-time in CMHTs had other activities, such as management, research and teaching, and worked additionally in in-patient, eating-disorders, family therapy, primary care and elderly services. The number of years of experience participants had since qualifying ranged from 3 to 27 years, with seven of the participants having experience between 9 and 14 years (two of the remaining participants had less than 9 years’ experience and two had more than 14 years).

The majority of the psychologists interviewed (8/11) described their main theoretical orientation as cognitive-behavioural, with one participant adding schema-focused therapy to that description, another solution-focused therapy and one other adding dialectical behavioural therapy to a cognitive-behavioural orientation. One psychologist described their main theoretical orientation as psychodynamic and two others described it as integrative/generic. All but one psychologist had had further training after qualifying in areas such as specialist cognitive-behavioural training, brief-solution focused therapy, attachment, group work, family therapy and neuropsychology.

Nine participants had attended workshops or had further training for the treatment of BPD, mainly in dialectical behavioural therapy. Six psychologists estimated the number of clients with BPD on their case load at any given time as being between 1 and 4, with the remaining five participants estimating the number of clients with BPD between 5 and 10.
Overview of Themes

Three main superordinate themes were identified in the transcripts and are presented in Table 1.

<table>
<thead>
<tr>
<th>Theme I: Conceptualisation of BPD</th>
<th>Theme II: Reflexivity</th>
<th>Theme III: Complexity of Relationships</th>
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</thead>
<tbody>
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<td>- Characteristics of BPD</td>
<td>- Clients’ difficulty in reflecting about themselves</td>
<td>- Description of therapeutic relationship</td>
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<tr>
<td>- Diagnostic system issues</td>
<td>- Difficulties in therapists and other staff in maintaining reflective capacity</td>
<td>- Psychologists’ emotional reactions to clients</td>
</tr>
<tr>
<td>- Reactions of staff as basis for diagnosis</td>
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<td>- Aetiological factors</td>
<td>- Developing a formulation with the client as a means of developing reflective capacity</td>
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<td>- Impact of services on maintenance of disorder</td>
<td>- Need to develop formulation as a means of maintaining reflective capacity</td>
<td>- Relationships within the care system</td>
</tr>
</tbody>
</table>

Table 1. Summary of themes that emerged from analytic process.

The first superordinate theme was named 'conceptualisation of BPD' and it encompassed the ideas psychologists in the study reported in relation to their understanding of BPD. This main theme included sub-themes which referred to the characteristics of BPD, the issues raised in relation to the diagnostic system and its use in clinical practice, the use of the reactions of staff as a basis for hypothesising on the presence of the diagnosis, the aetiological factors for the disorder, and the impact of services on the maintenance of the disorder. The second main theme was named 'reflexivity' and it encompassed ideas reported which referred to the difficulty that clients have in reflecting about themselves, the difficulty in therapists and other staff in maintaining a reflective capacity when working with clients with BPD and a need to
develop a formulation about clients’ difficulties and share it both with clients and other staff as a way to maintain and develop a reflective capacity. The third main theme was named 'complexity of relationships' and included sub-themes on the description of the therapeutic relationship offered by psychologists, the emotional reactions of psychologists when working with clients, the importance of addressing the relationship and offering a different type of relationship to clients and the relationships within the system of care as well as a need for team work and the limitations of services. A final brief section focused on the rewards of working with this client group.

Conceptualisation of BPD

Characteristics of BPD

When asked about their understanding of BPD, most participants mentioned a series of presenting features that would indicate the presence of the disorder. The characteristics mentioned included most of the diagnostic criteria set out in DSM-IV (APA, 1994, see Appendix I) such as difficulties in forming and maintaining interpersonal relationships, impulsivity, self-harming and/or suicidal behaviour, unstable sense of self, intense and unstable affect and episodes of dissociation. However, only two psychologists mentioned the fear of abandonment and feelings of emptiness as characteristics of BPD, although these are two of the criteria presented in DSM-IV. It appears therefore, that most participants in the study did not rely on these two characteristics in their conceptualisation of BPD.

One psychologist, Patricia, summarised the presentation of BPD in the following way:

    I suppose chaos is the word (laughs), that often sums up the picture, a kind of desperate chaos, because there is the chaos but the highlight is the awful desperation of not having any secure sense of one’s self or one’s place in the world. (Patricia)
In this quotation, there seems to be an emphasis on the instability of people with the disorder, which affects several areas of their lives. Some of the psychologists interviewed viewed the main characteristic of BPD as that of emotional dysregulation in a similar way to Linehan’s (1993a) approach.

_I guess my understanding from the clients I work with is of people who find it extremely difficult to tolerate emotions, lots of emotions who are experienced in a very extreme way that they often resort to self-harm, other acting-out, active behaviour to help cope with these emotions and high affect. I think it has a lot to do with emotional dysregulation._ (Sarah)

Some people focused on the interpersonal difficulties exhibited by clients, such as Patricia.

_The interpersonal difficulties are usually what strikes one immediately._ (Patricia)

**Diagnostic system issues**

Despite most people showing some knowledge about the DSM-IV criteria for BPD and actually using the criteria to describe the disorder, ten out of the eleven participants, discussed their reservations and confusion about these criteria and the negative connotations of the label when given to clients. Rose described it in the following way:

_I think it’s very, not clear at all, it’s often shorthand I think, some of these labels PD, personality disorder. It’s very unhelpful I think, people will just say, ‘oh it sounds as if it’s more personality disorder’ and I think it’s shorthand for long-standing problems, that the expectations of change are more limited, ahm, and I suppose there is some confusion in my mind as well about the differences between the personality disorders and an overlap._ (Rose)
Other participants pointed out the extreme heterogeneity of this client group.

I: So you would say that there's a huge variability within this group that is categorised as BPD?

Sarah: Oh yeah, it's massive, massive. It can sometimes be very very subtle. But also you see, it's people I work with again, I don't think they just meet the criteria for BPD. I think this is the problem with the diagnostic classification system, it's as if, you know, people, you know, are this or they're not and they are something different. And often it's, they may not meet all the criteria but you get a sense that it's more of a borderline presentation. Ahm, and you also have some of the criteria for narcissistic personality disorder. (Sarah)

It is interesting to note that in the above statements participants are expressing ideas from their own clinical experience that mirror the discussions held in the literature regarding the diagnosis of BPD, such as the issue of high levels of co-morbidity between BPD and other axis I and axis II diagnoses and the high heterogeneity of this group of clients (McGlashan, Grilo, Skodol, Gunderson, Shea, et al., 2000; Whewell, Ryman, Bonanno & Heather, 2000; see Mendes (2001), this portfolio, for review of these issues).

Sarah also seemed to express an idea that is similar to the conceptualisation of borderline organisation provided by Kernberg (Kernberg et al., 1989) that encompasses different personality disorder diagnoses as defined in DSM-IV. She also made reference to the subjectivity of the diagnosis and its interpersonal nature when she said 'you get a sense it's more of a borderline presentation', as if it is difficult to be absolutely clear about the features on which to base a diagnosis.

Another participant goes further to introduce the idea of dimensional features as opposed to diagnostic categories as is proposed by some authors (Bank & Silk, 2001; Maffei &
Fossati, 1999; Westen & Shedler, 1999; see Mendes (2001), this portfolio, for a discussion of this issue).

This is just based on my experience of working with people face to face. I assume those kinds of behaviours, the kinds of issues that characterise BPD are within a continuum and are not diagnostic, a cluster of certain kinds of things may well lead to a diagnosis of BPD but I don't feel very comfortable about the idea that there is something inherent about the individual that leads him to behave in particular ways. (Andrew)

Some participants reported some reluctance to make use of the diagnosis, but instead tried to make their own assessment and focus on the needs presented by the client. John conveyed this idea in the next passage, despite using the word 'symptom' which presupposes a diagnosis.

If I am given a diagnosis before the assessment I try to ignore it. I try to work on, you know, it will give me some ideas, it might be somebody who has very chaotic behaviours and relationships. Ahm, I try to make my own mind, I'd rather they didn't do that, I would rather have a referral with a specific sort of symptom rather than the diagnosis (). My own stance of working is to try and focus on what are the issues, the difficulties, needs for an individual, so basically, I'll try and be symptom focused rather than diagnosis focused. (John)

Other participants made reference to the negative connotations of the label of BPD and the way in which the diagnosis is sometimes given to clients. For example, Tara, expressed it in the following way:

For me, the part of being human is important in relation to the diagnosis. From a sociological point of view, why did they get diagnosed with BPD, is it because of the presentation or is it because in some way they are difficult? (Tara)
Reactions of staff as basis for diagnosis

The issue of giving the BPD diagnosis to ‘difficult’ clients has also been pointed out in the literature by Higgitt and Fonagy (1993) and O’Brien (1998), but the psychologists in this study took this point further by basing their hypothesising about the presence of the diagnosis on observations of the reactions of others (usually staff) in relation to clients.

With these clients, perhaps more than any others, the emotional reaction to them is defining almost. (Anna)

Aetiological factors

In their conceptualisations of BPD, most participants made reference to early negative experiences as aetiological factors for the disorder. Thus, psychologists used expressions such as ‘abusive relationships with caregivers’, ‘early traumatic experiences’ and ‘experiences of repetitive invalidation’ to refer to this aetiological factor.

Impact of services on maintenance of disorder

Some psychologists made comments about the negative impact that mental health services had on clients, implying that services had in some cases contributed to the maintenance and even amplification of the disorder. This was expressed by Andrew in the following way:

I think from my experience of working in the CMHT, there was often a kind of a notion that contact with the service is more damaging than beneficial, that there is a danger that because of the limited resources, sometimes, limited skills, ahm, that it would antagonise people. Bring them into contact with the service would provide a forum in which they could be more dysfunctional. (Andrew)
The above section presented some ideas psychologists reported in relation to the conceptualisation of BPD. It is interesting to note that some participants made specific reference to the interpersonal nature of the disorder and went further by making suggestions about the interactions between services and clients. There was an idea about the reactions of other people to clients being almost diagnostic and also the effect that services could have on the maintenance of the disorder. This interaction will be further explored in the following sections.

**Reflexivity as key to understanding and managing the disorder**

One of the most prevalent themes in the interviews was what was called reflexivity. This superordinate theme is similar to ideas introduced by Fonagy and colleagues (Fonagy, 1991; Fonagy, Target, Gergely, 2000) and seemed to capture some of the themes identified in the transcripts, that referred to the lack of capacity for self-reflection observed in BPD clients. However, whereas Fonagy (1991) seems to refer only to this aspect and the need to focus on this lack of self-reflection capacity in therapy, the participants in the study seemed to go further by referring to the difficulty among therapists and teams in maintaining that capacity when working with clients with BPD. Furthermore, some participants stressed the importance of developing an understanding and formulation of the clients’ difficulties and of sharing it with clients and teams that seemed to serve a function of developing a capacity for reflection in clients.

**Clients’ difficulty in reflecting about themselves**

In relation to the clients’ difficulties, some participants mentioned the impulsive behaviour (as presented above), such as alcohol abuse or self-harm as behaviours that are attempts to cope with high emotion. This seems to suggest that clients tend to act instead of using more reflective coping strategies, such as talking to others or trying to understand their emotions. A couple of participants made more direct comments in relation to the inability of clients to reflect about themselves and how this characteristic makes it difficult to work with clients psychologically.
I think the difference between thinking and action, you know, that basically a psychological type of approach is about thinking and taking time to, ahm, to use the mind to look at problems and resolve them and these clients solve their problems by action really. (Kate)

Rose talked about the reasons why she expected the work with these clients to be difficult.

I wonder if you’re going () to be able to engage them in this kind of reflective work, and they find that very very difficult to do so, so I would expect that to be difficult. (Rose)

Difficulties in therapists and other staff in maintaining reflective capacity
The majority of participants then described their and other staff's difficulties in maintaining an ability to reflect and understand these clients. Some people referred to a tendency to act instead of thinking in a way that mirrored the clients' own way of coping.

I find that if you’re not sort of prepared, ahm, for it you can easily... I can easily get pulled into the problem and you're automatically offering appointments when you haven’t really got a kind of contract yet or your... worked out your goals. So you tend to jump in and try and rescue that person rather than think about what would, ahm, be useful in terms of psychological input. (Rachel)

Other people spoke more directly of the difficulty in maintaining an understanding of the client and the therapeutic work.

I am not entirely sure where I am because of the confusions that are arising in the sessions as well, ahm, where am I? What am I heading for? Even though as a cognitive-
behaviour therapist you will set goals and everything, you know, I mean, tangibly there are things. But ahm, because of the lack of goal orientation in the patient’s mind, ahm, you are left in a limbo really. (Fiona)

Need to develop formulation as a means of maintaining reflective capacity
In relation to this difficulty in maintaining an understanding of the client, most psychologists stressed the importance of developing a clear formulation and understanding of the client’s difficulties. This seemed to be emphasised, despite the acknowledgement that all psychological work involves the development of a formulation.

I don’t know if you’d necessarily work harder, but you need to be, ahm, you need to be able to spend time afterwards reflecting on things I think a bit more. So, about what’s going on and what might be helpful, what things you need to address with, with them really to make the therapy more effective. So, I would probably do more preparing in that sense, not necessarily preparing for sessions but reflecting on and bringing to supervision and, so it would be more work in that sense. (Rachel)

This reflective capacity, translated in some cases as an ability to formulate, was mentioned not only in relation to the clients’ difficulties but also in relation to the therapeutic alliance and the way the therapist related to and experienced the clients. Some examples of this aspect, which was often identified as a capacity to be self-reflective, are presented below.

It’s a case of being very self-aware, you have to monitor, much more in this sort of case, you have to monitor what is going on in the countertransference, transference issues, it’s very very important. If this person is doing this to you, is that what they do to other people? Or is it a countertransference thing which has to do with your own issues? You have to monitor that state, whether it is you or the client and if you can, it’s difficult, but if you can, then you’ve got something to work on. (John)
Developing a formulation with the client as a means of developing reflective capacity

The psychologists in the study also stressed the importance of sharing their own formulations and understandings of the problems with the clients and seemed to view this as a way of developing clients' own reflective capacity.

*You know, you are really trying to build the thinking side of things, rather than the reactive, impulsive side.* (Kate)

Some psychologists presented this aspect of the work as a goal in itself.

*It's something about having a clear formulation and sharing an understanding and actually often that can be a goal ( ) using whatever model, you know, using the client's model, perhaps incorporating a more medical model with a more psychological one, saying 'look, that's what happened in the past and that's how you are in these situations'.* (Rose)

One participant, Sarah, reported that one of her goals for the work is helping clients to develop more positive views of themselves. She referred to the rigid and negative views clients have of themselves and this seems again to point to the ideas presented by Fonagy and colleagues (Fonagy et al., 2000), who suggest that the difficulty in reflecting can often be a result of the denigrated views people with this diagnosis have of themselves, as a result of their histories. Sarah also emphasised the strategy of having concrete formulations as a way of achieving this goal.

*I think the main goals are enabling the client to develop an alternative, more positive view of who they are as a human being, so not having very rigid negative views about themselves, having more flexibility, more options, more alternative ways to*
experience themselves in the world () I think having things on paper is really important actually with this client group because often they flip into another state () it's almost as if they are at a pre-operational stage of cognitive development at that moment in time. So I think you do need to give them sort of concrete anchors to reality to help them having a ground. (Sarah)

Patricia summarised the two themes presented above in the following quotation, by emphasising the importance of formulating as a way of developing a reflective (observant) capacity in both the therapist and the client.

I do find that having something, a very concrete formulation as it is used in CAT. ( ) it's almost doing with them what you're trying to do with yourself which is to somehow, being that kind of observer who is able to both have the feeling and be aware of the feeling but also try and look at its meaning and understanding it. And obviously it's not something you can expect someone to do, ahm, from the beginning but having the concreteness of the reformulation, it's always like saying 'let's go and look at the map'. (Patricia)

Despite the fact that most therapists saw the development of a reflective capacity in the client as essential to the work, some participants also mentioned the need to be balanced in the understanding that is offered because of how easily the clients can feel overwhelmed or rejected by these attempts.

I think there needs to be a gap between your understanding and what your use of it and not just going in and immediately interpreting everything to the client, because the point is that they are easily overwhelmed, so you have to find a way of using it that is accessible to them but is not overwhelming. (Anna)
Need to develop formulation as a means of maintaining reflective capacity in teams

The theme of reflexivity was identified in a broader way as also being part of the work in teams. Psychologists mentioned the difficulties and the need to develop a clear understanding of clients' difficulties in the teams they worked in.

You need teams which are very cohesive, with a very clear policy and that have a very clear understanding and I think it's something that would take quite a lot of psychologically sophisticated reasoning that sometimes it's quite difficult. (Anna)

The theme of reflexivity was presented above to try and convey the difficulties of maintaining a reflective capacity when working with clients with BPD, that seems to mirror some of the clients' own difficulties in reflecting about themselves. The difficulties and the need to maintain this capacity were stressed not just in relation to the individual work with clients, but also in relation to team work. Some of the comments presented above also show the way in which therapists and other staff can use their own experiences of working with clients to develop formulations of their difficulties. Two participants described this process in the following way:

I think you have to be able to think about transference, if you like, what the person is trying to get you to feel, ahm, the whole kind of relationships they've been involved in before, for you to experience. I think if you're not thinking about that model it will be difficult. I mean, there are other ways of looking at that as well, but, ahm, some understanding of the kind of dynamics and feelings that are likely to come up in the therapy and you being able to think about that for yourself and work with it. (Kate)

Sarah described it in the following way, as she was referring to some of the difficult behaviours clients can show in therapy:
I think it could be everything from the more subtle issues within the therapeutic relationship, I don’t think it’s just behaviour, concrete behaviour, I think it can be about constantly switching agendas, ahm, but that can, if you address that and ask what’s going on here, then it’s redeemable, it’s not a drama. In fact, I think it can be quite helpful because sometimes it gives you more information about what’s really going on, what’s going on with them at this particular moment in time. (Sarah)

It seems therefore that psychologists viewed the development of a formulation as central to the work with clients and they presented the idea that the therapeutic relationship can provide a basis for this. The issue of the therapeutic relationship but also the complexity of relationships within the system of care was another main theme identified in the transcripts and will be presented below.

Complexity of Relationships
Participants in the study offered descriptions of their experiences of the therapeutic relationship that they established with the clients. Some comments were similar to some of the descriptions in the literature presented above. Kate offered a very succinct summary of her experience of the relationships she established with clients.

you know it [the relationship] could sort of get wrecked at any minute, yeah, that’s how it feels. (Kate)

Description of therapeutic relationship
One of the aspects mentioned by some participants was the expression of anger towards the therapy that clients often showed.

I certainly feel that the hostility and the anger was something that was much more around for those people than was for other clients. (Andrew)
Psychologists in the study also mentioned the instability of clients as being manifested in therapy by frequent switches in how they viewed and presented in therapy. This description appears to be similar to the idea suggested by Ryle (1997) in relation to the frequent and abrupt switches between different reciprocal role procedures observed in BPD clients.

_I think the reason they are so difficult is because, ahm, of the different modes of behaviour and mood that they go into. Ahm, from session to session, within the session, ahm, the modes change. ( ) you know, one minute the person is in a very co-operative, collaborative mood with you, and in the next 5 minutes of the same session you might find that they are operating in a totally different mode._ (Fiona)

Another characteristic mentioned by participants was the expectation on the part of the clients that they were going to be rejected by the therapist.

_( ) particularly in a relationship where they sort of expect you to fail them, they expect you to abandon them, they expect you to abuse them, like they have had in other relationships. They are not really coming to you with a great deal of expectation of cure, that might be what they would like but that’s not going to be what they expect._ (John)

Rose summarised her experiences of the relationship as a strong wish on the part of the clients for closeness but an extreme anxiety about it, since their previous experiences of close relationships were characterised by rejection and/or abuse.

_They do really want closeness and help and emotional support but they really find it difficult trusting anybody, naturally because of the experiences that they had, so consequently, you know, maybe a real dance around, you know, ahm, being more open about experiences or being more trusting with the therapist and then after two weeks feel_
so violated by that or so angry or, ahm, or, obviously, that's around, them feeling enormously anxious and frightened by that. (Rose)

The above description is very similar to descriptions by some authors (Fonagy et al., 2000) who developed a theoretical model which linked BPD and attachment theory (Bowlby, 1969). According to the authors, when children are victims of abuse (which is the case for many clients with BPD (Liotti et al., 2000; Murray, 1993), two conflicting emotions will be present in relation to caregivers: on the one hand an extreme neediness for support and care and on the other an extreme anxiety since the people who are expected to provide care, reassurance and safety are also the ones who are abusive. The description by Rose seemed to reflect a similar pattern of relating in relation to her experiences of work with clients with BPD.

Psychologists' emotional reactions to clients

In relation to the way psychologists experienced the clients with this diagnosis some psychologists talked about a sense of burn-out that these clients can raise in them, which is similar to descriptions offered by Main (1957).

*If you're going to work exclusively with personality disorder I'd get burnt out very quickly because your own emotional reserves would be depleted, it's very hard work.* (Sarah)

Some psychologists also mentioned the difficulty, expressed in terms of feeling sad or disturbed, in hearing some of their clients' histories.

*I get upset with some of the stories that they tell, and they are horror stories but I also admire them for having been able to survive.* (Tara)
Rose also expressed a sense that the difficult feelings that are brought up in the work with clients leave the therapist feeling pushy and abusive in the relationship.

*I think the other thing, I think this relates to interpersonal issues that there is often quite a strong sense of, it can feel as if you’re abusing a client sometimes and I have experienced that quite a lot which is obviously very very uncomfortable ( ) it feels like you’re pushing somebody to do something that they don’t want to do, that is very painful for them. (Rose)*

Most participants also mentioned the frustration with the slow progress and sense of hopelessness in the work.

*I mean it’s frustrating. Ahm to, you know, to have certain goals in mind and, and see the person working towards them, and then suddenly it all kind of blows up in your face and you have to sort of back track a bit and retrench and, and then start trying to move forward with them again. (Peter)*

Some of the feelings associated with the work with clients, reported by the participants in the study, related to the risk of suicide or self-harm that the clients present. This is similar to the findings by Nehls (2000).

*It can feel quite frightening. This one client I am working with at the moment ( ) she felt responsible but without control and this led to a major suicide attempt a few weeks ago ( ) the situation is really horrendous and the feelings in me are of absolute fear and part of me just wishes that this would just go away because it just felt too much, it felt relentless. (Sarah)*
Patricia on the other hand, experienced the hostility of the clients and the management of her own reactions to this hostility as one of the most challenging aspects of the relationship.

I suppose managing at being very attacked, for me personally I find it very challenging. Both because it's an experience for yourself as a person but to be sitting with a person that's furious with you and quite attacking with you, I suppose it's like managing what needs to be done to allow this not to break down. And managing one's own fury (laughs) back at, you know, back to the individual. (Patricia)

Most psychologists in the study reported feelings of frustration, anger, hopelessness, incompetence and fear in a similar way to descriptions in the literature in relation to the work with clients with BPD (O'Brien, 1998; Watts & Morgan, 1994). In the following quotation, Peter reflected ideas similar to Watts and Morgan (1994) in which the countertransferential hate is responded to through malice or aversion (a wish to prematurely discharge the client and/or be punitive). An interesting point made by Peter is the need to reflect about this as a way of avoiding acting-out these feelings in the relationship. In this way, he seemed to link the theme of the therapeutic relationship with the theme of reflexivity addressed above.

I think I would often feel sometimes quite panicked and started thinking about options of prematurely bringing the work to an end. Sometimes in a punitive way, thinking, my immediate response to the lack of progress, the kind of poignant way in which the person would be blaming me for not being effective and not helping them, would often provoke a desire to be punitive and I had to kind of be prepared to accept that I would feel that sometimes and reflect on that as opposed to act in some way. (Andrew)
Some psychologists were able to articulate the way in which they conceptualised the feelings that were raised in them when working with clients with BPD as being part of the difficulties in the client in a similar way to an aspect of the concept of countertransference in psychoanalytic terms (Bateman & Holmes, 1995).

You’re being made to feel very, sort of, useless, horrible, a failure, or cruel or... all the kinds of feelings that presumably it’s too difficult for someone to have in themselves. (Kate)

Importance of addressing the therapeutic relationship

The quotation above shows that some psychologists viewed the feelings in the sessions as reflecting the clients’ difficulties. This idea was then linked with the importance of addressing the therapeutic relationship when working with this client group.

You’re probably not going to be able to make very much progress in terms of other aspects of the work (.). I mean, I probably couldn’t get very far with that unless you do pay attention to the therapeutic relationship and try and get that right or get it working well. To, having that working alliance is the, is the kind of base for whatever else you do, or whatever else you achieve really. It’s, as I say, probably more important here than, than in a more, anxiety or depression or other, you know. (Peter)

In a more practical way, Anna explained how the relationship can also be useful when assessing risk.

It would be different for different stages, ‘cause when you see somebody for the first time you do a thorough risk assessment, when you know someone over time you’re bringing in your own experience of what happens in these times and how they get through those times. So, yes, some of it is based on a formal risk assessment and some of it is based on your relationship and working out what is going on. (Anna)
Importance of offering a different type of relationship

Some psychologists saw the relationship they were able to establish with clients as a therapeutic tool in itself. Some participants, such as John, saw it as providing a new model of relating, whereas others, such as Sarah, viewed the relationship as a source of containment which seemed to be similar to the concept of corrective emotional experience (Alexander & French, 1946 cited in Bateman & Holmes, 1995) and the ideas of Safran and McMain (1992) described in the introduction.

I think it's been important for her that I've hung in there because she expected that I would just reject her as well, so I think to be honest, I think the essence is about that, about communicating that actually, 'you are worthwhile, I am going to stick in here with you'. Yeah, when I come to think of it, I think it's the most important thing in the work with these people (laughs), saying 'whatever you throw at me, I can help you to think about it and it helps them to feel that there is some kind of containment around themselves because they feel all over the place and frightened by their own violence and frightened by their own behaviour and if you can kind of tolerate that, then it's actually quite containing for the client I think. (Sarah)

In relation to the idea that part of the work with clients with BPD involves offering another type of experience of relating to another, Anna stressed the importance of being consistent and available over a long period of time.

If there was one thing, I think you would need to be consistent, because they need that over a long period of time to help them see that they can act-out but there will be someone there because they never had that from anyone. (Anna)

Most psychologists stressed the importance of having consistent and clear boundaries in relation to times of appointments, contact outside therapy hours, and what clients can
expect of the therapist, for example. However some participants also mentioned the need for a flexible approach due to the high level of need of clients. Anna expressed it in the following way:

_I think flexibility combined with boundaries is important and I think it's about balancing those things. If you're too serious, clients can feel that you don't really care, on the other hand if you're too flexible then there isn't any sense of safety._ (Anna)

Another aspect mentioned by psychologists when working with clients was the need for an acknowledgement of the limitations of what can be done to help clients.

_It's also, I think I don't have great expectations of, you know, so you're not assuming you're going to cure people. I don't kind of consider it a treatment model, you know, a cure model in that sense, but more managing difficulties more effectively. ( ) On the other hand you do have to have some hope for these clients otherwise you're not going to try very hard to help them. ( ) And you also have to be very wary of not thinking that you're going to be the one who helps them. Because they've often been, you know, through a huge amount of people and somehow sometimes we think 'Oh well, maybe we'll be the ones to change their lives' and this would be unlikely. Ahm, so being realistic about what you can offer._ (Rachel)

In the above quotation, Rachel seemed to also make reference to the idea of the therapist feeling special in relation to the client and 'the one' that really understands them. She also raised the importance of keeping these feelings in check. This is similar to ideas by several authors who studied the therapeutic relationship in relation to clients with BPD and who mentioned the tendency for some members of staff (usually individual therapists or key workers) to feel special or flattered while others feel angry or rejecting towards the clients (Gabbard, 1989b; Main, 1957; O’Brien, 1998). This aspect of the relationship was also mentioned by participants in relation to other members of staff.
Relationships within the care system

The dynamics within teams was another important theme that emerged from the transcripts, despite this not being directly addressed in the interview schedule.

She was in phases, there were good and bad phases. Still pushing, still trying to elicit, basically she did try to get the art therapist and myself in a confrontational position and try to get us to respond exactly as her parents did and we were having some success in refusing to do so. (John)

Psychologists mentioned feeling that they were often left to see the clients because no-one else would. This seemed to leave psychologists feeling set up and left with no options (Rachel) and also with a sense that the team saw them as the only one that could rescue the client from their difficulties (Kate).

Sometimes you feel a bit dumped upon because nobody else in the team wants to see them. (Rachel)

In some ways people were feeling that this is so difficult that this hero psychologist was going to come along, and I think it must have been quite powerful fantasy for everybody that psychologists would know what to do with her. (Kate)

Other feelings in psychologists were related to pressures within the team in relation to risk.

Tara: And so this is part of risk management, and every time this client pushes the boundaries, to have structures to contain that but on the other hand to be able to leave with a little bit of anxiety, so that's risk taking.

I: So it is important to be able to deal with your own anxiety.
Tara: Oh yes. And your own anxieties about justifying it to the system, if something goes wrong you feel that you are to blame, or if there is this unwritten rule that you have to do everything right at the right time for the right people and right for the first time. And that is a little bit hard. (Tara)

In relation to risk, participants sometimes mentioned the tensions between the needs of the system and the needs of the clients.

I think it's very challenging and sometimes a lot of the boundaries we have are to protect ourselves and not for the benefit of the clients, there's a real tension about that all the time, and negotiating that. (Anna)

Some participants made specific references to the lack of support they experienced within the team.

And particularly within the context of the CMHT, demands from other people, questions from people about 'what are you doing with this person, how long have you been seeing her and is it really worth continuing any further?', it was more difficult to kind of deal with those sorts of issues. You didn't really feel much support, you didn't feel that the other team members would share the theoretical perspectives, that we had the same ideas about a client. If you talked to your colleagues it would be much easier to feel hopeless as if the work wasn't really worth doing. (Andrew)

Need for team work and limitations of services
Despite the difficulties of working in a team, most psychologists acknowledged the importance of working with other staff when working with clients with BPD, although some participants reported that the support and resources they had available were not sufficient.
And I think most of all you need the things that I complained of not having, good, very good infrastructure of supportive colleagues with some kind of shared model of working with these people. (Patricia)

Almost all psychologists referred to the limitations of resources in CMHTs to deal with the multiplicity of needs clients with BPD present with. Psychologists mentioned the lack of support, supervision and training and the difficulties in dealing with risk since CMHTs are not 24 hour services. Another difficulty reported was the reduced number of staff that in some situations led psychologists to taking up a role of care co-ordinator for their clients that interfered with the therapeutic work. Also the limitations of the number of clients psychologists could have on their caseload that corresponded to a minute percentage of the total of clients referred to the CMHTs was seen as a limitation in their work. Most psychologists stated that they usually maintained clients with BPD on their caseload for 6 months to two years and said that the other staff in CMHTs acknowledged this need for longer term work. Despite the acknowledgement of the limitations of services, most participants saw some advantages in CMHTs providing a service to clients with BPD due to the frequent difficulty in diagnosing BPD and the strict intake criteria most specialist services had that excluded many clients with the disorder.

Rewards of work
Despite the difficulties in the work with clients with BPD, most psychologists referred to the rewards of working with this client group. This is reflected in the next two quotes.

I: What is it like for you working with these clients?
Andrew: () quite satisfying in a way. I mean, maybe it's because you often see things that are quite raw, people can be very complex in the way they present but often times when people are quite unsophisticated and quite crude about the way they express their thoughts and feelings, that made me feel almost quite refreshing in a way. (Andrew)
I think because it's difficult, when there are small gains and things begin to make some sense, you know, they're even more valuable, so you realise what a lot it has taken for someone to begin to make some sense of their experience and that makes it intensely rewarding really, you know, that keeps you going, yeah, yeah, that's good. (Kate)
DISCUSSION

The aim of this study was to explore the experiences of psychologists working in CMHTs in relation to their work with clients with BPD. More specific goals were to explore the understanding psychologists had in relation to the disorder, their subjective experiences of working with these clients and the strategies they used in their interventions. The study also attempted to explore issues surrounding the therapeutic relationship. It is considered that the goals of the study were achieved in that a wealth of data was collected and the themes identified through a systematic qualitative analysis provide information to answer the research questions (and this will be further developed below). However, it is recognised that there are limitations that need to be taken into account when evaluating the quality of the data and results gathered. These limitations are explored below, prior to the discussion of the themes elicited through the data analysis.

Limitations of the study

One of the important aspects to take into account when evaluating this study is that of generalisability. Due to the low number of participants and the qualitative nature of the research design, it is not possible to generalise the results to other settings and populations. However, to the extent that other studies have found or find similar results to the ones obtained, it can be possible to generate hypotheses that could be tested in further studies with more representative samples.

The group of participants also included a majority of psychologists who described their main approach to therapy as cognitive-behavioural and this may have influenced the results obtained and may not be replicated with a more representative sample. It is however, interesting to observe that most psychologists made reference to concepts used in other approaches (such as containment, transference, countertransference and idealisation/denigration), despite describing themselves as cognitive-behavioural therapists. This may indicate that some of the processes described by the participants are
not exclusive to a particular therapeutic approach, but are indeed more general issues in the treatment of BPD.

Another aspect that may have impacted on the results was the fact that the researcher was a clinical psychology trainee who interviewed experienced qualified psychologists. This difference in status may have affected the content of the data. For example, it is possible that psychologists found it difficult to report negative experiences of their work with clients with BPD that could have left them feeling exposed in front of a trainee clinical psychologist and fearful of being judged in relation to their general abilities as psychologists. However, the fact that all of the psychologists interviewed did report difficulties in working with this client group, and that these reports were similar to the wider literature, indicates that this may not have presented a significant problem in terms of the validity of the data.

The main limitation of the study is the fact that psychologists were asked about their experiences of working with clients with BPD but were not given a clear definition of this diagnosis. Therefore, the material presented by them in relation to their clinical work could not be judged against established definitions of BPD (e.g. the DSM-IV definition). Due to the difficulties described in the literature in relation to the definition and diagnosis of BPD (Westen & Shedler, 1999), it is possible that psychologists reported experiences with clients who may not have met the diagnostic criteria. This is an important aspect to take into account when analysing the results presented above. However, this limitation was unavoidable due to one of the goals of the project, which was precisely to obtain an understanding of the views psychologists had in relation to the diagnosis of this disorder. It is also relevant to consider that most psychologists were able to refer to at least some of the DSM-IV (APA, 1994) criteria for BPD, demonstrating an awareness of the diagnosis.

Finally, the analytic procedure may have been influenced by the position of the researcher, thus potentially biasing the analysis. The researcher's own interest in the study
of the therapeutic relationship and the emphasis on the reflective process, which constituted two of the main themes identified may have led to the neglect of other important issues. It is hoped that by having other contributors participate in the first stage of the analytic process this bias may have been to some extent reduced. In relation to the analytic process it is also important to recognise the influence of the researcher’s prior knowledge of the literature relating to BPD which may have influenced the way the data was interpreted.

Psychologists’ understanding of BPD
Psychologists revealed some awareness in relation to the concept of BPD as defined in DSM-IV (APA, 1994) by referring to most of the criteria for the disorder present in the manual. However, the majority of psychologists in the study did not readily identify the criteria of fear of abandonment and feelings of emptiness as characteristics of BPD. It appears therefore that most of the psychologists in this study did not rely on these two criteria to describe and conceptualise BPD. One possible explanation for this may be that psychologists do not see these two criteria as part of the core characteristics of BPD (and therefore did not mention them in the interviews) or that they see them as similar to the criteria of difficulties in forming and maintaining interpersonal relationships and identity disturbance respectively.

As most psychologists described their main approach as cognitive-behavioural and had received some training in DBT (the approach proposed by Linehan, 1993a), it was not surprising to find that many psychologists used this model to conceptualise the difficulties observed in BPD. Therefore, some psychologists saw the client’s presenting difficulties as the result of emotional dysregulation that they saw as a combination of high affect and an inability to deal with emotions leading to impulsivity and behaviours such as self-harm to cope with this high affect.
An interesting result in this study was the emphasis participants put on the criteria of difficulties in interpersonal relationships. This is in accordance with the definition proposed in the DSM-IV manual and other texts (APA, 1994, 2001) - however, psychologists in this study went further in basing their descriptions of the diagnosis on the reactions of others (usually staff) in relation to clients. Although the difficulties staff in mental health settings have in relating to BPD clients have been described in the literature (Bateman, 1998; Breeze & Repper, 1998; Gabbard, 1989a; Main, 1957; Norton & Dolan, 1995; O’Brien, 1998; Watts & Morgan, 1994), it is usually not referred to when discussing diagnostic issues. This would be an interesting issue to explore in further studies since it suggests that psychologists use the information provided by other members of staff as well as staff’s personal reactions to clients as a source of information in relation to the diagnosis of BPD. One suggestion that can be made in relation to this issue is that it could be useful to develop assessment strategies for BPD which take into account the perceptions of significant others (who may be staff who have extensive contact with the client). This is similar to a suggestion by Westen (1997) in relation to the assessment of personality disorders (not just BPD), who pointed out the limitations of using self-report measures for these disorders. The author stressed the difference between assessment of axis I disorders, which are usually a collection of symptoms that the individual is able to recognise and report on, as opposed to personality disorder characteristics that may be more difficult for individuals to identify in themselves since they are intrinsic to their personality and functioning.

In relation to the issue of diagnosis, psychologists reported some confusion and reservations about its usage. They reflected some of the issues discussed in the literature such as the overlap between the different categories of axis II disorders (Dolan, Evans & Norton, 1995; McGlashan et al., 2000) as well as the high heterogeneity observed in the group of clients with a diagnosis of BPD (Whewell et al., 2000). With regard to the first issue some authors have suggested the adoption of a dimensional classification system as opposed to a categorical one in relation to personality disorders (Bank & Silk, 2001;
Maffei & Fossati, 1999; Westen & Shedler, 1999). It is interesting to note that one
psychologist in the study also made specific reference to this issue by conceptualising
BPD within a continuum of human functioning instead of constituting a distinct group of
symptoms.

In relation to the diagnosis, psychologists also reported a sense from their own
experiences that the BPD category tends to be used in relation to ‘difficult’ clients and as
such, had negative connotations. Some psychologists made reference to the prejudices
observed in staff teams in relation to this client group. They believed an aspect of their
role to be the provision of a psychological understanding for other staff as a means of
reducing the stigmatisation of clients. In some of the reports there was also a belief that
services could sometimes have a negative effect on clients and contribute to the
maintenance and even amplification of the disorder. This negative effect was sometimes
attributable to the prejudices within services, other times to the lack of resources in
mental health services. This aspect has implications for the development of services in
that it seems to point to a need for training in order to increase the level of understanding
of BPD in staff and also the development of treatment models that take into account the
limitations of resources in community teams. It would be important to carry out further
studies in relation to these two aspects through, for example, a survey of mental health
staff’s understanding of BPD as well as strategies used in its treatment.

The reports of psychologists in this study supported the general idea that early negative
experiences constitute an aetiological factor for BPD (Liotti et al., 2000; Murray, 1993).
This points to the need to develop early intervention therapeutic models that may prevent
the development of the disorder in adulthood. One of the areas that has received some
attention and that may constitute an avenue for the development of preventative and early
intervention models is the link between attachment patterns and BPD (Fonagy, Leigh,
Steele, Steele, Kennedy et al., 1996; Fonagy, Steele, Steele, Moran & Higgitt, 1991;
Subjective experiences of psychologists

The experiences reported by psychologists in the study were similar to other studies of experiences of staff working in both in-patient and out-patient settings in relation to clients with BPD (Bateman, 1998; Breeze & Repper, 1998; Gabbard, 1989a; Main, 1957; Norton & Dolan, 1995; O'Brien, 1998; Watts & Morgan, 1994). Psychologists reported feelings of anger, hopelessness, incompetence, frustration, burn-out and fear in relation to their therapeutic work. Some of these feelings were related to the slow progress of clients when in therapy and the anger that clients themselves often expressed towards therapists. There were also strong feelings of worry and fear in relation to risk. In relation to this aspect most psychologists indicated the need for a team approach to risk where responsibility and support should be shared between team members.

The feelings of frustration reported by psychologists in the study seemed to confirm the hypothesis by Breeze & Repper (1998) who made reference to the challenges clients with BPD pose to health care professionals in relation to their self-image as providers of cure and progress. Psychologists in the study stressed the importance of self-awareness in relation to this process in order to avoid having a negative impact on clients (for example, by processing and understanding their desire to terminate therapy prematurely). Also, they mentioned the need to have limited but realistic expectations with regards to change in clients due to the complexity of their difficulties.

Despite the difficulties inherent to this work, most psychologists also reflected on the rewards of working with this client group. They mostly referred to the satisfaction of seeing clients with a multitude of difficulties being able to use some of the help offered to help themselves and change their behaviour and thinking. This is an important aspect to take into account in relation to this client group. It seems that the psychologists in this study were able to view their work as potentially beneficial and valuable to clients,
despite recognising the difficulties. This view contrasts with ideas reported earlier in the literature of seeing clients with personality disorders as untreatable (Campling, 1998). This may also reflect the recent development of models of treatment for BPD that provide concrete ways of intervening with this client group.

Another interesting point in relation to the experiences of psychologists was the way in which the feelings raised in therapy were conceptualised as being part of the clients’ difficulties and therefore an important aspect to focus on, both in relation to formulating the difficulties but also as a focus for the intervention. These two aspects will be developed further below.

**Strategies employed by psychologists**

The first strategy—psychologists mentioned in this study was the need to develop a formulation of clients’ difficulties. Although most participants recognised this need in relation to any psychological work, there was also an emphasis on this process in relation to clients with BPD. This formulation was seen by some psychologists as a way to maintain a compassionate view of clients despite the difficulties in the work but also to provide an anchor in the face of the clients’ instability. Participants also reported that it was important for them to share their formulation with both clients and other team members. Furthermore, they saw the development of a shared understanding with the client as a goal for therapy and as a way to provide insight and awareness. This view is in some ways similar to psychoanalytic approaches (Bateman & Holmes, 1995) that view the development of greater awareness as a goal in therapeutic work. However, some psychologists in the study made specific reference to a strategy used in CAT (Ryle, 1997) of developing a concrete formulation with the client that served as a ‘map’ to consult when difficulties arose. Psychologists mentioned this need for a concrete formulation as a way to help clients achieve an observant posture in relation to themselves. It is possible that the idea of developing concrete formulations was related to the sample in the study, that was constituted largely by psychologists whose main approach was cognitive-
behavioural and who therefore favoured a more active and collaborative position on the part of the therapist. However, it may also indicate an important strategy to use in community or out-patient contexts where the resources may not allow for a gradual working through that is more characteristic of long-term psychoanalytic approaches (Bateman & Holmes, 1995).

In relation to formulating, psychologists made reference to the use of their interpersonal experiences with clients as a source of information in the development of an understanding of clients' difficulties. In fact, work associated with the therapeutic relationship was a central theme in the data. Another important and related theme was the frequent reference to the team dynamics around clients with BPD that again was used as a source of information for the development of formulations but also as an important aspect influencing the work with clients. These two aspects, the therapeutic relationship and care system dynamics will be addressed next.

**Therapeutic Relationship**

All psychologists in the study stressed the importance of the therapeutic relationship when working with clients with BPD and they viewed it as a main therapeutic tool in their interventions. Psychologists tended to use the feelings raised in themselves as well as the expressions of feeling from clients in relation to them as a source of information for the development of a formulation of the clients' difficulties. For example, many psychologists viewed the anger clients tended to express towards them as a result of clients' own negative expectations in relation to others (due to their early experiences of rejection or abuse). The psychologists in the study also reported that they used the feelings raised in them as a source of information in this process of formulating in a similar way to the psychoanalytic concept of countertransference. Furthermore, they also showed some sensitivity with regard to the distinction between the countertransference process that is part of the clients' difficulties and the psychologists' own personal issues that could also be brought up in their work (Bateman & Holmes, 1995). They stressed the
importance of self-reflection as a way of distinguishing between these two types of countertransference so as not to affect the course of therapy in a negative way. This result was surprising since most of the psychologists in the study used mainly cognitive-behavioural approaches in their work that do not tend to focus on these issues. Participants in this way reflected a general trend present in the personality disorders literature towards integration of theoretical models (Bateman, 2000).

Another important aspect in relation to the therapeutic relationship was the idea that one of the therapeutic mechanisms in their interventions was the provision of an alternative type of relationship where the psychologist would model a different way of relating. This idea seems to be similar to the concept of corrective emotional experience (Alexander & French, 1946 cited in Bateman & Holmes, 1995, referred to in the introduction) as well as the suggestions by Safran and McMain (1992). This seems to be an important aspect of the work with these clients and it would be useful to research it further since it might constitute one of the active ingredients of the psychotherapeutic work.

In relation to specific strategies, psychologists stressed the importance of being consistent and of being very clear about what clients could expect from therapy. This seemed to be important in that it provided a level of predictability to clients in contrast with the instability clients experienced in their lives. However, participants also mentioned a need to be flexible in responding to clients' changing needs.

**Systems dynamics**

An interesting result in this study was the frequent reference to team issues in the interviews, despite this aspect not being directly focused upon in the interview schedule. In the context of community teams, the systems dynamics appeared to be quite significant in influencing the work carried out by the psychologists in this study. One of the aspects reported by psychologists was a sense of lack of understanding in teams in relation to BPD. This was related to the negative connotations frequently given to the BPD diagnosis.
by team members. The majority of the psychologists in this study viewed their role in teams as providing formulations and understanding in relation to clients diagnosed with the disorder. They also stressed the importance of having a team approach to intervention that clearly defined roles and a consistent understanding of clients' difficulties. However, participants stressed the difficulty of doing so.

Some psychologists reflected on the lack of resources in community services that prevented the development of cohesive team approaches. Others reflected on the inherent difficulties in the work with this client group. For example, participants made reference to the tendency in teams of staff adopting very polarised views in relation to clients with BPD in a similar way to the reports by Gabbard (1989b) in relation to splitting in hospital settings. Other participants pointed out the similarity between their own reactions of sometimes wanting to end therapy and other team members' wish to withdraw support or reject clients. They again conceptualised this process as being part of the clients' difficulties in being able to form stable and trusting relationships with others. Some participants stressed the importance of acknowledging and reflecting about the strong feelings in staff in order to develop more effective ways of intervening. The need for the use of a reflective capacity that was identified as a main theme in the transcripts will be focused on next.

**Reflexivity**

The theme of reflexivity seems to capture an idea developed by Fonagy and colleagues (Fonagy, 1991; Fonagy et al., 1991, 1996, 2000) in relation to BPD in which the disorder is conceptualised as a basic fault in a reflective capacity linked to the inadequacy of the person's early environment. As was reported earlier in this report, studies have found a strong link between child abuse and early traumatic experiences and the later diagnosis of BPD (Liotti, et al., 2000; Murray, 1993).
Some authors (Fonagy et al., 2000) suggest that in families where abuse occurs and, as a consequence, insecure attachment patterns develop, children will also develop a defective reflective capacity (Fonagy et al., 2000). It is suggested that proximity seeking behaviours in children who are abused usually lead to the amplification of distress instead of reassurance (through the inappropriate and abusive responses of caregivers), thus creating more need within the child and at the same time overwhelming anxiety. Emotional closeness then becomes a source of threat and this leads to difficulties in the development of a reflective capacity. To be able to think about other people's motivations (usually the parent's) in this situation could lead to the realisation for the child of being rejected and feeling unlovable, which is hypothesised as being too intolerable for the child. The response of the caregivers that totally denies or distorts the child's needs also leads to distorted self-representations on the part of the child that will then condition the way in which the child relates to others (Fonagy et al., 2000). This lack of reflective capacity can explain many of the symptoms observed in BPD, such as the unstable sense of self or a sense of emptiness.

One study focused on the adult attachment classification and psychiatric diagnoses and found that BPD clients were more likely to be fearfully preoccupied (Fonagy et al., 1996). This group of clients was also more likely to report experiences of childhood abuse and neglect and showed a lack of resolution in relation to these events, and also showed less capacity for self-reflection. Due to the complexity of the variables and measures used in this study, there is a need for replication of these results. However, the results point to a link between insecure patterns of attachment and BPD that may be mediated by a defective reflective capacity. Another study (Fonagy et al., 1991) with parents and children found a link between the parents' capacity for reflection with the development of secure attachment patterns and the later development in the child of a capacity for self-reflection. Although replication of these findings is needed, these studies seem to suggest a link between attachment, reflective capacity and BPD.
Fonagy and colleagues (Fonagy, 1991; Fonagy et al., 2000) suggest that the lack of ability to reflect about self and others has implications for clinical practice in that one of the goals of therapy with clients with BPD may be to develop an ability to reflect about the self and others. The experiences psychologists reported in this study seem to support this view in that they viewed the role of formulating clients' difficulties as central to their therapeutic work. Participants in this study reported not only the difficulty in reflecting that they observed in clients but also their own and other team members' difficulty in maintaining this capacity when working with BPD clients. Therefore they stressed the importance of reflecting about clients either in the context of supervision or team discussions. Furthermore, they viewed the development of a formulation in collaboration with clients as one of the goals of therapy as a way to develop the 'thinking side rather than the reactive, impulsive side', as one psychologist put it (Kate). This point is important in relation to the work with clients with BPD and models such as CAT that seem to incorporate in their goals and strategies the development of a joint formulation may be useful in relation to this aspect.

Future Research

Due to the broad areas covered in this study, several avenues for future research can be suggested. One of those avenues is related to the conceptualisation and diagnosis of BPD which was identified as one of the main themes in the study. Psychologists stressed the importance of the interpersonal nature of the disorder and described their experiences of using the reaction of other staff members as indicative of the presence of the diagnosis. This idea could be further explored in two ways: one would be to use the experiences of health care staff with BPD clients to develop more clinically relevant criteria as well as assessment tools for the diagnosis in a similar manner to research developed by Westen and Shedler (Westen, 1997; Westen & Shedler, 1999). As some psychologists expressed an opinion that other staff members frequently held negative views of clients with BPD, it would also be interesting to conduct surveys of mental health professionals' conceptualisation of the disorder to assess the level of understanding and the training needs of staff working in community teams.
Another interesting area for future research is related to the theme of reflexivity. This theme identified in the transcripts seemed to support some of the theoretical ideas put forward by Fonagy and colleagues (Fonagy, 1991; Fonagy et al., 1991, 1996; 2000) in relation to the role of lack of reflexive capacity as a mediating variable between attachment and BPD. These authors have begun to develop specific research tools (namely the reflective-self function scale (Fonagy et al., 1996)) to assess reflective capacity in both children and adults and it would be interesting to continue to develop these methods by both attempting to replicate their findings and further develop the link between lack of reflective capacity, BPD and treatment.

One unexpected finding in the present study was the importance psychologists gave to team dynamics in the treatment of BPD. Although this has been extensively researched in the literature (especially in relation to in-patient treatment), this aspect has failed to be integrated in treatment models of BPD. It would therefore be of interest to begin to develop systemic models of the treatment of BPD which could integrate both the individual relationship between worker and client but also the relationships between different team members. This was attempted in an interesting case study by Kerr (1999) who integrated organisational issues with a CAT model of treatment. Further efforts in this direction would provide interesting areas for research and clinical practice.

Conclusion
The wealth of data generated in this qualitative study provided several ideas in relation to the conceptualisation and treatment of BPD with implications for both research and practice in this area. Although the questions addressed have been researched by different authors (for example, Bergman & Eckerdal, 2000; Higgitt & Fonagy, 1993; Kernberg, 1999; Linehan, 1993a), the qualitative nature of the methodology used allowed for an integration of different aspects of the conceptualisation and treatment of BPD in the context of CMHTs. Thus, it is possible to see the relationships between the three broad themes identified from the transcripts (i.e. conceptualisation of BPD, reflexivity and complexity of relationships). For example, it can be seen that each of the three themes encompassed different levels of psychologists’ experiences. Psychologists referred not only to their experiences of
working directly with clients but also their relationships with other members of staff in the teams they worked in, as well as other staff's relationships with clients. The relationships within the system of care appear therefore to be extremely relevant in relation to this group of clients. The reactions of staff may provide valuable information for the conceptualisation and/or diagnosis of BPD. Also, the work with staff to develop understanding and treatment plans for this group of clients appeared to be central to the psychologists' perceived role within teams.

It is interesting to note that although the complexity of relationships within care systems has been addressed in several studies (for example, Bergman & Eckerdal, 2000; Breeze & Repper, 1998; Nehls, 2000; O'Brien), this body of literature has failed to be integrated in the theoretical and treatment models for BPD, such as the ones described in the introduction of this study (which tend to focus solely on the interaction between therapist and client). In relation to the work in CMHTs where it is likely that clients will have contact with more than one professional (Kerr, 1999), it may be important to develop models that take into account the interrelationships between the system of care and clients. This has been addressed in an interesting case study by Kerr (1999), where the author integrated the wider system issues with the individual formulation of the clients' difficulties within the CAT model. Other efforts in this direction would provide interesting avenues for research.

The theme of reflexivity encompassed similar ideas to those proposed by Fonagy and colleagues (Fonagy, 1991; Fonagy et al., 1991, 1996, 2000) in relation to the difficulty BPD clients have in reflecting about themselves and others. However, the data in the study seemed to specifically link this difficulty with psychologists' own and other staff's difficulties in carrying out therapeutic work with these clients. Psychologists seemed to stress the importance of developing therapeutic strategies which help professionals maintain this capacity in themselves as well as develop it in their clients. Further studies in this area, perhaps using similar methodologies to those used by Fonagy and colleagues (Fonagy et al., 1991, 1996) in relation to the assessment of a reflective capacity in clients and the link between this capacity and attachment would be relevant for the development of knowledge in this area.
In relation to the therapeutic relationship, psychologists in this study seemed to confirm the idea widely accepted in the literature of its importance in relation to this group of clients. Although the therapeutic relationship has long been identified as one of the most important factors affecting outcome in any therapy (Martin et al., 2000), this aspect has been recognised as central in the treatment of BPD. Therefore, the data in this study seem to support the wider literature in relation to the difficulties in establishing a good working alliance with this group of clients, and the importance of developing specific strategies to maintain it. Interestingly, the participants referred to the importance of providing a different relationship (to the ones clients experienced in their lives) as one of the healing aspects of therapy. Psychologists suggested that this healing process can be carried out by using the feelings raised in therapists and clients as information for the formulation of the difficulties presented and by addressing these difficulties directly with clients.

One of the more interesting aspects observed in this study was the level of theoretical integration shown by participants. Thus, most participants made references to several psychoanalytic concepts (such as transference, containment and boundaries) despite describing themselves mainly as cognitive-behaviour therapists. They also accepted the importance of addressing the therapeutic relationship despite this being more in the realm of traditional psychoanalytic thinking. Also, the reference to models such as DBT and CAT revealed some awareness regarding the recent developments in this area. The ideas of Bateman (2000) who pointed out the avenue for integration provided by BPD seems to be supported by the data in the study. It appears that the integration of concepts and/or strategies from different models whilst maintaining a coherent theoretical framework is not only possible but desirable in relation to the study and treatment of BPD.
REFERENCES


APPENDICES

- APPENDIX I: DSM-IV CRITERIA FOR BORDERLINE PERSONALITY DISORDER
- APPENDIX II: FIRST LETTER FROM ETHICS COMMITTEE
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- APPENDIX IV: INFORMATION SHEET
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- APPENDIX X: DEMOGRAPHIC SHEET
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- APPENDIX XII: TABLE OF ALL THEMES
APPENDIX I

DSM-IV Diagnostic Criteria for Borderline Personality Disorder
(APA, 1994, p. 654)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms
APPENDIX II

First Letter of approval from Ethics Committee
Dear Ms Mendes

The experiences of psychologists working with clients with borderline personality disorder: A phenomenological interpretative analysis (ACE/2001/46/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2001/46/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 20 August 2001
Date of expiry of approval by the Advisory Committee on Ethics: 19 August 2006

Please inform me when the research has been completed.

Yours sincerely
APPENDIX III

Second Letter of Approval from Ethics Committee
Dear Ana

Re: The Experience of Working With Clients With Borderline Personality disorder: An Interpretative Phenomenological Analysis

Your project has now received all the necessary approvals.

Please find enclosed two copies of the Research & Development Agreement, please sign them and return one to me at the above address.

Yours sincerely
APPENDIX IV

Information Sheet
INFORMATION SHEET

The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis.

Researcher: Ana Mendes, Trainee Clinical Psychologist, University of Surrey

Supervised by: Dr. Brian Solts, Clinical Tutor of the PsychD in Clinical Psychology, University of Surrey

We are interested in finding out about psychologists’ experiences of working with clients with borderline personality disorders, especially in relation to the establishment and maintenance of a therapeutic alliance. It is well established in the literature that the quality of the alliance is related to outcome and we are hoping that this study will further our understanding of the variables influencing the development of a good therapeutic alliance with clients with borderline personality disorder.

Participation in this research will involve an interview lasting between one and one and a half hours with the above researcher. You will be asked questions about your experiences
of working with clients with borderline personality disorder and about your understandings of the quality of the therapeutic alliance. You have the right to withdraw from the study at any time without needing to justify your decision.

The interviews will be audio-taped and transcribed for analysis, with each tape and transcript being allocated identification numbers in order to ensure anonymity. All data will be treated confidentially and used only for the purpose of the study. We may use quotations to illustrate our findings in the research report. However, no individual or organisation will be identifiable in these quotations as all potentially identifying information will be removed. Tapes will be erased once they have been transcribed.

If you agree to participate in this study, we will ask you to sign a consent form and a suitable time will be arranged to conduct the interview.

If you are interested in receiving feedback regarding the outcome of the study you can inform the main researcher during the interview or you can contact the researcher or her supervisor at the address below.

We are also aware that the participation in such in-depth interviews can touch upon some sensitive issues. If, at any point during or after the interview, you feel that you would like to discuss these with someone else, you can contact the researcher's supervisor in total confidentiality, at the address below.

Should you wish to speak to the researcher or her supervisor regarding any other issues related to the study, we can be contacted at the Department of Psychology, University of Surrey, Guildford, Surrey GU2 7XH.
APPENDIX V

Letter to potential participants
Dear [Psychologist's name],

Re: The experiences of working with clients with borderline personality disorder: An interpretative phenomenological analysis

I am a Trainee Clinical Psychologist at the University of Surrey in my final year of training. For my research dissertation, I have chosen to explore the area of working therapeutically with clients who have a diagnosis of borderline personality disorder. In particular, I am interested in the experiences of clinical psychologists, who work as part of a Community Mental Health Team, and have worked therapeutically with clients with borderline personality disorder. I obtained your name and work contact details from the Register of Chartered Psychologists published by The British Psychological Society. I am writing to ask for your collaboration in this project. Your participation will involve an interview lasting approximately one hour, and no more than one and a half hours. I enclose an information sheet about the project with more details of what your participation will involve.

The study is being supervised by Dr. Brian Solts, Clinical Tutor and Chartered Clinical Psychologist at the Psychology Department, University of Surrey, and he can be contacted at the address above. The project has obtained ethical approval from the Advisory Committee on Ethics of the University of Surrey.

I will contact you shortly to enquire about your willingness and availability to participate in the project. I would like to take this opportunity to thank you in advance for reading this letter and considering participation in this project.

Yours sincerely,

Ana Mendes
Trainee Clinical Psychologist
APPENDIX VI

Letter of Approval of Change from Ethics Committee
Dear Ms Mendes

The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis
(ACE/2001/46/Psych) – Amendment

I am writing to inform you that the Chairman, on behalf of the University Advisory Committee on Ethics, has considered the Amendment requested to the above protocol, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2001/46/Psych) – Amendment. The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 20 November 2001
Date of expiry of approval by the Advisory Committee on Ethics: 19 August 2006

Please inform me when the research has been completed.

Yours sincerely
APPENDIX VII

Interview Schedule
INTERVIEW SCHEDULE

The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis.

Part I - Concept of borderline personality disorder and core difficulties of clients diagnosed with the disorder.

- What do you understand as Borderline Personality Disorder?
- What comes to your mind when you are about to assess a client diagnosed with BPD?
- From your clinical experience, what are the things you associate with a BPD diagnosis?

- What do you think are the core difficulties of clients with this disorder?
- What kind of interpersonal difficulties do clients have?

Part II - Experiences of working with clients with borderline personality disorder.

- What is it like working with these clients?
- What are the challenges of working with BPD clients? (How do these challenges make you feel?; How do you deal with this?)
- What feelings or emotional reactions do you find yourself experiencing in relation to these clients? Do these have any impact on the course of therapy? If so, in what way? How do you deal with these issues?
  
  Positives, negatives, examples.

- How would you describe the therapeutic relationship you establish with these clients?
- What characteristics of clients impact on the development of a therapeutic alliance? In what way?
- Can you give me an example of a difficult situation with a client?
  What did you do about it, to resolve it?
  How did you feel about this situation then?
  How do you feel about the situation now?
  (One experience where situation was resolved and one example of unsuccessful attempt to help.)

- Are there any particular difficulties in establishing a working alliance?
  Examples. If yes, what do you think is the basis of these difficulties?

- Are there any particular difficulties in maintaining a working alliance?
  Examples. If yes, what do you think is the basis of these difficulties?

- How important is the therapeutic relationship when compared for example with skills training in the work with BPD clients?

Part III - Management of work.

- What is (are) for you the main goal(s) of therapy when working with these clients?
- What do you think is the best way to achieve it (them)?

- What do you think is helpful when working with these clients?

- What do you think would be unhelpful when working with these clients?

- What do you do that is helpful when difficulties arise?

- How do you manage risk with these clients?
- Have you ever felt unable to continue to work with a BPD client? Why?

- In what way can psychologists be helpful to these clients?

- What are the things you (or a psychologist) need(s) in order to work effectively with these clients?
  
  Individual qualities
  Training
  Team factors (support, multidisciplinary work)
  Supervision

- What are your views about the current provision of mental health services for clients with borderline personality disorder?
  
  Positive and negative factors.

Thank you very much for your help.

Debriefing time: discuss the process of the interview and address any issues or concerns which arose for the participant.
APPENDIX VIII

Example of full transcript
Interviewer (I): The interview is basically divided in three parts, ahm, and they are all related to your experiences of working with clients with BPD but the first part is about your ideas about the concept of BPD and what you associate with it. But the first question is what you understand as borderline personality disorder, but again, you don’t have to tell me all the characteristics of DSM, it’s more of your sense.

Anna: I suppose when I think about it, if I had to encapsulate it, what I would say to a client is that it is something that is not an isolated problem which it can be. It’s part of the way the person relates to the world, the way they respond to the world in particular ways and as I explained to clients before, they don’t have the kind of buffers that other people got, so they respond much more strongly emotionally to stimuli and to problems, it can be impulsive behaviour, self-harming behaviour, provokes very strong emotions. They’re very ambivalent about people, you know, expecting to be rejected, sort of ‘I hate you, don’t leave me’, that kind of idea of attachment being very ambivalent. And what I found personally is that often with clients is quite difficult to engage them, but when they do engage, they can engage very strongly. So that, I suppose are the main things, the impulsive behaviour, the difficulties in relationships and engaging in trusting relationships and the very strong emotional reactions would be the things that I would think about.

I: Great. What comes to your mind when you’re about to assess a client diagnosed with BPD?

Anna: I guess I would be anticipating that there would be difficulties around issues around trust. That they would also have been bounced around in the service a bit and who may have had some fairly, ahm, what could you call it, negative experiences that are going to colour how they react to me. I think also within that, it’s interesting that I suppose, the thing about these clients is that they cause you to reflect on yourself. Some people I have engaged very well with, but some people I haven’t been able to engage with at all, so it’s always something about, can I find something I can make a connection with
them and have that empathy with them, because personally if I haven’t got that empathy it’s very difficult to tolerate the behaviours that go with it, cutting and all the other things that come up, it’s very difficult to take those things unless you’ve got a bit of empathy. So I guess I would be thinking around things like trust and making a connection with them, and be aware that they may well have had negative experiences in the past. Those issues I think would be, what would come into my mind. And also that, you know, people have quite negative impressions of clients.

I: Other professionals you mean?

Anna: Yeah, other professionals, they tend to see people’s behaviour in terms of manipulative and attention seeking, so I would be aware that that is, the kind of behaviours that could cause those labels and I guess not labels that I would like to use themselves. Sometimes I don’t even read the file, if I can avoid it (laughs), because I like meeting somebody fresh...

I: Making your own impressions.

Anna: Yes, make my own impression first, rather than go with somebody else’s impression of the client. Because I think it is such, with these clients, perhaps more than any others, the emotional reaction to them is defining almost.

I: Right, right.

Anna: It’s interesting, because when I have had trainees and they’re describing a client and sometimes they are just puzzled or..., and you just think, this is somebody with borderline personality disorder and that’s what they are grappling with, these contradictions and I can, I wouldn’t like to make a diagnosis but it would be certainly a hypothesis I would have in mind. I would look at someone’s emotional reactions to them and what that’s based on.

I: And it also feels as if, you were saying about trying to look for something that would allow you to empathise with the client. It sounds as if it’s more hard work to do that than with other clients, is that true, you think?

Anna: It can be, because I think, people with this diagnosis, I always wonder, in some ways it is a really useful concept but there are those ways of reacting. I guess what I have
difficulty with is calling it a personality disorder because I think that's pejorative phrase and it's unfairly pejorative in many ways. Ahm, although I have often found that the clients are relieved to have something that they can hold on to because, you know, they say 'I have always felt different to other people' and that kind of explains it. So, sorry I lost track of the question.

I: It's harder to empathise.

Anna: Oh yes, yes it is because they are acting often out of these very strong emotional reactions out of fear and you have to look beyond that but it does mean that they can come in, in a very kind of adversarial style at times. Actually, somebody I have been working with for a very long time, and we have a very strong relationship now but I was really quite, I started seeing her not long after I qualified or not longer after I joined the team and I was quite intimidated. She was quite bolshy and also the sort of impulsive behaviour, cutting and so on. I think it's something which, again you've got to develop a philosophy, a way of thinking about it that makes sense, so all those things can make it difficult. Ahm, a couple of clients who have got this diagnosis, as I say, I haven't really managed to build up a relationship. Mostly because I think they were looking for something that I didn't have and couldn't offer them. They had been passed from one service to another, several services, looking for something that wasn't there or couldn't be given to them and then them getting passed around and on the one hand being aware of that, thinking, just stick with it and just say to the person, you know, 'we can't offer you that but we can offer you this' and they often end up rejecting the service anyway. So those are the one I find most difficult, I suppose, the ones that are quite angry and are looking for something that perhaps the service can't offer them and then being very angry and rejecting when they don't get whatever that they are looking for. They're not very clear what it is, 'cause they might ask you for something very specific and then when you offer it to them, it's rejected. So I think that they are looking for something more nebulous really, which you can't put a name on. I think probably those are the most difficult. The ones I get more in the service are the ones that are just overwhelmed by emotions and they don't know what they want and where they're going but they can
engages you, between you, you can kind of work it out, rather than them coming and demanding something which can be quite difficult. But I think, you know, like any diagnosis what diagnosis does is it tells you about the similarities but it doesn't tell you about the differences between the clients but I guess it's a group where people are very different and the way they express their symptoms, its expressed very differently for different people.

I: So you find that some people are easy to engage with and others are more difficult?

Anna: Yes they are very very difficult, very difficult and I think the whole personality disorder, you know, where they get put within that category is probably very arbitrary.

I: You mean the label of specific personality disorder?

Anna: Yes, borderline or narcissistic or dependent. Actually they don't call them borderline now, they call them emotionally unstable, which you and I know that (inaudible) So you know, I think it's actually pretty arbitrary which category they get put into.

I: So there are characteristics that are shared...?

Anna: Yes, because it's a personality thing and it's the way people relate to the world and, yeah I think there are overlaps and I think the research says that the category of personality disorder is fairly robust but within it, there's not such a clear definition and as I said I tend to use it more as a working hypothesis rather than diagnosis because I think, I think it's quite tricky to diagnose actually.

I: And it feels like from your experience it's very fuzzy.

Anna: Yes and as I said, the snapshot that I use and the way of thinking about it, the people that I have worked with this diagnosis, is that it's very different and the difficulties affect them in different ways and they react to it in different ways, so I think, I tend to be very flexible.

I: You mentioned something about trust, about how difficult it is for people to build up trust with clients. Where does that come from, why is it difficult?

Anna: I suppose we would get to the so called theories around borderline personality and I think probably it comes from earlier experiences. Clients I've worked with, with this
diagnosis have without fail had traumatic backgrounds, where they have been let down by
the main caregivers in various ways or in situations where it was impossible to please the
main caregivers. So I think it comes from very early experiences of trusting someone and
being let down and then of course as they grow older, because of the way they behave,
which of course reinforces and maintains that. I always see it as a combination of those
things and I guess if there was one thing, I think you would need to be consistent, because
they need that over a long period of time to help them to see that they can act out but
there will be someone there because they never had that from anyone. So, yes, I think it
comes from those earlier experiences and then is added by subsequent experiences
because of the way they are, it’s an interactive process, a dialectical, partly to do with
earlier experiences but also to do with maintaining experiences.
I: You mentioned a long time, can you give me some idea of how long?
Anna: Well, someone I mentioned that I started seeing shortly after joining the team, I've
been in this team 8 years. It changes in frequency but she has been in contact with me.
Yeah, when things are stable, we might meet every six weeks, at the moment she is going
through something more traumatic, so I see her more. When I started working with people
with this diagnosis we had various discussions about it and I think realistically it would
probably be a couple of years. Depending on what you are trying to do obviously, you can
do short-term pieces of work around particular issues but if you're looking at a long-term
perspective which you have to have in some ways then I think yeah, certainly a couple of
years. So when they come up in the team I say 'look I am happy to see this person but it's
likely to be a long-term piece of work'.
I: That was what I was going to ask. How is it that seen in the work context? Is it
accepted?
Anna: Well, in my team it is. I don't know if that's true. And also there are certain
changes going on in the team at the moment that could make it more complicated. But I
think certainly within the team I work in, we had a meeting at the end of last week,
because our consultant is leaving at the end of the month, so we are going to be without a
consultant and we were looking at ways of managing the caseload. You know, one of the
things we were looking at was that we will have to look at our acceptance criteria and somebody was saying, you know, some teams don't accept people with personality disorder diagnosis. He wasn't saying we should stop accepting them, he was using it as an example of how you can play around with your referral criteria. But we always have as a team worked with people with this diagnosis and, ahm, recognise that it is in our court, and I think there is in relation to psychology, not just people with personality disorders but also people with long-term psychosis, that the work you need to do is often a long time at a sort of consistent level and how that fits together with demands of improvement, I think it's a dilemma with a lot of teams, but I guess I am lucky because the team, in relation to the client I was talking about, she was seen as somebody who was extremely chaotic and extremely disorganised and you go through a patch where you think she is containing it, she is not self-harming, she is out of hospital and they can see that regular lower input from me is preventing, is actually saving resources because she is not going to hospital with the difficulties that that poses. So I think, you know, they are quite realistic with clients like this, they need a lot of work. I think when it becomes a problem is that I can't take on everybody with the diagnosis that comes to the team and what do we do with the people that are difficult to contain? You know, because I can't do that for everybody unless I become a specialist person for personality disorder therapist. You know, but with people like this, if you manage to engage them, then they tend to stay for a long time, if you don't engage them they keep coming back and using quite a lot of resources. I think it's a big issue where clients like this get treated?

I: Hopefully we'll talk a little bit about that later and hear your views about it. What kind of interpersonal difficulties do the clients have? You mentioned that they have a lot of difficulties in establishing relationships and issues about trust.

Anna: There's trust, yeah, building relationships in trust. Ahm, building positive relationships generally I think is very difficult for different reasons. Certainly some, the majority of the clients I see are female, I've seen a few men with the diagnosis, but building healthy relationships is very difficult for various reasons. Sometimes it's because
they get into abusive relationships, sometimes, one particular client I'm thinking about tended to get into relationships with what we called 'lame ducks'.

I: Tell me what you mean?

Anna: 'Lame ducks', they've got more problems than she has, people who are vulnerable which have long term problems in a relationship with someone who had long-term psychotic illness, he had, I think he had manic depression, I think that was his formal diagnosis, but he was cycling, constantly in a state of relapse or on the ward and even when she realised the relationship was detrimental to her, she found it very hard to get out of it, because she would say 'well, I can't leave when he is well because that will cause him to relapse and I can't leave him when he is ill because that would be a betrayal' so it was very difficult dilemma for her. So I think there are difficulties in establishing healthy relationships. And managing boundaries, again with this particular client, I mean, she has extreme difficult in putting boundaries and saying no to people. So she does tend to take things on, she is off sick from work at the moment but they are still ringing her at home, and to be fair she has practised things we suggested, like not answering the phone and just saying 'look, I'm sick, I can't do that' but they keep ringing because she does tend to take on a lot of things. And does, she does really want to champion the underdog and that is the problem and I think that can be a thread for some people with the diagnosis. It's different for different people. Other people as I say, a couple of clients I can think about are very difficult to engage with because it was very difficult with, and I think with both of them we didn't get past the first stage in that, they found it very difficult to trust and also because inevitably when you're working with people, you're going to say things that they don't agree with and then they immediately become very angry and rejecting. Now that is quite difficult because, you know, you can't watch every single word you say, it's not realistic, so if people can't tolerate then it's actually very difficult to build a kind of therapeutic relationship. With other clients I've worked with this diagnosis, we kind of got past that and a lot of the time if there was something they weren't happy about we were able to talk about it. So they can say 'there was something you said last week that bothered me and upset me' and then we can talk about it and negotiate it. So there are
this, sort of, prickliness, which obviously makes relationships very difficult and you have
to be able to negotiate that in therapy as well. If you haven't got to the point where you
got a rapport then it falls apart at that point and it certainly did with a couple of clients.
It's very difficult that it is so precarious, so, yeah, trust, unhealthy relationships,
difficulties with boundaries, what is appropriate and what isn't, what they can say no to,
those are big issues. There is for some clients this split between people who abuse or are
abused and there can therefore be a difficulty there, if you're not being compliant and
you're kind of challenging, they experience you as being abusive and that can be quite
difficult and obviously that's something that in therapy can be quite tricky but also in the
world outside it's very difficult for them because it makes it very difficult to make
friends, people aren't perfect, so there's that around. Just a lot of that is very difficult.

I: So a high level of sensitivity to others.
Anna: Yes, it's a prickly sensitivity.
I: But also very high expectations of others.
Anna: High expectations, absolutely. Certainly a client who was very difficult. I didn't
actually engage with her, she said in the session that what she was wanting, she watched a
lot of these chat shows and what she picked up from it, I can't remember the way she said
it, was that they go into therapy (inaudible), and there would be this kind of magical
match who would be everything she wanted. So that was what she had picked up from
these day time shows and she had been shopping around looking for this magical click
but of course it wasn't happening and sort of trying to address that was very difficult, she
wasn't really interested because that hadn't happened she wasn't going to listen to me, so
it was very difficult, very high expectations and wanting something now. I think that's
something else, a low frustration tolerance. In this case it was also, she would also seen
by somebody else and she would call in distress saying 'I've got to see you, I've got to
see you' and then (name of colleague) would say 'I'll come to see you tomorrow' and she
would say 'Oh, I can't tomorrow because I'm working' or 'I can't on Thursday because
I've got child care problems'. So she would ring up and say that she needed to be seen
immediately but when you offered something she was kind of, there were all these
difficulties, a paradox really. There was the immediacy of her distress but also this ability to just switch it off which I think is also typical of BPD. Something can be so immediate and so overbearing in one session and then the next one they might not even mention it and there is this hot cognitions thing with them but once it's switched off, it's switched off and it's very difficult to access it. This is where continuity over time comes in because once you're seeing someone more regularly you can start seeing some patterns which is difficult to see when you just met somebody. You can say, 'well, do you remember last year when you felt like this and how you handled it then' which you can use, but if you're only seeing someone a short time it's quite difficult.

I: You mentioned several experiences of your work which is really useful to have. What is it like for you working with these clients?

Anna: Oh, all sorts of things. It can be very frustrating, it can be very frightening, it can be very fun, very challenging, interesting, you never get bored with them. I guess that they're the clients you engage the most or the least, they're extreme. So it can be that you're seeing someone and they're working and you get good rapport and you feel brilliant because you can help people through things and you feel very concretely that you're doing something but it can be extremely frustrating and extremely scary when they are cutting their wrists or... I suppose the other thing that occurs to me there is where it places you in relation to the people you're working with, because they can be very intense relationships so the supervision aspect is important but also the classic thing of one of the signs you're dealing with borderline personality is the team dividing and so it does put you, how you negotiate that interface between yourself and the team. Because I think ideally, of course it's not always possible, with clients like this is to have one person who is working with them consistently is very important and then how you interface with the rest of the team is difficult. They are also clients who throw up a lot of feelings, a lot of emotions and no doubt somebody in the team will have very strong feelings about them. Things like self-harm, how that should be dealt with, people often have very heart felt ideas about it being manipulative and attention seeking and therefore should be ignored or even punished. One client I saw, she is not strictly borderline personality, she is
developmentally disordered but the issue of self-harm came up with her. It was a slightly complicated situation, I was actually working with her in primary care so she wasn't being seen in the CMHT but we had a network meeting and the consultant, not the consultant, the psychiatrist there was saying ‘Well if she wants to self-harm during the session then you should cancel the next session’ and I said ‘Well I'm not happy to do that’ and in fact my thinking about it... It’s quite complicated this whole issue of self-harm because it’s different for different people, their reasons for doing it, so I would also try to understand it for that individual person before coming up with a plan and with this particular client there were lot of issues around intolerable feelings, about the fear of harming somebody else, she was experiencing voices that told her to harm herself rather than harm someone else, a feeling she was very disgusted and ashamed by it and I guess, having read some of (inaudible) work with multiple personality disorder, there were some very powerful things about this particular description which kind of struck me in several levels, sitting with a client whilst she was stabbing herself with a syringe and just being able to tolerate that and on one level, you know, you’re thinking ‘My God, how awful’ but on the other level, well how courageous, to be able to sit with somebody and say ‘yes, I still accept you’ and to try and get that across to people who have these ideas about them being manipulative is very difficult, so the compromise we came up in the end was that if she wished to self-harm during the session we would end the session then. I would say ‘look, we are trying to learn other ways of coping, if you choose to do it that way you can, but you need to do it outside the session’ and that was the compromise we reached. I mean, I was actually quite willing to sit with it but they said it felt like I was condoning it. I don’t think it’s condoning it so we had to compromise. And I think that’s one the big issues and one of the big problems again with working with clients is with clients who is on the ward and self-harming and you need a consistent approach to that. One client who was on the ward, her parents had a big row with them and she stormed off and she came back to ward and went up to one of the nurses and said ‘I’ve got this piece of glass, I’m feeling really stressed, I felt like cutting myself but I don’t want to’ and I could have killed the nurse, she said to her ‘Oh, that’s very disappointing, I thought you got past that'
and those kind of things are just so difficult, the whole self-harming and I think to think about self-harm it’s not as simple as attention seeking because a lot of the time people self-harm and don’t seek anyone anyway, or manipulative or whatever, it’s almost like a mantra, ‘oh this only attention seeking behaviour, it’s only to get attention’. Well, a) we’re all attention seeking but some of us are better at doing it and b) if someone needs attention that bad, we need to think about that, but anyway, those are the processes of working with these clients, it’s not only about your own emotional reactions, but the emotional reaction of your colleagues and negotiating that and at the same time trying not to let your own feelings influencing too much either way. You can have very positive views about these clients but also very negative, you see that in team meetings and it’s about balancing that that would be useful for the client but it’s colossally difficult sometimes.

I: I think that links a lot with the next question. What are the challenges of working with these clients? It does sound like managing the team is one.

Anna: Managing the team, yeah. Lots of challenges, your own emotional reaction, which is, I think yeah, they do bring up quite powerful emotions. I think transference, countertransference issues are very important with this client group. The way you feel about them, the way you react to them, ahm, and that things are brought up in the team and you’re using your relationship, is very important. I would say a big thing is the interface with other professionals in the team and balancing up the need to be an advocate for the client but also allowing them to take responsibility and be advocates for themselves. Certainly you will see that people will put themselves into positions of being the client’s advocate when actually the client needs to go and negotiate and how to balance those with the client. Encouraging them to go and talk to their GP rather than you doing it for them. And again, you know, I think the DBT stuff is very good. I was only at a two day workshop we did but a lot of the concepts were very useful for these clients, you know, being containing and how to manage self-harming behaviour, in a way that is safe but also over-reacting or under-reacting. Yeah, lots of challenges.

I: Yes, it feels like your response to the client needs to be so well thought about.
Anna: I need to be aware of it because obviously if you can’t volunteer yourself the whole time. With these clients more than with any others you carry something of them with you the whole time and I feel like ‘stop bothering me’. Personally, when I was a trainee I had a very good psychodynamic training placement and just with this client I had this feeling and I felt like it didn’t belong to me and I remember my supervisor at the time was very good and said ‘this is actually hers’ and they’re very good at locking this feeling in you. Often when you identify it, it will go, you know this is the client’s emotion. And much more than in any other group, I think. They leave a little bit of themselves with you that is problematic for them and you can work with this. With a couple of clients I thought ‘I really don’t want to see this client’, but the session goes okay, but it’s something about them that raises feelings in you or feelings in them that get lodged in you.

I: Would you use that experience to try to understand the client?

Anna: Yeah, I would use to try and understand their experience because obviously, I suppose with one client I experienced, I’ve got this feeling and this doesn’t feel right, something about being unclean or tainted and it’s something about, you know, it didn’t feel like me, and then I thought, ‘Yeah, that’s how she felt’. I guess that’s how she felt and then it made a lot more sense.

I: Would you then address that directly in the session or would you use it more to help your understanding?

Anna: It depends on the client. I think, you know, because, there has to be. I wouldn’t necessarily use it directly but once it helped me to see how, my emotional reactions now are tied more to just the present. So for example, last week we had a session, I won’t get into details, but basically she stood up in her own mind to the abuser and then she became very suicidal which was quite scary. And then it kind of came to me that this suicidality wasn’t now, it had to do with the threats the abuser made when she was a child that if she ever told anyone or stood up to them that they would kill her and they also said things like that, I’m not sure if they said it in this way, but for her she had to kill herself to protect other people, so if she stood up to them she kind of had to kill herself to protect other people. And I did interpret that to her but I wouldn’t always to that, it depends on the
client. I think there needs to be a gap between your understanding and what your use of it and not just going in and immediately interpreting everything to the client, because the point is that they are easily overwhelmed, so you have to find a way of using it that is accessible to them but is not overwhelming. So there is always this balance.

I: You mentioned a lot of the emotional reactions you experience, frustration, and other negative reactions, and how difficult it can be. Do these have an impact on the course of therapy?

Anna: Yeah, they can do, that’s why you need to be aware of them. A colleague was on the Christine Padesky course and one of the things she was very struck by and we discussed it. Imagine one of these borderline personality clients, they fail to attend to an appointment and then imagine one client that you tend to get on very well with and they fail to attend. Thing about your emotional reactions, how you feel and what you do about it and she was very struck at how she would react very differently. To the client she got on well with, she would be much more tolerant and understanding whereas with the client that had the more negative things. Obviously it does influence, just about whether you offer another appointment and when you offer and how you offer. Personally I find that I have to have that connection, if I haven't got that connection, I can't do my best for the client 'cause you've got to have that so you can work through things with the client. If I haven’t got that, you know, fairly or unfairly, I just don’t think I can do my best for the client. There has to be something at some level that I can connect with, so then I can work. If you haven’t got that, you just end up being punitive to them and that isn’t fair on them. So it can affect it, you end up being punitive towards them, ahm, people end up being passed around to different services. But maybe some people would have a different view, maybe they would say, you know, 'as a professional it doesn’t matter if I like somebody or not, I will work with them anyway', but personally I would find that extremely difficult. I think you just haven’t got the same tolerance and if you haven't got that tolerance, you lose your ability to deal with all the ups and downs. I mean, it’s human nature, you want to work with people you like.

I: Is there something about the clients about being good at not being liked?
Anna: They’re good at not being liked, that’s why you have to see beyond that and if I can’t see beyond that, I would just say, really and it’s difficult. I would say that on the whole I can, I only met a couple of people that I couldn’t engage with at some level, but yeah, I think obviously your feelings will influence the course of therapy, because you will be more or less willing to do things for them.

I: How would you describe the therapeutic relationship you are able to establish with clients? It probably varies a lot.

Anna: It does, I think they are clients you can end up having very intense relationships with. Ahm, because, they are so, you know, I was just thinking about other clients who might come with other problems and you deal with them at a different level. It may be depression or anxiety or other diagnosis, but they’re there in a very pragmatic way to get a course of treatment and then it works and then that’s fine and you never really know much more about them beyond that and that’s fine, that’s great. But with these clients because it is so much part of their personality and so, it is very intense. These are the clients who either cause very positive or very negative reactions, so yeah, they are very intense. I think it can be very rewarding and I think they are very interesting people and very often rewarding and very satisfying to work with. But then you can hit a bad patch, you know, it can be quite frightening, very scary. And something I haven’t mentioned which are issues to do with control, control, out of control spectrum, and you can end up being quite out of control sometimes, when people are kind of acting out, cutting, threatening suicide and that can be quite frightening really. One of the helpful things I learned when I was in this placement, psychodynamic. I remember with one client I was seeing for psychotherapy and I was really worried about her suicidality and my supervisor said ‘you don’t have to worry until she is in casualty’ and I was very shocked by that. But actually I think it was the most helpful thing that anyone has ever said, so, you know, you can’t get into a state every time a client is suicidal but it’s only when actually somebody has demonstrated they’re suicidal, and that’s quite risky, but in a way you can’t afford to worry about every client says something like that. And in the end she didn’t, but it kind of shocked me but it was very containing, you know ‘it’s okay, you don’t have to panic’ and
I think that was very useful. And again, when you know someone over time, that's easier, because you know more about their switching on and off and their ability to deal with things. And I think probably one of the difficulties with these clients is that often you get involved with them when they are in crisis and so they come in with this very hyped up situation and that's difficult. Once you're working with someone you get to know them pretty well and usually you know how much you need to worry. You know one of the things is that they tell you this in one session and then come back and don't even mention it the next session and you learn that over time, but you have to be a bit careful about the intensity of the emotional response they're bringing. You probably don't have to worry as much as you might feel you should.

I: It feels like there is a lot of anxiety around.

Anna: Yeah, they are a very anxiety provoking group and how much is actually necessary. I think again, this is coming from them and you pick it up and act it out. So they're feeling overwhelmed and scared and then you start feeling overwhelmed and scared and you start acting and admitting them. And it's quite interesting because half way through the admission, suddenly something would click, and then the whole plan changes, right we are not going to admit this person under any circumstances and you know, very extreme circumstances. I remember we had one chap on the ward last year who, I really liked him, he was a real sweetie, but the social work really found him difficult, and there was this really quite impulsive thing and he got himself into trouble because he put his flat on the market and then he didn't have anywhere to go and the social worker thought we should discharge him anyway, it's his problem, and myself and the SPR thought this wasn't actually very helpful, you know, and there was really quite a tussle over that and we referred him to the (specialist service), so yeah, very strong emotions there. I think if felt very punitive, I must admit I am a bit softie, but I don't think he would have done that with other clients.

I: What are the characteristics of the clients that impact on the development of the therapeutic alliance?
Anna: It is to do with their difficulties in relationships, really and that they are going to test you out and that’s why you need the time because they need to know that you are, they need to know where the boundaries are, and in a way, I don’t know that it’s that important where your boundaries are, you can have much more permeable boundaries or much more strict ones, but they need to know the line beyond which you don’t go. I mean, I am very flexible with my clients unlike some of my colleagues, but I am very firm about where my boundaries are and I think being consistent and being clear where those boundaries are is very important with these clients and they will test them. I had one client in primary care and she was very tense and very distressed, during the session she was saying ‘nobody really cares about me, all these professionals are just doing it for the pay they get, they are not really interested about you, they don’t care about you, they don’t care whether I lived or died’ so I asked ‘what would show to you that they do care?’ ‘well, if they saw me in their own time without getting paid or if they came and saw me at home, they only get out their diaries and fit you where it’s convenient for them’ but at the end of the session I got out my diary and said ‘right, well, I will see you in two weeks’ because I think she was trying to test out, you know she felt I didn’t really care, but I think if I had gone along with it she would felt it to be quite alarming and destabilising and upsetting and so on and so I was very firm on that one. Whereas with another client I am actually seeing her at home at the moment because she has a back problem and she can’t move, so that’s very different because our relationship is on very different footing and I am very clear about where I will and won’t go with people and I think that’s very important. They need that to feel contained. You need tight boundaries but it depends on the client. I think it is related to trust, if you keep shifting your boundaries, then people can’t trust you and I think these clients, you cannot bullshit them, they just know when you’re not telling the truth about something. So, I mean, I wouldn’t lie with any client but with this client group they ask a direct question, I will give them a direct answer because I think it is important to them a direct answer, it they ask a direct question. You know, with that client if she had asked ‘will you come and see me at home’ I would have said no. But if they do ask you a direct question, you know, a couple of them have asked ‘what’s my
diagnosis? it can actually send you into a panic ‘God, if somebody told me I had a borderline personality disorder I would be distraught’ but I found that if I say ‘well, what it says in your notes is this and it means this’ it’s actually been fine. If you try to say well it’s depression, they know it’s not true. So I think there’s a lot of things that more than with any other clients the relationship is so important, the way they are and the way you react to them.

I: You mentioned something about this several times and I am interested in hearing a bit more about it. You know, this thing about once you know a client, you can see a pattern, you have trust, they know where the boundaries are, etc. It feels like the initial stages are actually quite crucial.

Anna: I think they are, I think being quite tolerant in the initial stages with the ambivalence and not taking it as a rejection. Another client, I referred her to the personality disorders service and this is a specialist service. And first they were very unclear whether they were going to take her or not, she had three or four assessment appointments and it still wasn’t clear and I went to a network meeting and it was interesting (change of tape - some material lost).

I: This is really two questions in one. What do you find helpful and unhelpful when you’re working with these clients?

Anna: One thing that is very helpful for me is to have a good team of people who are there and are supportive and aware of the difficulties of working with this client group and you. For them to understand the complexities and difficulties and what you’re taking on is very helpful. To have good supervision is very important. And as I say to have some kind of empathy and compassion for the clients I think is very helpful. And as I said from the client point of view, someone who is consistent, somebody who is just not going to react, and somebody who is going to be straight with them. As I said that kind of comes once you build a trusting relationship with them. And I think it depends on what sort of stage they’re at, I think if they’re in a very distressed state, some kind of containment is important. In later stages I think it’s something about somebody being able to help them to reflect and look at patterns in a helpful way and humour I think it’s important, being
able to build humorous relationships with them. So yeah, a lot of different things can be helpful, I think flexibility combined with boundaries is important and I think it's about balancing those things. If you're too serious clients can feel that you don't really care, on the other hand if you're too flexible then there isn't any sense of safety. I tell you the thing about these clients is that they are all different but they've got similarities.

I: So you think it is unhelpful to be too rigid?

Anna: I think it's unhelpful to be too rigid and too boundaried, yes. I suppose so much depends on the model you're working with and I think you have to work in the way that is comfortable for you and there's big differences about how people feel about different things. Things like self-disclosure, some people are very uncomfortable. I think if you're very uncomfortable about something you shouldn't do it, so I think it's a very personal thing. With me, some of my clients know quite personal things about me in some ways and if they ask me a question... One of my clients would say, 'what do you think, not as a therapist but as a person, what do you think about this' and I think, well, you know, I will give her an honest answer because I am not working in a strict psychodynamic way I won't say 'what does that mean to you what I think, what difference does that make?'; 'cause I think with this client, she missed school a lot when she was growing up and she missed out on a lot of girlie stuff and some of that is just checking out, you know, what is normal. It's very interesting, because recently we had a good chat about her school, her mother had a serious mental health problem and she was the eldest daughter and was expected to kind of help her mother and how at school at first she started to act out and had quite a few behavioural problems and then realised that that wasn't working and ended up doing extremely well academically but both of those strategies were quite isolating for her, so she would often say, 'what do you think about this?' and she wants some feedback. I think it can be helpful to just be yourself. I think if you are not being yourself, they will pick it up, they can tell, they're very good at telling if you're not being genuine. In some ways they are very good at that.

I: In some ways they developed a high sensitivity.

Anna: Yeah, very interesting.
I: *How do you manage risk with clients?*

Anna: Managing risk. Well, we have a standard risk assessment, which is history of risk behaviour, current thoughts about risk, and what kind of risk, because there is obviously a clear difference between self-harm and suicide. So yes, there is a difference between was the person wanting to die or because they couldn’t bear the feelings anymore? If I’m not sure I will get another assessment by the psychiatrist in the team. So it would be looking at the usual things we look at really, intensity of the ideation, how much were they thinking, did they have any plans or in the past, whether they have the means now, those things. But also, and again it would be different for different stages, cause when you see somebody for the first time you do a thorough risk assessment, when you know someone over time you’re bringing in your own experience of what happens in these times and how they get through those times. So, yes, some of it is based on a formal risk assessment and some of it is based on your relationship and working out what is going on. And I think the distinction between self-harming behaviour and suicide is quite an important one really, and trying to be, ahm, as non-judgmental about self-harm as possible and ask them what they think is the best thing to do, and how to make things safer for them, I tend to use those words.

I: So you try to get them involved...

Anna: Oh yes, I try to involve them actively in it. Ask them what we should do about this, ‘if you were me what do you think would be helpful?’. So I would try to involve people with it and have a discussion. As I said, what you do in the initial stages may not be identical to what you do when you know them because you do kind of realise, if they’re cutting, you do realise that actually what they’re doing is not really dangerous or actually they do do things that are really dangerous, you kind of get to know. Of course there’s always unpredictable picture that you’re not going to find out, but that’s how it is with most clients.

I: You mentioned about clients that you weren’t able to work with, people that want something you can’t give?
Anna: Yes, and they come back each time asking for something I can’t give them. Something that they want something that I haven’t got.

I: Would you discuss with the client what was happening?

Anna: Yes, I would say that, you know, ‘you mentioned this, this and this, what is it you really want?’. One client said, ‘What I want is for you to come with me and confront my abuser’ and I said ‘Well, I can’t do that, that isn’t something that I am able to do, it isn’t something I think would be helpful, it’s not something I’m prepared to be involved in’ so I was quite explicit and I went back and discussed it with the team and felt that given what she was presenting she should be referred to the family therapy team. She was a bit naughty, she had certain symptoms depending on which team she was in. So when we referred her to the family therapy team, when I saw her I asked her if she wanted to talk about the abuse and she said ‘No, I don’t think I could do any more work on that at the moment’ but then from the family therapy she was referred to the PTSD service, it was just very difficult.

I: How did you feel about that at the time?

Anna: Oh very frustrated, she brought up a lot of feelings of frustration. Yeah, it’s difficult because you know that someone is suffering in distress but if they don’t allow you to help them, that puts you in a disempowered position and that’s probably how they feel in their lives, very disempowered, so how do you get out of that, sometimes is very difficult, if a client is determined not to let you succeed.

I: Just a little bit now about the services, about your ideas of the current provision of mental health services to these clients.

Anna: I don’t think it’s good. I really don’t. Because they need longer term and because whether you’re working in primary or secondary care, there aren’t enough resources. Because sometimes they can’t keep regular appointments and that’s how we work. I think they need probably services that can be more flexible. And with women who have got these problems have often been abused and they get admitted into mixed sex wards, women who are very vulnerable to men and who get themselves involved into very unhappy and unhealthy relationships and probably one of the best places to meet
somebody like that are psychiatric wards. I think there’s a lot of problems there. But I don’t think that they necessarily need long term admissions but being in hospital with all the problems there makes it more difficult to get them back at home. So I think they need more kind of short-term crisis places, type of thing where they can get back home quickly which is very difficult in a very medical ward, they get very scared about going back. Yeah, they need flexibility.

I: Do you think they would be better off with specialist services?

Anna: I think the problem with specialist services is that there are a lot of people with this diagnosis and they would just need big specialist services to embrace them all and, you know, I know about the specialist services here and they all have cut-off points and they will take people over one line but not underneath and the people underneath are still very difficult. And as I say my concern with the specialist services here it doesn’t really. It’s difficult because people think that clients have just a personality disorder and it sounds very cosy, but they don’t. And to me the models can offer a lot of hope for people, like DBT, but you need teams which are very cohesive, with a very clear policy and that have a very clear understanding and I think it’s something that would take quite a lot of psychologically sophisticated reasoning that sometimes it’s quite difficult. So I think the services are not well set up at the moment, but in terms of being able to use CBT or psychotherapy, that some people can’t use psychotherapy, some people can’t use CBT, and because of all of the changing picture, you need a sort of psychotherapy understanding I think on the relationship but you also need the practical stuff from CBT. I think that’s why DBT is great on bringing a lot of this together but again, it’s quite time consuming. When we had the training I thought it was great but I just thought I haven’t got the time to do this, and if I do, then being on my own in the team doing DBT is impossible. I think it’s very challenging and sometimes a lot of the boundaries we have are to protect ourselves and not for the benefit of the clients, there’s a real tension about that all the time, and negotiating that. I don’t know how the services should be, but I think there’s something about flexibility, I think something about helping people to use community resources more, that’s the problem with specialist services, you just feel thing
are getting more and more split into all these different specialist services but what about
the people who fall between two stools, you know, if you’ve got BPD and PTSD, you
know if you have depression, you end up being chopped in different pieces, rather than
being holistic, so I think there are issues around that. I am not sure that specialist services
are always the best option. On the other hand if you have that you can provide perhaps
more psychological therapy and that would be a good thing.
I: So there are pros and cons.
Anna: Yes, I think it’s a difficult one, the issue about specialist services.
I: Thank you so much for your help, we reached the end now.
APPENDIX IX

Consent Form
CONSENT FORM

The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis.

I consent to participate in the research into psychologists' experiences of working with clients with borderline personality disorder. I understand that participation is voluntary and I can withdraw my consent at any time.

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I understand that participation will involve an interview of approximately one and a half hours. I consent to the audio taping of this interview.
I understand that data collection will be confidential and identifiable by an assigned number only. I understand that quotations from my interview may be used in the write-up of the research and I also understand that no individual or organisation will be identifiable in these quotations since all potentially identifying information will be removed.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer ........................................................................

(BLOCK CAPITALS)

Signed ......................................................................................

Date ...................................................

As the researcher, I agree to maintain confidentiality by assigning the data a number, by which the participants shall be known thereafter in the study. I agree to erase any audio tapes once the date has been analysed. I agree to anonymise any direct quotations that are used in the write-up.

Name or researcher ........................................................................

(BLOCK CAPITALS)

Signed ......................................................................................

Date ......................................................
APPENDIX X
Demographic Sheet
The experiences of psychologists working with clients with borderline personality disorder: An interpretative phenomenological analysis.

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Number of sessions per week working in CMHT: ...........................................
Number of sessions per week working at other services: .............................
Which services: ..................................................................................................
Years of experience since qualifying: .........................................................
Main Theoretical Orientation: ..........................................................................
Specialist training after qualifying: .................................................................
Specialist training for working with clients with Borderline Personality Disorder:
 ..........................................................................................................................
Estimate of number of clients with Borderline Personality Disorder out of case load at any
given time: .................................................................................................
APPENDIX XI

Example of table of themes for one transcript
Interview 8 - Analysis (preliminary themes)

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<tr>
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<td>Offering new way of relating, need for consistency, boundaries</td>
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<td>Adversarial style of client/angry</td>
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<td>Need for compassion, empathy, positive view of client</td>
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<td>Rapid change, intense</td>
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<td>Engagement issues (difficulties)</td>
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<td>- Client not wanting to hear about process or not wanting to change</td>
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<td>- Therapy interrupting behaviours</td>
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<td><strong>- Service needs vs. clients needs</strong></td>
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<td><strong>- Need for long-term work (creating dependence)</strong></td>
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APPENDIX XII

Table of themes
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**Description:**

- **Client switching between extremes**
- **Client making therapist feel in a certain way**
- **Fragile with lots of interruptions**
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