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Assessing Biased Attitudes Towards Clients with Cluster B Personality Disorders: A Literature Review

Samantha B. England M.S.

A Doctoral Project Presented to the Graduate School in Partial Fulfillment of the Requirements

for the Degree of Doctor of Psychology

Eastern Kentucky University

2021

Doctoral Project Approval Form

Eastern Kentucky University

This doctoral project was submitted by Samantha B. England under the direction of the chair of the doctoral project committee listed below. It was submitted and approved in partial fulfillment of the requirements for the degree of Doctor of Psychology at Eastern Kentucky University.

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Date of Final Approval: 4/30/2021

Abstract

This original contribution to practice explores the significance of clinician biases and countertransference in assessing, diagnosing, and treating Cluster B personality disorders (Cluster B PD). An extensive literature review examines research on defining Cluster B PD (e.g., Antisocial, Borderline, Narcissistic, and Histrionic), current evidence-based treatments, barriers to treatment, stigma related to overall mental health and to Cluster B PD, gender and culture bias, countertransference, and burnout. Further, a qualitative study examined the experiences of licensed psychologists and student trainees under the supervision of licensed psychologists to answer the following research questions: What are the experiences of psychologist working with Cluster B PD? From their perspective, what challenges and/or barriers do they encounter? How do they overcome these challenges and/or barriers? A total of 15 participants responded to a questionnaire discussing their experience. Data analysis revealed clinicians personally experiencing challenges and treatment interfering behaviors from their patients. Many participants spoke about personally experiencing countertransference while working with this population and that it has impacted their therapeutic relationship with patients. To overcome these challenges and barriers, the participants emphasized the importance of consultation, supervision, continuing education, awareness of own biases and the significance of self-care.

Keywords: Cluster B Personality Disorders, Countertransference, Burnout, Continuing Education, Self-Care, Challenges, Barriers

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Section I: Introduction

Statement of the Problem

Cluster B PD (e.g., Antisocial Personality Disorder (ASPD), Borderline Personality Disorder (BPD), Narcissistic Personality Disorder (NPD), and Histrionic Personality Disorder (HPD) have been characterized as dramatic, emotional, or erratic (American Psychiatric Association, 2013). Moreover, individuals who have been diagnosed with these conditions seem to have an underlying theme as having a general lack of empathy for others, albeit for different reasons (Kraus & Reynolds, 2001). It has been estimated that 10% of the United States population meets criteria for any personality disorder (American Psychiatric Association, 2013). More specifically, about 1-6% of the general population have been diagnosed with a Cluster B PD (Cailhol et al., 2017). Although this may seem like a small percentage, there has been an increase in Cluster B PD diagnosis roughly within the last ten years (Young et al., 2018). While about 70% of Cluster B PD appear in criminal and correctional settings, Feinberg & Greene (1997) state that these disorders appear in a variety of other clinical settings including between 33% -52% of the population in outpatient settings and 50%-70% in inpatient settings. It is important for all clinicians to understand that Cluster B PD are essential to every clinician, whether their practice focuses on this area of disorders or not. Almost all psychiatric symptomology has characterological treatment implications both for the patient as well as the clinician (Kraus & Reynolds, 2001).

Current literature indicates that Cluster B PD have historically been viewed by clinicians as challenging to assess and treat (Cambanis, 2012). Moreover, a large portion of clinicians in the mental health field hold pejorative attitudes towards those with Cluster B PD (Kling, 2014). The characteristics of these individuals often also have a negative effect on the therapeutic

process and on the clinician themselves (Kling, 2014). Studies have indicated those clinicians working with Cluster B PD are likely to experience negative attitudes, burnout, stress, and countertransference (Freestone et al., 2015). Many clinicians spend a great deal of their time trying to help individuals with Cluster B PD, others try merely to cope with their presence or purposely avoid clients with these conditions (Rosenbluth &Yalom, 1997). As practicing clinicians, becoming aware of one's own bias attitudes when working with this population deserves our utmost attention for our patients as well as ourselves.

Significance of the Issue

This issue is of great importance within the mental health community. As mentioned previously, though 70% of Cluster B PD appear in correctional and forensic settings, the literature indicates that they are still relatively prevalent in a variety of other clinical settings including inpatient and outpatient services (Yakeley, 2019). In the book, *Treating Difficult Personality Disorders*, Michael Rosenbluth and Irvin D. Yalom (1997), report that mental health professionals have often described patients with Cluster B PD as "They should not receive treatment." "They all just have affective disorders." "They are hopeless and untreatable." "I don't treat personality disorders" (p. xiii). These comments should be alarming to clinicians. Biased attitudes towards patients, such as the comments previously described have a strong potential to disrupt the therapeutic alliance making treatment almost ineffective. Studies have empirically demonstrated that countertransference and attitudes play a crucial role in the psychotherapy outcomes, especially in the treatment of personality disorders (Colli & Ferri, 2015; Hayes et al., 2011; Gabbard, 2014). A first step in decreasing these biased thoughts and attitudes is to increase clinician's awareness of their own biased attitudes and how they can impact working (assessing and treating) patients with Cluster B PD.

Often times it may be difficult for clinicians treating Cluster B PD to recognize that they are experiencing burnout, that is, a chronic stress syndrome that develops gradually as a consequence of prolonged stress (Cieslak, 2016; Ahola et al., 2006, p. 11). This can significantly interfere with the clinician's quality of life and impact treatment outcomes (Ortega et al., 2019). Addressing the issue of assessing biased attitudes before a clinician experiences burnout and/or biased attitudes will help therapeutic alliance, the well-being of patients and clinicians, and hopefully decrease the stigma related to working with patients with Cluster B PD.

Purpose

The primary focus of this doctoral project was to create an original contribution to practice by expanding on existing literature and developing a qualitative study to further explore clinicians' own experience when working with individuals who have a Cluster B PD. A questionnaire was created and provided in an effort to have a better understanding of possible countertransference in clinicians working with Cluster B PD. This qualitative approach was used to address the following research questions: What are the experiences of working with Cluster B PD? From their perspective, what are challenges/barriers they have faced when working with this population? How do they overcome these challenges and/or barriers? It is the author's hope that this qualitative study and expanding on current literature will bridge the gap in finding appropriate ways to address the issues previously discussed. While there is an abundance of literature on the correlation between countertransference, stigma, and bias with Cluster B PD, a large portion of research merely focuses on BPD and ASPD. This project targets to expand this literature to Cluster B PD in its entirety.

Section II: Literature Review

Methods and Overview of Literature Search

This literature review was conducted by making use of the PsychINFO, PsycARTICLES, PubMed and Google Scholar databases as the primary search tools. Search items included, but were not limited to, the following: defining Cluster B personality disorders (e.g., Antisocial, Borderline, Narcissistic, and Histrionic), evidence-based treatment interventions with Cluster B PD, interfering behaviors to treatment, gender and cultural bias, stigma, burnout, countertransference and suggestions for countertransference. Several international journals were utilized for this project, as well as academic journals in the United States. These journals include but are not limited to: *Journal of Abnormal Psychology*, *Journal of Personality Disorders*, and *Journal of Personality and Mental Health*. Additionally, Eastern Kentucky University faculty and student trainees, as well as Eastern State Hospital staff members with relevant research and treatment interests were consulted. Specifically, they were asked to participate in the qualitative study that entailed completing a questionnaire regarding their experience working with Cluster B PD. The questionnaire was targeted to address the research questions noted above. A more in-depth description of the study is described below.

This literature review will provide an overview of the research regarding defining and discussing the etiology of Cluster B PD, current methods for treating Cluster B PD, interfering behaviors to treatment, defining biases, exploring basic concepts of biases and mental health, societal and mental health provider stigma, gender and sex bias, countertransference, and burnout. No restrictions on treatment setting (e.g., prison, inpatient, outpatient, etc.) were placed in regard to this literature search. The focus of this specific doctoral project has been narrowed

by excluding other cluster personality disorders (A&C), and only specific attention to Cluster B PD.

Defining Cluster B Personality Disorders and Etiology

A Personality Disorder (PD) is defined by the World Health Organization as "*a severe disturbance in the characterological condition and behavioral tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption*" (McGilloway et al., 2010, p. 1). This literature review will solely focus on Cluster B PD, as noted earlier, they are defined as dramatic, emotional, or erratic (American Psychiatric Association, 2013). Cluster B PD account for the least prevalent of the clusters (1.5%) when compared to Cluster A, (5.7%), and Cluster C (6.0%) (American Psychiatric Association, 2013, p 646). The following provides detail in defining and exploring the etiology of each Cluster B personality disorder.

Antisocial Personality Disorder

ASPD is characterized by violating or disregarding others' rights, committing crimes, deceiving others, behaving impulsively, exhibiting agitation through frequent fights/altercations, acting recklessly, and lacking responsibility and empathy (American Psychiatric Association, 2013). The pattern of ASPD has been referred to as "psychopathy, sociopathy, dissocial, or criminal personality disorder" (American Psychiatric Association, 2013, p. 659; Rosenbluth & Yalom, 1997). Hallmarks of the disorder are repeated criminal offenses, manipulation, and mistreatment of others for personal gain, amusement, or in the throes of passion, and little or no remorse for misdeeds (Hare et al., 1991). It should be noted while ASPD and psychopathy share overlapping characteristics, they are vastly different. Simply put, only about one third of those with ASPD in the general population meet the criteria of psychopathy. Psychopathy is

characterized by features that are not diagnostic criteria for ASPD, such as lack of empathy, arrogance, and excessive vanity (Blair, 2003). Thus, not every psychopath necessarily has ASPD, but the construct psychopathy may include different traits of various types of PD (Blair, 2003).

In the infamous book, *The Mask of Sanity: An Attempt to Clarify Some Issues About the So Called Psychopathic Personality,* Hervey Cleckley (1988) described patients with ASPD as “the forgotten men of psychiatry” who “probably cause more unhappiness and more perplexity to the public than any other mentally disordered patients combined” (Cleckley, 1988, p. 16). He further suggested these individuals cause sorrow to not only the community but towards those in their daily life including family and friends. He also indicated the disorder is resistant to treatment and efforts to treat these patients are typically unsuccessful. Although, Cleckley’s (1988) literature on psychopathology was originally published in 1941, current literature remains corresponding to Cleckley’s original ideas that ASPD is ambiguous to society and clinicians as well as the idea of difficulty to manage and treat remains to this day.

The etiology of ASPD continues to be an intense debate. ASPD seems to have higher prevalence within the same family constellation, both hereditary and psychosocial factors are implicated in its etiology (Kaplan et al.,1994). To explore this, Pardini et al. (2013) examined whether male subjects with lower amygdala volume have a history of aggression and psychopathic features dating back to the participants childhood and are at increased risk for engaging in the future. In this longitudinal study, participants (N=503) were recruited in first grade and participated in assessments periodically every 6 months for the first 4 years, then annually until they reached age 26. Final assessments were conducted when the participants reached age 29. Results concluded that men with lower amygdala volume exhibited higher levels

of aggression and psychopathic features from childhood to adulthood (Pardini et al., 2013). These findings suggest biological components can indicate an increased risk for future violence, as well as psychopathic features related to ASPD.

In 1994, Raine and colleagues hypothesized that birth complications combined with early maternal rejection of an infant, will predispose an individual to adult violent crime. A total of 4,269 male subjects were included after experiencing birth complications. Subsequently, the participants were followed up within one year. Variables of factor conditions included: parental socioeconomic status, marital status, infant care, home condition, young maternal age, and unwanted pregnancy. Criminal status of the infant was later completed when the child aged 17 to 19 years. In this longitudinal study, results indicated a significant interaction between birth complications, early maternal rejection and violent offenses in adulthood. While only 4.5% of the participants had both risk factors, this small group accounted for 18% of the violent crimes (Raine et al., 1994). These findings suggest the critical importance of integrating biological and social factors to fully understand violent and antisocial behaviors.

Borderline Personality Disorder

Among all those diagnosed with a Cluster B PD, patients with BPD are believed to experience the greatest suffering (Kraus & Reynolds, 2001). The essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affect, and marked impulsivity that begins by early adulthood and present in a variety of context. For instance, individuals with BPD may make frantic efforts to avoid real or imagined abandonment, have intense interpersonal relationships, suffer from identity disturbance, are likely to be impulsive, engage in recurrent suicidal behavior, have affective instability, have chronic feelings of emptiness, have difficulty controlling anger, and have stress related paranoid ideations. The

median population prevalence of BPD is estimated to be 1.6% but may be as high as 5.9%. (Kraus & Reynolds, 2001). The median population prevalence is about 6% in primary care settings, 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatient settings (American Psychiatric Association, 2013).

For many clinicians, a history of self-harming or self-destructive behavior is the defining feature of BPD, the most lethal from of which is suicide (Gunderson et al., 1997). Supporting this statement, in 1981, Gunderson et al. noted that within a group of 57 inpatients diagnosed with BPD, 75% had previous suicide attempts: 70% via overdose and 65% by mutilation (e.g., cutting, banging, burning, or puncturing).

Recently, Titus and DeShong (2020) added that individuals with BPD tend to engage in maladaptive ruminative thinking that is also related to an increase in suicidal ideation and attempts. These authors aimed to investigate and understand the five strategies of thought control (e.g., distraction, punishment, reappraisal, worry, and social control) as predictors of BPD symptoms and suicide risk. In a university sample of 403 participants, 74.4 % female and 25.6% male, they asked participants to complete a number of measures including the Five Factor Borderline Inventory-Short Form (DeShong et al., 2016), Personality Assessment Inventory (Morey, 1991), Personality Diagnostic Questionnaire-4 (Hyler 1994), and the Thought Control Questionnaire (Wells & Davies, 1994). Results demonstrated that distraction was negatively associated with BPD and suicide risk while worry and punishment were positively associated with BPD and suicide risk across the three different measures of BPD. Also, social control was negatively associated with BPD and suicide risk, while reappraisal was positively correlated (Titus & DeShong, 2020). These findings suggest the importance of thought control strategies in

the relation of BPD patients and suicide risk. Further, it can target clinical interventions to possibly reduce BPD symptoms and suicide risk.

Moreover, the overlap of BPD with mood disorders have been estimated to be between 40% and 60% (Marziali & Munroe-Blum, 1994). More recently, Sarhan and colleagues (2019), conducted a comparative study where 150 patients with depressive disorders and 150 patients with bipolar depression were assessed for the prevalence of BPD. In each group, patients with BPD versus without BPD were evaluated for suicide risk and overall global functioning. Additionally, patients with BPD in the whole sample were also assessed for factors correlated with suicide risk. Results indicated that 23.3% of patients with depressive disorders and 21% of patients with bipolar depression were also diagnosed with BPD. Further, among patients with depressive disorders and BPD, were associated with higher suicide risk and lower global functioning (Sarhan et al., 2019). This study points to the importance of support in global functioning in patients and the high prevalence of suicide risk in BPD patients.

Unfortunately, BPD is not confined to merely one etiology. Perhaps one of the most researched liability factors for BPD are poor attachment, and trauma. Pourshahriar and colleagues (2018) explored attachment styles and emotional regulation in the relationship of childhood emotional abuse and borderline personality features. In a university sample of 312 students, participants responded to the Child Trauma Questionnaire (Bernstein & Fink, 1998), Borderline Personality Inventory (Leichsenring, 1999), Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), and the Revised Adult Attachment Scale (Collins, 1996). Using a Path Analysis type, results showed that anxious attachment style and difficulties in emotion regulation can predict BPD features in full mediation (Purshahriar et al., 2018)

Around the same time, Godbout and colleagues (2018) examined an integrative model of the role of different forms of maternal and parental childhood maltreatment in the development of BPD as mediated by insecure attachment, in women and men. Using a total of 954 participants (73%) women, with the mean age of 24, participants completed various measures related to childhood maltreatment, attachment, and borderline personality-related symptoms. Results found that both maternal and paternal maltreatment were directly associated with borderline personality related symptoms. Further, researchers found that in women, paternal maltreatment was indirectly associated with borderline personality related symptoms through attachment anxiety but not through attachment avoidance. In men, maternal maltreatment was indirectly associated with BPD symptoms through attachment anxiety but not through attachment avoidance (Godbout et al., 2018).

As noted previously, a majority of the BPD literature focuses on attachment theory and trauma history. However, in 2001, Timothy Trull assessed the structural relations between BPD features and etiological correlates including a parental history of mood disorder, childhood history of abuse, and a parental history of disinhibitory disorder. In a sample of 421 college freshmen sample, of which approximately half had been diagnosed with BPD participants completed a number of psychological measures including the MMPI-BPD (Morey et al.,1985), PAI-BOR (Morey, 1991), the NEO-PI-R (Costa & McCrae, 1992) and an extensive diagnostic interview to assess a history of a variety of mental disorders in biological parents. The authors categorized the parental diagnostic history into two categories: parent mood disorder or disinhibitory disorder. Additionally, all participants completed the Familial Experience Interview (Ogata, 1988), which assess physical, sexual abuse and neglect. Findings suggested that parental disinhibitory disorder, parental mood disorder, childhood abuse, negative affectivity, and

disinhibition play a role in the manifestation of BPD. Though this study does not directly address the degree to which this mediation reflects environmental or genetic factors, overall, it indicates that not only do environmental factors play an important role in the etiology of BPD, but genetics do as well (Trull, 2001).

Narcissistic PD

NPD has a complex history and an expansive review of the literature on narcissism is beyond the scope of this project. Therefore, this section will briefly discuss the history of narcissism along with the etiology. In 1911, Otto Rank wrote the first psychoanalytic paper focusing on narcissism, and this was followed by the publication of Freud's now classic text *On Narcissism* (Freud, 1914). These manuscripts highlighted the defensive function of narcissism in protecting the individual from feelings of low self-worth and self-esteem, as well as conceptualizing narcissism as dimensional psychological state that ranged from normal to pathological (Yakeley, 2018). However, as psychoanalysts' theories began to conflict, Kohut, Rank and Kernberg are coined as having the most influence on modern conceptualization of narcissism and on shaping the construct of NPD. In looking at the conceptualism of narcissism, Kohut (1971) argued that narcissistic individuals are prone to experiencing emptiness and depression in response to narcissistic injury. By contrast, Kernberg (1970) emphasized that narcissistic individuals use primitive defense mechanisms of idealization, denigration and splitting predominate, the capacity for sadness and guilt is lacking and the main effects are shame, envy and aggression, adding that these feelings evolve into a pathological grandiose self-structure (Yakeley, 2018).

In regard to definition, Kernburg and Kohut (1980) along with other psychologists led the introduction of NPD into the third edition of the DSM. The NPD construct was further refined

and modified throughout time. Currently, the essential feature of NPD in the DSM-5 (American Psychiatric Association, 2013) is a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins by early adulthood. Core cognitive, affective, interpersonal, and behavioral features include impulsivity, volatility, low self-esteem, and unstable interpersonal relationships that result in pervasive pattern of interpersonal difficulties, occupational problems and significant psychosocial distress (Kacel et al., 2017; Yakeley, 2018). Prevalence estimates of NPD range from 0 to 6.2% of the population, of those are 50%-75% male and is highly comorbid with other personality disorders, specifically other Cluster B PD, substance use, and bipolar disorder (American Psychiatric Association, 2013).

A considerable debate continues to exist over the conceptualization of NPD, given that narcissism has been described as having both grandiose and vulnerable presentations. Ackerman et al. (2017) characterized grandiose narcissism as exhibiting arrogance, exhibitionism, and exploitativeness. The prominent features described as characterizing vulnerable narcissism include shyness, self-criticism, feelings of inadequacy, and affective liability. The authors further detail that clinicians tend to view grandiose features as the central conceptualization of narcissism, where there being less consensus regarding the centrality of vulnerable features (Ackerman et al., 2017). Moreover, the DSM-5 has been criticized for focusing too heavily on grandiosity features and failing to capture vulnerable narcissistic features (e.g., feelings of inadequacy; Ackerman et al., 2017).

In 2018, Stanton and Zimmerman examined the degree to which clinician ratings of traits related to specifically vulnerability in a large sample of adult outpatients (N=2,149). The authors also examined relations with other psychopathology and psychosocial impairment for both narcissistic trait relationships including both vulnerable and grandiose features. Results indicated

that some personality features related to vulnerability including perfectionism and inadequacy were unrelated to ratings of grandiose narcissistic personality features. Additionally, results suggested that emphasizing vulnerable features within narcissism trait configurations may increase NPD's overlap with other disorders such as BPD, bipolar disorder, post-traumatic stress disorder and social anxiety and does not appear discriminate pathological narcissism from ASPD. In regard to the inclusion of specific features with NPD conceptualization, results suggested that clinician ratings of both perfectionism and avoidance due to shame and social judgment appear unrelated to grandiose narcissistic traits. These results suggest that emphasizing various vulnerable features when assessing narcissism may make discriminating NPD from other disorders more difficult due to the overlap with other disorders (Stanton & Zimmerman, 2018).

Earlier, it was noted that the conceptualization of NPD can be quite complex. This may be due to the literature points to many different theoretical perspectives. The literature regarding the etiology of NPD, predominately stems from psychoanalytic perspectives, social learning theory, and from attachment research. Despite having these many differences in conceptualization, majority of the literature primarily focuses on parental behavior relevant to both grandiose and vulnerable narcissism.

Regarding etiology, Kohut (1971) offered the “deficit model” of narcissism, which asserts that pathological narcissism originates in childhood as a result of the failure of parents to empathize with the child. To the contrary, Kernberg (1984) emphasizes aggression and conflict in the psychological development of narcissism, focusing on the individual's aggression towards and envy of others, what he describes as “conflict model.” He added that this model indicates that early childhood experiences of cold, indifferent of aggressive parental figures push the child to develop feelings of specialness as a retreat (Kernberg, 1984). Lastly, Theodore Millon's

(1987) social learning perspective proposed that children learn about themselves and others from their parents' behavior, and in narcissistic individuals, beliefs about specialness and entitlement are thought to stem from early parental overindulgence (Millon, 1987; Yakeley, 2018).

More recently, Horton et al. (2006) investigated the relations between parenting dimensions (e.g., warmth, monitoring, and psychological control) and narcissism both with and without removing variance associated with self-esteem traits. A sample of college students (N=222) and high school students (N=212) completed the Narcissistic Personality Inventory (a trait self-esteem scale and standard measures of the three parenting dimensions) (Raskin & Hall, 1979). Horton and colleagues (2006) indicated that parental warmth was associated positively, and monitoring was associated negatively with both types of narcissism. Additionally, psychological control was also positively associated with narcissism, suggesting that narcissism has strong associations with parental behavior (Horton et al., 2006).

Interestingly, Miles and Francis (2014) investigated 144 participants belonging to 36 biological family groups who completed the Narcissistic Personality Inventory (Raskin & Hall, 1979) and the Parental Authority Questionnaire (Baumrind, 1971) measuring perception of parenting styles. The authors found a significant father-daughter correlation for levels of narcissism but found minimal correlation for other parent-offspring dyads. Miles and Francis (2014) cautiously interpreted this as evidence for a possible genetic bias, including X-chromosome involvement, for narcissistic personality traits, with parenting style contributing relatively little, conflicting with previous research.

Although the theoretical and empirical studies previously mentioned target the etiology and conceptualization of narcissism, it is clear that relatively little is known about the factors that are correlated with narcissism. Additionally, little is known about the conceptualization of NPD.

The previous literature suggests a framework however it is evident that more research needs to be conducted in this area.

Histrionic PD

Derived from the Latin word for "actor," HPD has a style of presentation that is excessively dramatic and emotionally exhibitionistic (Novais et al., 2015). HPD has been described as being driven by intense need for affection, being self-centered, seductive, and blatantly conspicuous in their shallow manipulation of others (American Psychiatric Association, 2013). According to the DSM-5, these individuals have difficulty achieving emotional intimacy in romantic or sexual relationships and may alienate friends with demands for constant attention (American Psychiatric Association, 2013). HPD has been associated with higher rates of somatic symptom disorder, conversion disorder, and major depressive disorder. Additionally, borderline, narcissistic, antisocial and dependent personality disorders often co-occur (American Psychiatric Association, 2013). Unfortunately, of all the personality disorders in the Cluster B group, the least amount of research has been devoted to HPD (Kraus & Reynolds, 2001).

Like NPD, the history of HPD is quite complex and ambiguous. HPD was originally coined from the term *hysteria* (Greek term for uterus or womb), a classical term that includes a wide variety of psychopathological states (Novais et al, 2015). Ancient Egyptians and Greeks blamed a displaced womb, for many women's afflictions (Novais et al., 2015). Several researchers from the 18th and 19th centuries studied this theme, specifically, Jean Charcot who defined hysteria as the term "neurosis" with an organic basis and Sigmund Freud who redefined "neurosis" as a re-experience of past psychological trauma (Novais et al., 2015). HPD made its first official appearance in the Diagnostic and Statistical Manual of Mental Disorders II (DSM-II) and since the DSM-III, HPD is the only disorder that kept the term derived from the old

concept of hysteria (Novais et al., 2015). Currently, the DSM-5 reports a prevalence rate of HPD as 1.84% (American Psychiatric Association, 2013).

It can be argued that people with HPD are extroverts and as extroverts their temperaments are partially genetically determined (Wilson et al., 1992). However, there is no empirical support for an organic link to HPD (Kraus & Reynolds, 2001). Unfortunately, the etiology of HPD is significantly limited. Guided by limited empirical research, HPD is believed to be primarily developmental in origin, arising out of a childhood inability to legitimately get parental attention (Turner, 1994). Turner (1994) believed that an excessive, unmet need for attention and an inability to successfully complete with others in getting these needs met leads to an inappropriate pursuit to acquire attention, often in a dramatic fashion. Therefore, environmental factors including individual's interaction with developmental issues are also assumed to play a role in HPD (Turner, 1994).

Due to the rate of presentation of "hysteria," the literature has indicated a debate as to delete HPD from the DSM (Bakkevig & Karterud, 2010). Bakkevig and Karterud (2010) investigated an inpatient hospital sample (N=2,289) and the construct validity of the DSM-IV HPD category. Construct validity was assessed by means of prevalence, comorbidity with other personality disorders, internal consistency among HPD criteria, severity indices, as well as factor analysis. Results indicated that the prevalence of HPD was very low (0.4%) and comorbidity was high, especially with borderline, narcissistic, and dependent personality disorders. The authors of this study suggested that the HPD category should be deleted from the DSM-5. They added that the criteria seemed to form two clusters, exhibitionism and attention-seeking, which are dominant personality features of HPD, and should be preserved in an exhibitionistic subtype of narcissism (Bakkevig & Karterud, 2010).

It should be noted that researchers have called for the abandonment of the categorical system of personality disorder diagnosis in favor of a more alternative dimensional approach or model of personality disorders (Costa & McCrae, 1992). One of the most widely researched alternative models is the Five-Factor Model (FFM) (McCrae & Costa, 1992). FFM consists of five broad dimensions of openness, conscientiousness, extraversion, agreeableness, and neuroticism (Costa & McCrae, 1992). Since this initial theory, FFM has provided a useful dimensional framework for understanding the DSM personality disorders.

Evidence-Based Treatment(s)

As with many of the other personality clusters, patients with Cluster B PD do not typically seek out treatment on their own and are frequently referred by courts for treatment. However, individuals who have a comorbid mental disorder along with a Cluster B PD, are likely to seek treatment on their own (Hatchett, 2015). The purpose of this section is to discuss evidence-based treatments for each Cluster B PD.

Antisocial Personality Disorder

ASPD is extremely difficulty to treat (Kraus & Reynolds, 2001). It is important to note that there is no “gold standard” in treatment, though the literature suggests a wide variety of treatments within individual therapy and group therapy. A majority of the research regarding treatment has focused on positive reinforcement, cognitive behavioral approaches and empathy training (Kraus & Reynolds, 2001).

In a meta-analysis, Salekin et al. (2002) analyzed 42 studies for individuals who were classified as psychopathic. Comparing patients in a treatment group versus controlled groups, the authors found that 60% of individuals showed improvements receiving overall treatment compared to those who were not. Additionally, they concluded that cognitive behavioral therapy

(CBT) and psychoanalytic therapy were the most successful treatment modalities, with 62% and 59% of their participants improving (Salekin et al., 2002). A therapeutic community approach was shown to be the least successful, with only a 25% success rate. In looking at the control group, 19.8% improved over time without any therapeutic intervention. It was also demonstrated that those who entered treatment at a younger age and had a long duration of treatment experienced better outcomes (Salekin et al., 2002). These results suggest that despite the notation that it is difficult to treat ASPD, there has been success rates among treatment modalities.

As mentioned in the previous study, CBT was the most successful treatment modality for psychopathy (Salekin et al., 2002). With the CBT modality, the fundamental principle is to alter the thinking process to induce behavioral change. To further investigate CBT with ASPD, Kunz et al. (2004) investigated a sample of 181 individuals after they received CBT in an inpatient setting. After a 4-year follow-up, they found that 35% were considered stable, meaning that these individuals were without behavioral problems, rearrests, or rehospitalization (Kunz et al., 2004).

Helping the antisocial patient understand how others are affected by their behaviors has also been shown to be effective (Black, 2010). For instance, Hare (1993) has shown that for prisoners with ASPD, empathy training can be successful in reducing recidivism. However, he cautions that empathy training with ASPD at times can turn them into “predators” (Hare, 1993). Additionally, pharmacological therapy has also been explored for ASPD. Research indicates that psychopharmacology has been considered ineffective and not recommended, however, it has a place in treating concurrent psychiatric disorders such as depression and anxiety (Black, 2010).

Although the literature regarding group therapy and ASPD reports that it is ill advised, which will be discussed in a later sectioned titled Treatment Interfering Behaviors, there are various forms of group treatments that have demonstrated some effectiveness Rosenbluth &

Yalom, 1995). For instance, marital and group therapy have been shown to be effective with ASPD individuals (Rosenbluth & Yalom, 1995). These authors argue that individuals with a significant other tends to view their partner as a stronger motivator for change than their relationship with the therapist and is likely the likely to accept confrontation from them (significant other). Additionally, milieu therapy has also shown some success with antisocial individuals (Rosenbluth & Yalom, 1995). Group treatments such as this may work because the individuals are able to see the flaws in others that are more like them, they may be more likely than the therapist to confront other patients' behaviors and are likely to gain support from other similar individuals, therefore they may be more accepting of confrontations from them rather than the therapist (Dolan, 1998).

It is clear that there are multiple suggestions for evidence-based therapies for ASPD. Although it has been confirmed that these individuals are difficult to treat, we can see based on the literature that it is possible and be successful. However, there are many suggestions and treatment interfering behaviors that will be discussed later in this paper when treating ASPD.

Borderline Personality Disorder

A broad range of therapies exist for BPD. Therapies are presented as individual or group or can be a combination of these two treatment modalities. Several specific treatment approaches have been developed within recent decades to meet the challenges of BPD treatment and are typically structured and manualized (Bateman & Fogney, 2015). Strategies within these specific treatments are provided for addressing interpersonal challenges, including emotion dysregulation and impulsivity, which are core problems for individuals diagnosed with BPD.

Pioneer Marsha Linehan developed Dialectical Behavior Therapy (DBT), a multicomponent evidence-based psychological treatment specifically for BPD. DBT is a broad-

based cognitive-behavioral treatment originally developed for chronically suicidal individuals diagnosed with BPD (Chapman, 2006; Linehan, 1993). This complex psychological therapy consists of a combination of individual psychotherapy, group skills training, telephone coaching and a therapist consultation team. DBT aims to change behavior and enhance the ability to tolerate difficult or painful feelings by focusing on improving skills in stress tolerances, emotion regulation, interpersonal behavior and mindfulness. DBT was the first psychotherapy shown through controlled trials to be effective with BPD (Linehan, 1993).

Additionally, Linehan (2015) created the DBT skills (DBT-S) training, a group-based mode of standard DBT, wherein patients are taught the four modules (stress tolerance, emotion regulation, interpersonal effectiveness and mindfulness). These skills target emotion dysregulation and aims to improve emotion regulation capacities through the development of new coping responses (Linehan, 2015). DBT-S has shown promise in being effective as a stand-alone intervention for a variety of other mental health problems, with the most support being effective for BPD. For instance, Linehan and colleagues (Linehan, 2015) conducted a randomized control group in which individuals with BPD and recent suicidal or self-harming behaviors received 12 months of either standard DBT (i.e., individual DBT plus group DBT-S), group DBT-s plus intensive case management, or individual DBT alone. Results indicated that DBT-S when compared with the other groups showed greater reduction in BPD symptoms including anger, impulsivity, suicidal/self-harming behaviors, symptoms distress, social adjustment, as well as an increase in coping skills (Linehan, 2015).

A study carried out by Lin and colleagues (2019), compared Dialectical Behavior Therapy Skills Training Group (DBTSTG) and Cognitive Therapy Group (CTG) in reducing depression, suicide attempts, and modifying emotion regulation among those who have been

diagnosed with BPD. Using a sample of 82 college students, participants were randomized into each group for 6 months of intervention. While both groups showed significant improvements, the DBTSTG group revealed significant gain in emotion regulation with increases in acceptance and decrease in suppression. This study showed that while both CTG and DBTSTG were effective in decreasing BPD features, DBTSTG showed a stronger effect Lin et al., 2019

While DBT is effective and very widely used, Mentalization-Based Therapy (MBT) has also shown to be a successful and common intervention for BPD. MBT is a complex psychodynamic and attachment-based psychological therapy program that aims to increase the reflective functioning or mentalizing capacity of the individual, helping the person to understand and recognize the feelings they evoke in others and the feelings they experience themselves, as well as improving the capacity for emotion regulation in interpersonal relations (Bateman & Fogney, 2015). MBT includes introductory group-based psychoeducation on core features of personality functioning, specifically BPD, the treatment program and disorder-related personal management (Bateman & Fogney, 2015). Ditlefsen (2020) found that patients diagnosed with BPD who attended an introductory group of MBT based only on psychoeducation was found to be helpful in itself and participants were more likely to feel less shame, feeling different from others, felt more prepared for therapy and were more willing to attend long term therapy.

Based on the existing research on MBT, this brings into questions its effectiveness. In looking at the effectiveness of MBT, Vogt and Norman (2019) performed a meta-analysis with results indicating that MBT achieved either superior or equal reductions in psychiatric symptoms when compared to other treatments including supportive group therapy, treatment as usual (TAU), structured clinical management and specialized clinical management. These results

suggest that MBT can achieve significant reductions in BPD symptom severity as well as increase the overall quality of life (Vogt & Norman, 2019).

Overall, the literature is clear that DBT and MBT are effective psychotherapies for BPD. However, Barnicot and Crawford (2018), compared the outcomes of both DBT and MBT in patients with BPD. Using a group of 90 patients with BPD receiving either DBT or MBT over a 12-month period, patients who received DBT showed greater reductions in self-harm and improvements in emotional regulations than those amongst who received MBT (Barnicot & Crawford, 2018).

It should be noted that DBT and MBT are not the only effective treatments for BPD. Other common evidence-based treatments include Schema-Focused Therapy, Transference Focused Therapy, and Cognitive Analytic Therapy. Similar to DBT and MBT, these specific treatments are typically highly focused on affect and the therapeutic relationship, with a relatively active therapist implementing interventions with a supportive and validating atmosphere (Bateman, 2015).

Narcissistic Personality Disorder

There is no evidence that any psychopharmacological treatment is effective for NPD, although there is evidence that the mainstay of treatment for NPD is psychotherapy (Yakeley, 2018). A number of specific modalities and strategies have been developed and advocated for people with NPD, though none have been strongly tested for efficacy, and although there is emerging empirical evidence for their effectiveness, there does not appear to be one modality that exceeds others when treating NPD.

Psychotherapeutic treatments of NPD have been developed from within two main traditions: psychoanalytic and cognitive behavioral. Typically, treatment is individual therapy,

however, group therapy may also be effective in difficulties related to shame, dependency, self-sufficiency, and contempt for and envy others. However, it should be noted with caution that highly narcissistic individuals may dominate or disrupt groups and compete with the therapist to be a group leader (Yakeley, 2018).

It appears the most predominate psychodynamic psychotherapy that has been specifically related to NPD is Transference-Focused Therapy (TFT) (Clarkin, 2007). As noted previously, Transference focused therapy can also be used to treat BPD and was originally developed specifically for the treatment of BPD. The treatment is based on in the principles of psychoanalytic object relation theory and its technique is aimed at the active exploration of the patient's aggression, envy, grandiosity, and defensiveness. Further, it is targeted towards uncovering the negative transference, challenging the individual's pathological grandiose defenses, and exploring their sensitivity to shame and humiliation. The therapist's countertransference is purposefully used as a tool to understand the individual's projection of unacceptable aspects to themselves (Clarkin, 2007).

In 2013, Diamond and colleagues revealed that TFT was successful for patients with comorbid BPD and NPD due to their overlapping and comorbid traits. More recently, Diamond and Hersh (2020) argued that TFT has clinical utility for individuals with NPD standing on its own. Given the effectiveness of TFT for patients with BPD, including a number of individuals with comorbid NPD, the authors have adapted tactics and techniques with TFT with specific modifications for individuals with NPD or narcissistic traits. Otherwise known as TFT for NPD (TFT-N) aims to focus on disturbed interpersonal patterns of relating to the here-and-now of the therapeutic interaction and to assist the individual with maximum flexibility that comes from a capacity for self-reflection. It differs from treating BPD in that TFT for individuals with NPD

offers clinicians as well considered, deliberate approach that uses key elements including comprehensive assessment, the development and maintenance of a treatment frame, and interpretive process designed to address the exploration of the narcissistic patient's defensive use of grandiosity, sensitivity to humiliation and envy, and emotional detachment. It should be noted that TFT for those with NPD has not yet been empirically studied, the authors argue that due to the commonalities and comorbidity of BPD and NPD suggest that TFT can have genuine success with the NPD population. This study indicates that while the empirical evidence for NPD is limited, the future of psychology is headed in the direction of applying empirically based interventions towards this population.

Looking at more of a cognitive-behavioral approach to NPD, includes using cognitive techniques such as cognitive reframing, problem-solving and altering dysfunctional thoughts, coupled with behavioral modification techniques such as impulse control, maintain eye contact and reducing grandiosity. These have all been demonstrated in NPD individuals to strengthen the therapeutic alliance as well as increase adherence to therapy and ultimately reaching therapeutic goals (Campbell & Miller, 2011).

To ameliorate NPD symptoms, many researchers and clinicians have incorporated cognitive and behavioral model techniques including impulse control, maintaining eye contact, and decreasing grandiosity. Accordingly, therapy focuses on modifying behaviors and cognitions such as increasing empathy for others and decreasing common problems that are seen in therapy including building a strong therapeutic alliance and addressing comorbid diagnosis (Cukrowicz & Joiner, 2007). Cognitive techniques coupled with behavioral modifications may increase the individual's compliance with the therapist and the overall therapeutic goals. Additionally,

techniques such as cognitive reframing, active problem solving and altering dysfunctional thoughts may facilitate behavioral change.

Cukrowicz and Joiner (2007) described the use of Self-Control Regulation/Interpersonal Psychotherapy (SCRIPT), a cognitive behavioral approach, to the treatment of five cases with NPD. This approach involved examining the specific interpretations and behaviors in individual situations in which a desired outcome was not achieved. For those interpretations and behaviors that were detrimental to the desired outcome, alternative “helpful” ones are generated. This approach to examining NPD thoughts and behaviors allow the therapist to rely on the individual to determine their own thoughts and behaviors that are problematic, thus reducing perceived criticism from the therapist. This approach has also been used in concurrence with motivational interviewing, interpersonal psychotherapy, and relaxation treatment for individuals with NPD and comorbid conditions such as mood disorders, substance use, anxiety and other personality disorders (Cukrowicz & Joiner, 2007).

When it comes to targeting NPD, current treatment recommendations are based largely on clinical experience and theoretical formulations. While we see in this literature review that there has been research indicating that psychoanalytic and cognitive behavioral are effective for NPD, the research is limited regarding the outcomes of treatments due to lack of randomized control groups. Available evidence suggests that treatments lead to improvements of co-occurring disorders such as mood disorders, substance use disorders, interpersonal relationships, impulse control and treatment compliance. Future research is needed when comparing the efficacy of different treatment approaches with NPD.

Histrionic Personality Disorder

Similar to previous approaches, the treatment approach for HPD comes from a psychoanalytic/psychodynamic approach. Long term therapies using a psychodynamic approach have been considered the best method for treatment (Tuner, 1994). However, cognitive behavioral approaches to treatment are gaining support and recognition. It is important to note that in the light of the high comorbidity with other mental health disorders, compliant-specific approaches to treating HPD are often misapplied (Tuner, 1994).

Horowitz and Lerner (2010) have studied HPD extensively throughout their career, specifically treatment. Horowitz (2010) recommended a three-phase approach based on clinical formulation of integrating psychodynamic and cognitive behavioral conceptualizations. Horowitz (2010) describes the first stage as consisting of clarifying symptoms, establishing an alliance based on supportive techniques, and clarifying chronological sequencing outside events, internal mental states and symptoms. He noted that some individuals can present as intense negative emotions including rage, anger, fear shame, disgust, etc. and may be in a sense of being out of control emotionally. Additionally, individuals may be experiencing their communication style as hindered due to feeling comorbid symptoms such as anxiety and depression and cannot provide a clear psychiatric history. This stage is crucial to stabilize the individuals mental state. In this stage, the clinician should encourage the individual to engage in behavioral restraint from harm and avoid emotional flooding.

Phase two consists of reexamination of the reasons for treatment. Horowitz (2010) indicates that the clinician can begin to teach the individual how to think and talk about conflict and how to reflect on their intentions and motives as well as those of others. Horowitz details that it is best to clarify verbal communication such as modeling contemplation to the individual

speaking clearly and calmly while talking about emotional topics. Additionally, this phase consists of modifying defensive processes used to control unmanageable effect. HPD individuals use a variety of defensive control processes to ward of emotionally dangerous ideas as well as become avoidant. It is argued that taking the approach of modification of defensive control processes including showing the patient how to infer intentions rationally rather than making habitual irrational assumptions about other people may lead to further clarification of communication for them.

Lastly, Phase three encourages the individual to modify interpersonal behaviors and to integrate their own identity into their relationships with others. This phase focuses on the emphasis of modifying the meaning of internal events such as irrational beliefs about the self and others are altered into more healthy patterns of thought, feelings, and action. Common beliefs for these individuals include excessive fears of abandonment, dependence, idealization, and other scripts based on dysfunctional and inappropriate role-relationships from their past. The authors argue that these behaviors can be changed through practice of rehearsal and repetition through phase three combined with other psychological techniques (Kraus & Reynolds, 2001; Horowitz, 2010).

Treatment Interfering Behaviors

Behavioral control and violations of treatment are serious clinical problems during psychotherapy, especially in treating patients with a personality disorder. Dropout rates, that is, premature termination of psychotherapy is a recurring challenge for the therapist and patients in mental health services. Meta-analyses have suggested that the overall dropout rate of psychotherapy is roughly around 20% (Barrett, 2009). Regarding personality disorders, these numbers tend to increase. For example, Swift and Greenberg (2012) found that the dropout rate

of patients with a personality disorder was significantly higher (25.6%) compared to patients with mood disorders (15.4%) or anxiety disorders (16.2%).

This brings question as to why personality disorders have such a more significant drop out rate compared to other mental health disorders. In a recent study by Busmann and colleagues (2019), they aimed to investigate the dropout rating in a naturalistic sample of 132 patients with a personality disorder in an inpatient setting. Exclusion criteria were patients with substance abuse one week prior to hospital admission, psychotic symptoms, intellectual disability, and age below 18. Treatment in the study consisted of a highly structured and multimodal psychotherapy program combining evidence-based psychotherapeutic approaches. During an 80-day inpatient stay, these treatments included two weekly 45 minute sessions of individual short-term psychodynamic psychotherapy and three weekly 75 minute sessions of Metallization Based Group Therapy. It should be noted that the therapists were advanced clinical psychologist and psychiatrists under regular weekly supervision of a senior psychiatrist. Furthermore, the patients were participating in two weekly sessions of clinical management by primary nurses, consultation upon request, art therapy, music therapy, body work therapy, and group training in mindfulness and skills according to the DBT curriculum. Overall, results revealed that 28% of all patients prematurely discontinued psychotherapy. Those who did not complete treatment, obtained 52.5 treatment days on average. The authors found that the most central findings to drop out ratings were low self-functioning, indicating that the lack of boundaries between the self and others, an instable self-esteem, and a disturbed emotion regulation, as well as an inability to pursuit long and short-term goals, and an inability for self-reflection. Second, the study indicated that therapeutic alliance was also a significant predictor in dropout rating. It has already been discussed that those with Cluster B PD have very difficult interpersonal patterns

including repeating strains and estrangements that influence their day to day life. This can also influence the therapeutic alliance in psychotherapy which may lead to dropout.

Corresponding with these findings, Tufekcioglu (2013), suggested that alliance ruptures occur more often in the therapeutic alliance of patients with a personality disorder than those with non-personality disorders. The author suggests that in order to prevent dropout, the therapist's perception should be very attentive to signals of negative alliance, such as alliance ruptures. Fortunately, all evidence-based treatments for personality disorders conceptualize the issue of alliance building as one of the major targets of treatment. For example, recommendations refer to the implementation of trust, the clinician's responsiveness, and handing disruptive situations. DBT specifically aims at decreasing therapy interfering behaviors such as missing or coming late to session, phoning at unreasonable hours and parasuicide acts (Dimeff & Linehan, 2001). Research indicates that the clinician's perception of an impaired alliance might serve as an important signal to introduce specific interventions to prevent dropout. What is unfortunate, is that clinicians may unintentionally disrupt the therapeutic alliance because of countertransference and may lack this awareness. This will be discussed in a greater detail in a later section.

A study carried out by Ingenhoven et al. (2011), assessed 89 inpatients with various personality disorders in psychotherapeutic treatment. Findings suggested that during the first month of treatment, behaviors and contract violations were observed in 63 out of 89 patients (71%). Further, impulsive acts were the most common disruption behaviors (52%), followed by contract violations (49%), suicidal behaviors (43%) and anger outbursts (23%). Moreover, women were more likely to engage in suicidal behaviors, while men were more likely to violate basic commitment in their treatment contract (Ingenhoven et al., 2011).

The majority of interfering behaviors in the literature seems mostly related to a specific Cluster B PD. There has been an increasing amount of literature related to specifically BPD and treatment interfering behaviors. In particular, Allen (1997) describes specific interfering behaviors that are common with BPD. As mentioned previously, suicidal behaviors and ideation are common in BPD patients. When patients with BPD threaten suicide, therapist are in a predicament as to whether or not hospitalize the patient because this can interfere with exploration and the resolution of the underlying problems that triggered the suicidal impulse in the first place (Allen, 1997). Literature also indicates that there is likely to be intrusions and unreasonable demands. Patients with BPD are prone to asking therapists for "extra help" that may sometimes lead to boundary violations, demanding immediate relief from complicated symptoms and interpersonal difficulties. For instance, frequent telephone calls to the clinician after work hours is likely to be a boundary issue that commonly occurs. Moreover, patients with BPD often take positions in therapy that can be contradictory or unreasonable. Patients may argue that self-defeating behavior is somehow constructive or claim that the clinician has a tool that can help them but believe the clinician refuses to provide them with fair treatment. Lastly, Allen (1997) suggests that BPD patients may complain of being abused or misused by individuals with whom the therapist must work with such as other mental health professionals in a multidisciplinary setting. It is not difficult to imagine that these behaviors can invoke feelings of strong hostility, guilt, fear, doubt, helplessness, and/or inadequacy, even in clinicians who are otherwise calm and self-confident. Additionally, clinicians may find themselves doing or saying things in therapy that they would not consider with less provocative patients.

While there has been an abundant amount of literature on BPD and interfering behaviors, other Cluster B PDs have not been neglected. Gutheil (2005) demonstrates that Histrionic PD

also tends to play a role in boundary violations. For instance, he argues that these individuals are more likely to have an intense need for contact, self-esteem or approval, or relief from anxiety or tension, which may pressure the clinicians into hasty actions that cross boundaries, which may inevitably lead to a board registration report. Gutheil (2005) also details that individuals with ASPD may strain the boundary envelope with the intent of furthering manipulation of the therapist. For example, the patient might ask the therapist to advocate for the patient at work, school, and in other areas in which the therapist is induced to step out of their limits of the clinical role to assist the patient's purposes. Further, the patient in this category may use excessive familiarity and pseudo-closeness designed to get the therapist to perform uncharacteristic actions that transgress boundaries, which can include obtaining excusing or exculpatory letters sent to nonclinical recipients, obtaining inappropriate prescriptions, or inappropriately large amounts of controlled substances, and intervention in the patient's extra therapeutic reality (e.g., " I need you to meet with my parole officer to go easier on me; you know how ill I am") (Gutheil, 2005). Again, much like the reactions to HPD, these behaviors may lead to boundary violations, as well as possible repercussions such as board registration reports or termination.

Regarding NPD and treatment interfering behaviors, Weinberg and Ronningstam (2020) identify a hierarchy of 10 interfering behaviors in NPD 1) Suicidal Behaviors 2) Substance Misuse, 3) Attendance Problems, including requests for "exceptions" and special treatment arrangements, 4) Parasitic arrangements that stall the treatment, including unjustified disability or external support as well as engagement of others in "enabling" arrangements, 5) Withholding, selective reporting, dishonestly, 6) Nonpaying for therapy, not making necessary arrangement to pay, employment problems, creating or not resolving circumstances that interfere with treatment,

7) Disengagement through devaluation, idealization, attachment dissolution, or emotional avoidance, 8) Extreme defiance of, rebelliousness against, and competition with the therapist, 9) Intolerance of different perspectives, rejection of logical explanations, and 10) Misuse of treatment process and therapist's intervention (Weinberg & Ronningstam, 2020). The authors caution that these behaviors are likely to appear in the patient's detailed history, especially in relational history and experiences with prior treatments. Therefore, it is important to explore how these problems manifest in not only the relationship with the therapist, but also in their relationship with others.

It is clear that treatment interfering behaviors are common in psychotherapy, but specifically related to personality disorders. Where the majority of Cluster B PD research as well as interfering behaviors are focused on BPD, it is not surprising due to the amount of literature on BPD. Research also suggests that DBT is one of the most significant evidence-based treatments to decrease and handle treatment interfering behaviors. Not addressing patient's interfering behaviors, particularly frequent and frustrating instances, will likely negatively impact the clinician, the patient, and the overall therapeutic alliance. Addressing these issues will strengthen the therapeutic relationship and can reduce treatment interfering behaviors within in the treatment and in the patient's day to day life (Kirby, 2009).

Stigma and Mental Health

Many people with mental illness are faced with challenges of not only their own symptoms and disabilities, but also the stereotypes and prejudice from the public that result from misconceptions about mental illness. Unfortunately, this can impact the individual's quality of life and well-being, such as external circumstances including finding a job, healthcare, and

housing. This section will focus on strictly stigma, stereotypes, and misconceptions surrounding mental illness in its entirety.

Mental illness has been described in the literature as being less than human (Boysen et al., 2020). Corrigan and Watson (2002) explain that the impact of stigma is twofold. They argue that there is the idea of public stigma, which refers to the reaction of general population views of mental illness. Then, they argue there is self-stigma, which refers to prejudice which people with mental illness turn against themselves. Further, these two components (public and self) may be understood in three components: stereotypes, prejudice and discrimination. While these terms may seem similar in nature, Corrigan and Watson (2002) explains the important difference in the following description.

Public Stigma:

- Stereotype: Negative belief about a group (e.g., dangerousness, incompetence, character weakness)
- Prejudice: Agreement with belief and/or negative emotional reaction (e.g., anger, fear)
- Discrimination: Behavior responses to prejudice (e.g., avoidance, withholding employment, housing, withhold help)

Self-Stigma:

- Stereotype: Negative belief about the self (e.g., character weakness, incompetence)
- Prejudice: Agreement with belief and/or negative emotional reaction (e.g., low self-esteem, low self-efficacy)

- Discrimination: Behavior responses to prejudice (e.g., fails to pursue work or housing opportunities)

(Corrigan & Watson, 2002)

There are several themes to describe these misconceptions about mental illness and stigmatizing attitudes. First, one can argue that media plays a large role in these themes. Media analyses of film and print have identified people with mental illness as “homicidal maniacs” who need to be feared, having childlike perceptions of the world, and are responsible for their illness because they have weak character (Gabbard, 1992). Similar to this theme, Brockington et al. (1993) conducted a survey to a population of 2000 English and American citizens to investigate how the public views people with mental illness. In both the UK and the US their findings were parallel in that people viewed people with mental illness in the following themes: 1) fear and exclusion: persons with severe mental illness should be feared and, therefore, be kept out of communities; 2) authoritarianism: persons with severe mental illness are irresponsible, so life decisions should be made by others; and 3) benevolence: persons with severe mental illness are childlike and need to be cared for. Further, respondents were less likely to have sympathy for persons with mental illness, instead reacting to psychiatric disability with anger and having beliefs that help is not deserved (Brockington et al., 1993).

Although stigma attitudes are not just limited to mental illness, research indicates that the public appears to disapprove individuals with psychiatric disabilities significantly more than persons with physical conditions. Unlike physical disabilities, persons with mental illness are perceived by the public to be in *control* of their disabilities and therefore are responsible for causing them (Corrigan et. al, 2004; Weiner et al., 1988). In regard to discrimination, this can result from public stigma in many forms, such as withholding help, avoiding, coercive treatment,

and segregated institutions. A more extreme of this behavior, as discussed earlier, is social avoidance, where the public strives to not interact with people with mental illness altogether. To illustrate this form, in 1996 The General Social Survey, in which the MacArthur Mental Health Module (a vignette about an individual experiencing symptom 1 of 5 different mental health related conditions) was administered to a sample of 1,444 adults in the U.S. The results indicated that more than half of the respondents were unwilling to spend an evening socializing, work next to, or to have a family member marry a person with mental illness (Pescosolido & Tuch, 2000). Moreover, this survey revealed that 40% of respondents agreed that people with schizophrenia should be legally forced into treatment. Additionally, this survey revealed that the public endorsed segregation in institutions as the best service for people with serious psychiatric disorders (Pescosolido & Tuch, 2002).

More recently, Follmer and Jones (2020), investigated those who have mental illness in their place of work by their coworkers. Using the stereotype content model (a proposed model that all group stereotypes and interpersonal impressions form along two dimensions: warmth and competence) as a framework, the authors investigated warmth and competence stereotypes associated with employees who have been diagnosed with anxiety, depression, and bipolar disorder. Using a sample of 217, participants completed a survey looking at stereotypes for each disorder (anxiety, depression, bipolar). Results indicated that those with these disorders stated they were perceived as having low warmth and competence, with the exception of anxiety. The ratings for warmth and competence were most associated with bipolar disorder. Results revealed that stereotype content associated with employees who have a mental illness may contribute to subtle discriminatory behaviors in the workplace, such as avoiding or social distancing. In turn, interpersonal discrimination can affect how employees with mental illness manage their

disorders, including disclosing their mental illness to their coworkers in the workplace (Folmer & Jones, 2020).

Parallel to these findings, many people who would benefit from mental health services, often opt out of pursuing them or if they do or often fail to fully participate. Corrigan (2004) argues that the source of this lack of reaching out to resources or a lack of disconnect when in treatment is related to stigma, or more so to avoid the label of mental illness and the harm that it can bring. Corrigan argues that the stigma yields two kinds of harm that may impede treatment, that is, diminishing one's self-esteem and takes away people's social opportunities such as jobs, housing, and health care.

Cluster B Personality Disorders and Societal Stigma

As discussed, mental illness suffers greatly from public and unfortunately mental health provider stigma, stereotypes, prejudice and discrimination. Like those with other forms of mental illness, personality disorders also experience, if not more of the impact of societal stigma. Evidence suggests that personality disorders might be even more stigmatized than any other psychiatric diagnosis, with exploitation and frustration among the common public reactions to personality disorders (Catthoor et al., 2015; Magallon-Neri et al., 2013). Specifically, those with personality disorders are often viewed as being able to exhibit control over their behavior which results in symptoms being viewed as manipulations or rejection for help (Aviram et al., 2006). Of course, this can lead to cause individuals to be seen as difficult and misbehaving rather than their mental illness being the contributor to their behaviors. Further, the public views those with personality disorder(s) as less sympathetically and are less likely to think these individuals should receive or need professional help than those with other psychiatric disorders such as mood and trauma related disorders (Furnhan et al., 2015). However, literature indicates that the

general public has less knowledge about personality disorders than about other mental illnesses (Furnham et al., 2015, Wright & Furnham, 2014). For instance, in a study completed by Furnham et al., 2015, it was revealed that when participants were presented with a vignette describing someone with BPD, only 2.3% of the respondents recognized the symptoms of BPD, whereas 72.5% recognized depression and 65.5% recognized schizophrenia (Furnham et al., 2015).

Of all the stigmatized mental health disorders, more specifically Cluster B PD, BPD is among the most stigmatized and is the most researched in regard to stigma, treatment, and etiology (Bonnington & Rose, 2014; Catthoor et al., 2015; Martin, 2015). Individuals with BPD are often viewed by society as “annoying” and “undeserving,” which results in inadequate treatment and help (Aviram et al., 2006). Due to the frequent encounters individuals with BPD have with law enforcement, due to suicidality and at times, aggression, Martin (2015) explored police encounters with people experiencing mental illness, specifically personality disorders. Results revealed that police officers expressed frustration, anger, powerlessness, and resignation with their referrals to this group. Officers also reported that emergency departments were reluctant to assess people with personality disorders and when they did, responders believed they did not meet criteria for admission to mental health service, or if admitted, they were quickly discharged. Additionally, people with personality disorders, specifically BPD, were reported to take up a considerable amount of police resources (Martin & Thomas, 2015). Sheehan and colleagues (2016) argue that while negative emotions from police are understandable responses, this may also reflect stigma. That is, an officer’s anger may be intensified when they endorse the stereotype that people with a personality disorder are troublesome. Consequently, the police are likely to view that people with BPD are seen as wasting police resources and time, therefore,

these individuals are likely to experience harsher treatment and services that are not well-designed to serve their unique needs (Martin & Thomas, 2015).

ASPD is also widely researched in regard to stigma. The stigma of dangerousness that is associated with ASPD can lead individuals to be denied the prospects of treatment and recovery, especially those within the justice system. As noted earlier, individuals with ASPD often are referred to as psychopaths or sociopaths and are sometimes stigmatized as this idea that they are "evil" (Wayland & O'Brien, 2013). In 2004, Smith and colleagues surveyed 400 individuals on jury duty regarding various perceptions, attitudes, and beliefs they had concerning psychopathic personality. They found that individuals with ASPD are viewed as more violent, but generally sane and responsible for their actions (Smith et al., 2014). In the justice system, ASPD diagnosis may cause the person to be labeled as dangerous and untreatable, ultimately affecting the individuals sentencing and possibility for the death penalty if legal in the presenting state. According to Wayland & O'Brien (2013), partly due to these attitudes (e.g., dangerousness and untreatable), people with ASPD are sometimes unable to complete rehabilitation while in the prison system strictly due to their diagnosis.

Earlier mentioned, BPD and ASPD are widely researched, thus making it easier access for the general public to be more familiar with these disorders. However, NPD not as a familiar disorder to the public (Wright & Furnhan, 2014). Unfortunately, there is little to no research on the stigma surrounding NPD, or HPD for that matter. This lack of public understanding of NPD can lead to potential stigma and need for further rigorous explanation (Sheehan et al., 2016).

As noted earlier, media plays a large role into the stigma related to mental illness in general. Specifically looking at Cluster B PD, media and cinematic roles such as Anthony Hopkin's Hannibal "The Cannibal" Lecter in The Silence of the Lambs (Demme, 1990) highlight

the most extreme and severe forms of this disorder. Other cinematic roles and Cluster B PD include Borderline PD- Glen Close in Fatal Attraction (Lynn, 1987), Narcissistic- Shirley MacLaine in Terms of Endearment (Brooks, 1983), and Histrionic- Viviane Lee Gone with the Wind (Flemming, 1939; Kraus & Reynolds, 2001). Further, Bowen (2019) explored how the linguistic characteristics of press articles on personality disorders in population tabloids in the UK over than span of ten years (2008-2018). Analysis of the language used by the press in accounts about mental health focused on the overuse of words that are pejorative and have associations with mental health, such as "psycho" and "monster." Moreover, it revealed that the media had used a range of words that are associated with violence, which would construct images to the reader of violence linked to personality disorders. The author argues that the power of these words would arise from both repetition and from the relationships that exist between them, which include four categories of words that highlight elements of those relationships. Category one includes words naming act of violence (e.g., murder, killed, stabbed, shot) would be amplified through sensationalistic language describing those acts (e.g., wicked, deranged, horrific) and through the repeated focus on the actual implements of violence (e.g., knife, hammer, axe, gun). It is important to note that while this specific study did not directly examine the impact that the media articles had on individuals, the results can be considered in relation to the process of stigma. Additionally, the author argues the repetition of images of violence in representing people with a diagnosis of personality disorder may well encourage individuals to adopt overly cautious behavior in relation to this group of individuals, based on an unrealistic fear of threat of serious violence, and affective responses of fear (Bowen, 2019). This suggests that media plays an important role in how society can form stereotypes on personality disorders, solely based on the exposure to negative connotation.

How do these negative stigmatizations affect patients? While they can affect an individual's environmental factors such as housing, occupation, etc., Dinos and colleagues (2004) conducted a qualitative study that aimed to describe the relationship of stigma with mental illness, psychiatric diagnosis, treatment and its consequences of stigma for the individual. They conducted narrative interviews with 46 patients who were recruited from community and day mental health services in North London. Based on the results, researchers found that stigma was a pervasive concern to almost all participants. Specifically, people with psychosis or drug dependence. These individuals were most likely to report feelings and experiences of stigma and reported to be most affected by them. Those with depression, anxiety, and personality disorders were more affected by patronizing attitudes and feelings of stigma, even if they had not experienced any overt discrimination (Dinos et al., 2004).

Cluster B Personality Disorders and Mental Health Provider Stigma

Thus far, we have discussed how society views mental health, specifically personality disorders. However, the purpose of this literature review is to look at mental health providers and biased attitudes towards Cluster B PD. Therefore, this next section will specifically discuss literature looking at how mental health providers view personality disorders. We have established that those with personality disorders have stigma and stereotypes surrounding them from society. We would expect that since mental health professionals are exposed to these disorders, their attitudes would be more empathetic, understanding, and tolerable of personality disorders. It is imperative to understand how personality disorders influence mental health provider's attitudes. Interestingly, majority of the findings presented in the literature spanning from the 1980's to present day, the findings are similar across the decades.

While the public may also give into the stigma of mental illness and serve as an initial barrier for individuals to enter treatment, once in treatment, they are then confronted with the label of a mental illness which also may be stigmatizing (Bonnington & Rose, 2014) In 2011, Black and Colleagues (2011) sought to determine attitudes towards patients with BPD among mental health clinicians at nine academic centers in the United States. Using a self-report questionnaire to a total of 706 mental health clinicians (e.g., psychiatrists, psychiatry residents, social workers, nurses and psychologists), results indicated that while the majority of clinician's view BPD as a valid diagnosis, nearly half of the clinicians reported that they preferred to avoid these patients. Staff nurses had the lowest self-ratings on overall caring attitudes, while social workers had the highest. Moreover, social workers and psychiatrists showed the highest ratings on treatment optimism; social workers and psychologists were most optimistic about psychotherapy effectiveness, while psychiatrists were most optimistic in regard to medication effectiveness. Again, staff nurses were within the lowest ratings in respect on empathy toward patients with BPD and treatment optimism. We see in this particular study that negative attitudes persist among mental health providers toward BPD but differ among occupational subgroups. Overall, empathy, caring attitudes, and treatment optimism were more significant among care providers who had cared for a greater number of BPD patients within the last year (Black, 2011). These findings hold important implications to advocate for clinician education and coordination of care for patients with BPD.

Internationally, a similar study was conducted in Israel asking 710 mental health providers (e.g., psychiatrist, psychologists, social workers and nurses) to complete a questionnaire on attitudes towards patients with BPD. Similar to the results of the previous study, they found that nurses and psychiatrists exhibited more negative attitudes and less empathy

towards these patients than the other two professions. The sample as a whole evaluated the decision to hospitalize personality disorder patients as less justified than the decision to hospitalize a patient with Major Depressive Disorder. Additionally, negative attitudes were positively correlated with caring for greater numbers of patients with BPD within the past 12 months. Interestingly, nursing staff expressed the highest interest in studying short-term methods for treating patients with BPD and a lower percentage of psychiatrists expressed an interest in improving their professional skills in treating patients. These findings suggest that patients with a personality disorder, specifically BPD in this case, experience stigma and negative attitudes from those with whom they are working with. Further, those who have more experience working with BPD, experience a higher negative view of these individuals (Bodner et al., 2015). Based on these results, it is important to implement workshops and interventions for improving provider's attitudes is essential. However, very few studies have examined stigma change interventions specific to personality disorders.

The results of these articles lead to the question of how can the stigma from mental health providers directly affect the patient? Kling (2014) bravely wrote about her experience as a patient with BPD as well as her experience as a clinician working with the BPD population. She writes in her 2014 paper, *Borderline Personality Disorder, Language, and Stigma:*

> "I was in a gym talking to an acquaintance who was a therapist about going to school to become a psychologist. I mentioned that I wanted to have a practice composed of people struggling with BPD. 'Well you can have mine,' she snorted. I was flooded with a familiar feeling of shame, the sense that I was part of a group of people were inherently not likeable, not worthy, not worth helping" (Kling, 2014, p.114-115).

She further explains her struggle when seeking mental health treatment for BPD in that the language in media and from those who knew her as “You’re just trying to get attention.” “Stop being manipulative.” She argues that language shapes the perception of the clinician. The perceptions inform the way that clinicians interact with clients, and the negative responses are perceived and feed into self-loathing by the client. Further, that clinicians describe BPD patients in pejorative terms such as “difficult, treatment resistant, manipulative, demanding, and attention seeking.” While each of these descriptors may reflect certain aspects of the patient’s behavior, these pejorative language choices can impact upon the provider’s expectations. If left unexamined, these descriptors can potentially become a justification for stigmatization which can lead to discrimination, early termination, as well as other possible negative outcomes that have been discussed throughout (Kling, 2014; Lewis & Appleby, 1988, p. 250).

Corresponding with Kling’s statements, Fallon (2003), interviewed patients with BPD in order to explore their contact with mental health provider(s). His research revealed that 6 out of 7 experienced negative attitudes from their treating clinicians. Additionally, patients reported that it was not specifically therapy they were seeking, it was just to be listened to and given time and emotional support, to which they believed they did not receive (Fallon, 2003, p.397, Kling, 2014).

In an effort to facilitate a more systematic understanding of the effects of associative stigma among mental health clinicians, Yanos et al. (2017) developed the Clinician Associative Stigma Scale (CASS) (Yanos et al., 2017). This scale aimed to be the first validated scale of associative stigma among mental health professionals. The CASS also demonstrates a four-factor structure (Negative Stereotypes about Professional Effectiveness, Discomfort with Disclosure,

Negative Stereotypes about People with Mental Illness, and Stereotypes about Professionals' Mental Health) and was significantly related to measures of burnout and quality of care.

Recently, Yanos et al. (2020) wanted to further investigate the psychometric properties and utility of the CASS by examining its association with measures of burnout, job satisfaction, and intent to leave one's job (turnover intention) with a group of clinicians at community mental health settings. Further, the association between CASS scores and these other measures were examined at two points in time, including baseline and a six month follow up. It was hypothesized that the CASS would continue to demonstrate strong psychometric properties, would continue to be stable over time, and would be associated with increased burnout and turnover intention and negatively associated with job satisfaction. A total of 68 mental health providers in community mental health settings completed the CASS, as well as measures of burnout, job satisfaction, and turnover intention. Results indicated that the CASS significantly predicted burnout and job satisfaction when examined cross-sectionally. Additionally, longitudinal analyses showed that increased associative stigma was associated with increased burnout and lower job satisfaction over time. It can be concluded from these results that associative stigma may have negative consequences for mental health service providers, as well as the consumers they serve, and the CASS appears to be a useful tool to explore this phenomenon.

There are also anti-stigma interventions that target provider's diagnostic-specific stigma. In 2014 Clarke et al., (2014) had health professionals complete two days of BPD anti-stigma training. The professionals were assigned to either self-management, which consisted of using Acceptance and Commitment Therapy (ACT) (Hayes et al., 2012), or skills training, which consisted of Dialectical Behavioral Therapy (DBT). In comparison to pre-test, after receiving

anti-stigma training, clinicians in both groups had more positive attitudes, improved relationship with clients, and a lower desire for social distance from their clients after the intervention. Additionally, stigma reduction was maintained at a 6-month follow up (Clarke et. al., 2014).

Further, recent research suggests another approach to stigma change. Current brain imaging studies have provided evidence that personality disorders have a visible neurobiological difference and challenges that are merely a character flaw or the intentional actions of the person (Krause-Utz et al., 2014; Rossi et al., 2015; Schulze et al., 2013; Whalley et al., 2015). Literature indicates that brief trainings that highlight the neurological basis of neurology and PD, showed change in knowledge and attitudes, however, not towards empathy of healthcare staff (Clarke et al., 2014). However, using experimental vignettes, Leobowitz and Ahn (2014) found that combining the neurobiological information about the causes of personality with recovery-oriented information was found to be more effective in reducing stigma that solely the neurobiological approach or treatment information alone.

Stigma experienced by individuals with a personality disorder clearly can threaten the multifaceted psychiatric symptoms and may compromise treatment, particularly pertaining to when the stigma is coming from those within the mental health field. This is not to say that those with a personality disorder, do not benefit from treatment, however, the misconception that they are not worthy of treatment or they are untreatable may seriously limit the efforts of the mental health providers and the development of comprehensive programs. Research suggests that contact-based anti-stigma interventions that specifically emphasize recovery possibilities and educate about the biological underpinning of personality disorders appear to be the most effective. However, there are some gaps within the literature. A majority of the research and literature focuses on stigma surrounding ASPD and BPD.

Gender and Sex Bias

One of the most difficult and controversial issues for the diagnosis of personality disorders is gender and sex biases (Funtowicz & Widiger, 1999), specifically with regard to the Diagnostic and Statistical Manual of Mental Disorder-Fifth Edition (DSM-5) personality criteria. The current DSM-5 suggests that the prevalence of antisocial and narcissistic are more frequently found in men, whereas borderline and histrionic are more prevalent in women (American Psychiatric Association, 2013). Kaplan (1983) has criticized DSM criteria and argues that these prevalence's are due to gender bias, further arguing that personality criteria assumes unfairly that stereotypical female characteristics are pathological.

Following Kaplan's remarks on gender biases, many other researchers have sought out to find the link between gender biases and personality disorders. Specifically, Widiger (1998) described six ways in which gender biases could be related to differential prevalence rates, including: biases in diagnostic construct, diagnostic thresholds, sampling of the population, application of the diagnostic criteria, assessment instruments, and diagnostic criteria (Widiger, 1998). Around the same time, Funtowicz and Widiger (1999) looked at whether the DSM-IV at that time was biased against women by requiring less dysfunction for the personality disorders that are more common in women, such as HPD. Using a sample 590 participants of clinical psychologist, participants were mailed a questionnaire of the DSM-IV adult diagnostic criteria for borderline, dependent, histrionic, obsessive-compulsive, antisocial and paranoid personality disorders. Participants were asked to provide their own judgment to the extent to which each of the DSM-IV personality disorder criteria involved social dysfunction, occupational dysfunction, or subjective distress. Results failed to support a bias against women in the threshold for a diagnosis of a personality disorder. Overall, there was no difference in the level of impairment

suggested by the personality disorder diagnostic criteria between the male-typed versus the female-typed personality disorders averaged across all of the criteria.

Garb, 1997 looked at clinicians (both male and female) who were provided different case vignette histories that are identical except for the designation of gender. Results found that clinicians labeled the vignettes as females are more likely than males to be diagnosed as having a HPD, and males are more likely than females to be diagnosed with ASPD, even when female and male patients do not differ in symptomatology. These studies suggest that while some evidence does support a link between diagnostic constructs and gender stereotypes other diagnostic thresholds for personality disorders do not seem to be biased. These differential findings point out the controversy in research and future research is needed to combat these arguments.

Over the past three decades, research findings utilizing the case vignette methodology have repeatedly indicated a gender bias within histrionic diagnosis. Samuel & Widiger (2009), replicates these findings using a novel case vignette, but extends the vignettes to investigate the potential for gender biases within the alternative dimensional model of personality, noted earlier, the Five Factor Model (FFM). 141 participating clinicians rated either male or a female version of a case vignette in terms of either the FFM or the personality disorders from the DSM-IV. Results supported a concern of gender bias, with the female case less likely to be diagnosed with ASPD and the male case less likely to be diagnosed with HPD. However, when the FFM conceptualizations of these two disorders were compared, no significant differences were noted. The results indicate that the FFM may be less prone to gender bias than the current DSM nomenclature (Samuel & Widiger, 2009).

Cultural Bias

Winsper et al., 2020 looked at worldwide prevalence of personality disorders and examined whether rates varied between high-income countries and low-and middle-income countries. In a meta-analysis, using a variety of databases to gather articles ranging from January 1980 to May 2018, the authors found that the worldwide pooled prevalence of personality disorders were greater in high-income countries (9.6%) compared to lower middle-income countries (4.3%) (Winsper et al., 2020). Looking specifically at Cluster B PD, these disorders were found to be less common in lower-middle class. Further, results found that the global pooled prevalence of any personality disorder was 7.8%. This figure exceeds the WHO World Mental Health personality disorder figure of 6.1% (Chisholm, 2015; Winsper et al.,2020). The authors attribute these findings to cultural and social factors, arguing that due to the behavioral norms across cultures (e.g., individualistic versus collectivist societies) could have some direction on diagnosing personality disorders. Additionally, hypothesizing that mental disorders can present with different symptoms in different cultures and current diagnostic tools and criteria might underestimate the prevalence of personality disorders in lower middle-income countries (Winsper et al., 2020). This research indicates that personality pathology continues to be overlooked in clinical practice, particularly in lower middle-income countries where resources are limited, and personality disorders tend to be a lower priority.

Several studies looking at BPD between and across countries, particularly immigrant populations, identify variations in symptom prevalence based on culture. While reviewing 23 studies in 1986, Akhatar et al. (1986) found that suspiciously fewer African American patients received a BPD diagnosis. Further, other meta-analysis studies confirmed Akhatar et al. (1986) findings, reporting that they found a significant difference in prevalence of personality disorders

between African American and Caucasian patients, with African American patients receiving a lower diagnosis of BPD compared to Caucasian groups (Jani et al., 2016). Around the same time of Akhatar et al. (1986), Castaneda and Franco (1985) examined specifically 101 psychiatric inpatients with BPD. Interestingly, they found that women were more often diagnosed with BPD that men in Caucasian or African American populations. However, in Hispanic populations, women and men were diagnoses with BPD as the same rate. The authors attributed these differences to clinician cultural bias and identity confusion from immigration (Castaneda & Franco, 1985).

More recently, Chavira et al. (2003) found that patients from Hispanic populations had received higher rates of BPD diagnosis compared to White and African American patients, endorsing anger, affective instability and unstable relationships more frequently. The authors attributed their findings to clinician bias, as well as possible marginalization to a feeling of powerlessness that can predispose minorities to BPD, with an additional stress of acculturation (Chavira et al., 2003). These findings reveal a need for more unified dimensional-based categorization of BPD to reduce cross-cultural bias. As we have seen from the previous studies discussed, evaluations of BPD by mental health providers of cultural backgrounds that differ from patients, several studies indicate bias in diagnosis.

Using the case-vignette method, Mikton and Grounds (2007) investigated cross-cultural clinical judgement bias in the diagnosis of personality disorder in African Caribbean men with clinical features indicative of BPD and ASPD. In a sample of 220 forensic psychiatrist in the UK, two vignettes each describing a male referred for a psychiatric assessment were created, one case vignette was suggestive of BPD and one indicative of ASPD. Each vignette came in two versions, the case identical except for the ethnicity of the person changed from “African

Caribbean" to Caucasian." Clinicians were asked to indicate what individual diagnoses were present in the vignette they were given, solely on the basis of the available history. Each participant was randomly assigned to one of the two conditions. It is important to note the demographics of the sample which included, 220 forensic psychiatrists (66% men, 34% women, 80.4% white, 11% Indian. 3.8% Black African and 4.8%) (Mikton & Grounds, 2007). Results showed that the vignette describing possible DSM-IV ASPD, Caucasians were 2.8 times more likely to be given a diagnosis of personality disorder than African Caribbean by the participants. Diagnoses also varied according to the ethnicity of the clinicians. Interestingly, no cross-cultural bias was found in the vignette describing possible DSM-IV BPD. These findings are important to the current focus on delivering race equality in mental health services and further support the previous literature that has been discussed. Further, the results of this vignette study indicate that cross-cultural clinical judgement bias is present in the attribution of ASPD to African Caribbean patients presenting with clinical histories indicative of this condition. It is important to keep in mind the demographics of this study, in that majority of clinician participants were Caucasian. The authors note that it is expected that generally, Caucasian clinicians are likely to be unfamiliar with African Caribbean culture, therefore, may experience unconscious clinician biases.

Defining Countertransference

Countertransference is best conceptualized as the unconscious re-creation of the patient's internal object world in the relationship with the psychotherapist (Gabbard, 2009). The concept of countertransference ages back to 1910 when the term was created by Freud (1910). For instance, Freud wrote:

"We have begun to consider the countertransference which arises in the physician as a result of the patient's influence on his unconscious feelings and have nearly come to the point of requiring the physician to recognize and overcome this countertransference in himself" (Freud, 1910, p. 144-145).

For many decades following Freud's view of countertransference, this topic was considered taboo and neglected. However, during the 1950's newer concepts of countertransference began to rise. During this decade, the first empirical studies on the topic also emerged. From this point on, there appears to be a steady increase in both clinical and theoretical writing on countertransference.

Interestingly, there have been four major concepts of countertransference that have emerged from the literature over the years, including *classical, totalistic, complementary, and relational.* As we see, in the classical definition from Freud (1910), countertransference was defined as the therapist's unconscious, conflict-based reaction to the patient's transference. Additionally, unresolved conflicts originated from the therapist's childhood are triggered by the patient's transferred and are acted out by the therapist (Hayes, et al., 2011).

In the 1950's, the totalistic conception of countertransference originated from Little (1951). According to this conception, countertransference represents all of the therapist's reactions to the patients. That is, all reactions are important, all should be studied and understood, and all are placed under the broad umbrella of countertransference. This definition aimed to make countertransference an object of the therapist's self-investigation (Hayes, et al., 2011).

Looking at the complementary conception of countertransference, the therapist's reactions are viewed as a complement to the patient's style of relating (Levenson, 1995; Racker,

1957). This means that the patient exhibits certain reactions on the therapist. The therapist, however, does not act out in retaliation, even though this may seem the typical. Preferably, therapists are to restrain their reaction impulses and try to understand what the patient is doing to cause these reactions. This conception can lead to an understanding of the patient's interpersonal style of relating to the therapists and themselves, as well as for therapeutic interventions (Hayes, et al., 2011).

Lastly, the most recent is the relational perspective in which this concept views countertransference as mutually constructed by the patient and therapist (Mitchell, 1993). This indicates the needs, unresolved conflicts, and behaviors of both the patient and therapist are believed to contribute to the manifestation of countertransference in sessions (Hayes, et al., 2011).

All constructs in the definition of countertransference are used interchangeably and can be ambiguous. It should be noted that these four views of countertransference possess fundamental limitations. Despite its history of definitional ambiguity and inconsistency, most recent empirical studies on countertransference have employed a definition that involves the therapist's unresolved conflicts as the course, often with patient characteristics and behaviors as the trigger (Hayes, et al., 2011).

Although countertransference has been conceptualized in relation to the specific setting of psychotherapy, there has been evidence that doctor-patient relationship noticing that clinicians showed reactions towards the patient from the very first consultation (Michadud et al., 2019). In the emergency setting, this first interaction has been called instant countertransference (iCT). iCT is defined as an instant spontaneous set of feelings that form towards patients, even in the shortest of clinical interactions (Michadud et al., 2019).

The Effects of Countertransference on the Therapist

In looking at the definitions of countertransference, it brings to question, how does this concept affect mental health providers? Freestone (2015) aimed to provide an overview of studies examining the impact on staff of working with offenders who have a personality disorder. Conducting a review of literature stemming from 1964 to 2014 across 20 databases in the medical and social sciences, a total of 27 papers were included in this review to look specifically at clinician attitudes, burnout, countertransference, perceived risk of violence, and job satisfaction. Results indicated that the greatest area of impact for clinicians were related to negative attitudes among staff. Across the literature associated with criminal justice and hospital settings, authors noted that the label of personality disorder in general were associated with negative connotations, and staff reacted in a less therapeutic manner, and more in a managerial way to individuals with this label. Additionally, staff felt that those with personality disorders inspired a greater sense of blameworthiness and susceptibility to criticism and lower levels of pathological symptoms. Regarding burnout and countertransference, authors found that those working with personality disorders experienced hate, difficulty communicating with other staff, stress, and fear. On the contrary, two studies within this literature review identified a minimal sense of risk and anxiety associated with work with personality disorders and noted that greater experience in working with personality disorders were associated with a perception of a decreased risk to staff. Further, job enjoyment was associated with lower rates of staff interaction with personality disorders. Lastly, clinical work with personality disorders was described as "exciting and cutting edge" (Freestone, 2015).

Countertransference responses to NPD particularly can be intense, frustrating, and difficult to manage, as is it often reported in the clinical literature as we have seen, though not

clearly supported empirically. Tanzilli et al. (2017), aimed to investigate the relationship between patient's with NPD and therapists' responses. Additionally, the authors looked at the associations between patient, clinician, therapy variables and clinicians' reactions during treatment of NPD patients, and provided an empirically derived portrait of countertransference with NPD. In a sample of 67 clinical psychologist, participants completed the Therapist Response Questionnaire to identify patterns of countertransference and two additional measures (Shedler-Western Assessment Procedure 200 and the Global Assessment of Functioning Scale) to assess the personality pathology and psychosocial functioning of the patient. Results showed that NPD tended to induce clinicians intense and negative emotional reactions, potentially disrupting the ability to benefit from the therapeutic relationship. Clinicians reported feeling devalued, unappreciated, demeaned, or belittled by their patient, as well as experiencing hostile and angry pattern, which indicated feelings of anger, resentment, and irritation. These countertransference reactions are likely to provoke depictions of judgement, harsh comments, premature interpretation, criticism, and/or accusatory statements (Gabbard, 2009). Additionally, the authors found that therapist reactions associated with NPD were characterized by feelings of distraction, distance, indifference, and a withdrawal connection between the therapist and patient. Therapists also reported feeling helpless and inadequate patterns, indicating they felt strongly incompetent, ineffective, invisible, insecure, anxious and less confident when working with those with NPD. These findings support that in a therapeutic setting, this could lead to difficulty managing or maintaining therapeutic boundaries, such as accepting the provision of special modifications to patient's, possibly challenging demands (Tanzilli et al., 2017).

Burnout

Burnout is particularly common amongst those working with clients with personality disorders (Perseius et al., 2007). Burnout is defined as "a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity" (Malach et al., 1996; Feinberg, 2020).

Crawford et al. (2010), examined levels of burnout among staff working in a community-based services for individuals who have been diagnosed with a personality disorder. The authors aimed to explore factors that added to or lowered the risk of burnouts among people working in these types of services. A total of 118 clinicians who perform personality disorder services in England, were provided the Maslach Burnout Inventory (MBI) (Malach et al., 1996) and were interviewed. It should be noted the MBI (Malach et al., 1996) measures three related concepts of emotional exhaustion (depletion of emotional resources), depersonalization (negative attitudes and feelings about patients) and sense of personal accomplishment at work (negative evaluation of one's self, especially regarding dealing with patients) (Crawford et al., 2010; Malach et al., 1996). Results revealed the levels of burnout were generally lower when compared to previous studies among mental health providers and the levels of personal accomplishments were deemed higher. Results from the interviews revealed that staff reported positive as well as negative experiences of working with people with personality disorders. Participants added that strong teamwork, clear leadership and opportunities for reflective practice were though to protect staff from burnout (Crawford et al., 2010)

In 2000, Linehan, Cochran and Mar introduced the phenomenon of client burnout to describe the similar feelings of emotional exhaustion and helplessness in that patients with BPD can experience in the context of therapy. Linehan, Cochran & Mar (2000) noted that similar to

therapists, patients with BPD can also experience burnout, as they are working in the therapeutic relationship. Using an adapted version of the MBI (Malach et al., 1996) to be given to patients, the authors indeed found that therapist and client burnout appear to be quite similar (Linehan et al., 2000). Specifically, clients experience comparable feelings of emotional exhaustion in the context of the therapeutic relationship, and subsequently experience increased feelings of accomplishment and efficacy when therapeutic work is successful. This novel concept of client burnout presents many possible avenues to further investigate the challenges of therapeutic work with patients with BPD. Firstly, patients with BPD are known to be high utilizers of psychological treatment over their lifespan, and thus may be at greater risk of developing client burnout than other patients with mental health diagnoses (Linehan et al., 2000).

Secondly, clients with BPD and therapists who are experiencing comparable burnout at the onset of psychological treatment may inevitably experience a more challenging therapeutic relationship (Linehan et al., 2000). Interestingly, Linehan et al. (2000) found that the severity of symptomology in the patient with BPD was not necessarily correlated with the experience of burnout in either client or therapist. The authors did find however that therapists' high expectations of successful treatment outcomes did contribute to great experience of burnout. Considering this possible risk factor, the authors recommend a realistic level of expectation of therapeutic success when working with patients with BPD. It appears that this process may be challenging in that the therapist must also be cautious not to underestimate their patients with BPD as "weak or fragile", as this may only increase stigma and bias towards this diagnostic group. Therefore, it is important to find a balance (Linehan et al., 2000).

The Effects of Countertransference and Treatment

A qualitative study conducted by Treloar (2009) in Australia and New Zealand investigated transference and countertransference in work with patients diagnosed with BPD. The results of this study concluded that difficulties in the mental health system as well as interpersonal difficulties between patient and provider strongly predict treatment outcomes for patients with BPD (Treloar, 2009). The participants of this study were 140 providers of some type of mental health services to patients with BPD, including psychiatrists, psychologists, social workers and mental health nurses. In written form, participants were asked, “Please provide some comments about your experience or interest in working with patients diagnosed with Borderline Personality Disorder” (p. 31). Results were subsequently organized into four categories: the generation of uncomfortable personal response from clinicians, characteristics of BPD that contribute to negative responses from clinicians and health services, inadequacies in the health system and, and techniques needed to improve services for this population (Treloar, 2009). Uncomfortable feelings described by clinicians centered around inadequacy, incompetency and the arousal of conflict and negative emotionality. Clinicians also identified specific distressing traits of patients with BPD, including being chaotic, manipulative and difficult to treat because of their challenging behaviors. Clinicians also cited systemic failures that may contribute to the poor prognosis of patients with BPD, including a lack of resources for patients with BPD and a lack of providers who have experience working with these patients.

Participants also cited the negative views of professionals that they themselves reiterated as being problematic in addressing the needs of these patients. Specifically, they referenced diagnostic labeling, refusal to treat patients with BPD, neglect and a lack of understanding from mental health providers. Lastly, clinicians cited education and training, rapport building and

utilization of crisis management skills as key to improving treatment for patients with BPD (Treloar, 2009). Training, supervision and ongoing education appear to be essential in developing more provider competence and confidence in working with this group (Treloar, 2009). The results of this study are consistent with other research in revealing the presence of bias, stigma and derogatory views towards patients with BPD. However, this study also reveals that many mental health providers are able to feel compassion for this group for the barriers they face in accessing quality treatment. Essentially, it appears that providers feel a dichotomy of judgment towards these patients as well as compassion for their struggle in coping with this judgment. Those who do harbor this stigma and dislike to treat patients with BPD, can harm the therapeutic alliance.

Professional Development

Consultation

Consultation teams have been extensively researched and is viewed as a vital part to the DBT treatment model (Linehan, 1993). Moreover, lacking access to DBT consultation is known as a barrier to effective implementation of DBT (Toms et al., 2019). Linehan, 1993 supports that the rational for a consultation team is that individuals with a BPD diagnosis or other persons experiencing severe emotional dysregulation can be challenging to treat (Linehan, 1993). Further, it is argued that those without pro-active self-care and adequate support, for those who are not as experienced trainee therapists, as well as even the most skilled therapist who work with Cluster B PD may be prone to falling into a pattern of distancing behaviors, which may stimulate and reinforce client maladaptive coping behavior (Hellman, Morrison, & Abramowitz, 1986; Linehan, 1993). A growing body of empirical literature suggests that DBT consultation team plays a key role in improving therapist motivation, emotion regulation, adherence to the

DBT model, and decreasing burnout (Hellman et al., 1986; Linehan, 1993). Overall, the aim of DBT consultation team is an invaluable resource that helps therapist utilize DBT skills to stay regulated and avoid burnout, ultimately to provide a high level of care and support of their patients (Noll, et al., 2019).

There has been some indication to advance consultation beyond DBT. For instance, The Offender Personality Disorder Pathway is a joint venture between the Department of Health and the National Offender Management Service (DH/NOMS Offender Personality Pathway Team, 2011) aimed to initiate a workforce that has the appropriate skills to work effectively with high-risk offenders, who present in a way consistent with a diagnosis of personality disorder, through specialist psychological advice and case formulation. Specialist personality disorder services have therefore offered consultation to criminal justice teams and pilot studies suggest improved outcomes for offenders. Further, improvement in staff ability to identify personality disorder traits and develop appropriate care pathways have also been found. However, there is a gap in the literature that expanding consultation is only to those who work with offenders (Knauer et al., 2017). Research throughout this literature review is clear in that while majority of Cluster B PD appear in criminal and correctional settings, these disorders also appear in a variety of other clinical settings, between 33% and 52% outpatient and 50%-70% inpatient, therefore creating consultation among all Cluster B PD in a variety of settings is relevant.

Peer Supervision Groups

Similar to consultation groups, research has suggested that a useful method of understanding countertransference is peer supervision groups (Rosenbluth & Yalom, 1997). Peer supervision, as the name implies, involves colleagues in shared responsibility for supervision, leadership roles, and responsibilities (Moore, 2012). Rosenbluth & Yalom (1997), suggests that

majority of group consists of anywhere between six to ten "like-minded" members who meet once a month in an ongoing way. The members then discuss patients that they experience as troubling and challenging. Then, as a group, attempt to understand what is happening. The discussions should be conducted in an open, collegial, uncritical manner. It should be noted that there may be limitations to this, as some mental health providers may feel awkward or embarrassed to share their experiences.

Therapy

Based off the literature, it is clear that there is considerable body of evidence showing that mental health professionals working with "difficult" patients are exposed to an increased risk of frustration and stress which can lead to burnout and countertransference, which in turn is predictive of poorer treatment outcome. Linehan (1993), has pointed out that those who treat BPD patients need consultation or therapy themselves (Linehan, 1993). The literature indicates that there is a controversial overlap between many of the Cluster B PD. However, it appears that while all of these disorders are demanding towards the provider, BPD is most widely researched in how to address this issue. For these reasons, it is vital to have someone with whom to discuss the case and clinicians feeling and reactions to cases. If already in a consultation or a team setting, it is possible that the fellow team members may be experiencing similar crisis and consultation is not only what a clinician can rely on. Additionally, if working in a consultation group, several studies have shown that those with Cluster B PD tend to generate a "splitting process" and creating conflict and disagreement between consultation teams (Caruso, 2013). As expected, team splitting, moreover, is likely to cause burnout and preset as a poorly cohesive workgroup (Caruso, 2013). Therefore, having a person or a therapy group outside the case in a HIIPA compliant manner to discuss reactions or feelings to the case will likely to manage or

contain countertransference reactions, improve the clinician's overall mental health on the case, and improve their quality of self-care.

Professional Meetings and Continuing Education

Specific meetings of local, regional, and national disciplined-based organizations including the American Psychological Association and the American Psychiatric Association, often have sections that focus on psychotherapy, which frequently contains issues relating to countertransference (Rosenbluth & Yalom, 2017). Per the American Psychological Association website (https://www.apa.org/), the website offers continuing education topics related to burnout, countertransference, stigma and biases. It is difficult to estimate the price of continuing education credits related to countertransference, as the price varies significantly based on the training. Additionally, a variety of articles, blogs, as well as continuing education that range from three to nine continuing education credit training are available on the website. A study by Cleary, et al. (2002) surveyed 229 mental health staff members in order to evaluate their experiences working with individuals with BPD in public mental health. The authors found that although 100% of their sample reported having some contact with patients diagnosed with BPD, only one third of those individuals had received specific training regarding BPD (Cleary et al., 2002). It appears that many mental health professionals do not in fact receive adequate training, despite the vast literature asserting that education and training with this population is essential. Fortunately, Cleary and colleagues (2002) also found that 95% of surveyed clinicians reported being willing to spend at least one hour or more per month participating in continuing education or training to better their understanding of this population. This article supports that clinicians are not receiving specific trainings related to Cluster B PD, particularly *all* Cluster B PD. However, the desire to seek this training at least one hour per month.

Section III: Original Contribution to Practice

Reintroduction to the topic and Current Study

This literature review highlights bias and stigma related to each Cluster B PD (e.g., Antisocial, Borderline, Narcissistic, Histrionic) and the impact on the clinician and the patient. The literature review begins with a historical overview of Cluster B PD as well as the etiology behind each disorder. Further, important implications for evidence-based treatments for these disorders and how treatment interference comes into play are discussed.

Critical attention is given to the stigma and countertransference, as well as how these phenomena can affect the clinician and the patient. As a whole, this literature review provides an overview of research findings on how to combat stigma and countertransference. Research also indicates that countertransference feelings usually remain out of the awareness to the clinician, we respond to these impulses, wishes, and fears by attempting to overlook, sweep them aside, and instead we label the patient as difficult (Rosenbluth & Yalom, 1997). Both the increasing numbers of countertransference that clinicians experience, the effects on treatment, and the lack of awareness to the clinician, make this a vital area to increase awareness of bias and countertransference, as well as ways to decrease countertransference.

The present study aims to shed light on the experiences of clinicians and student trainees who work with Cluster B PD. It is with hope that increasing the discussion on this topic will improve the stigmatization around Cluster B PD population. Further, it is the authors hope that findings from this study will expand on current literature surrounding this topic and to serve as a foundation for future research in this area.

Method

To expand more in depth on the literature described above, a qualitative research method was selected to add to this doctoral project. In order to understand lived experience working with Cluster B PD population, it is essential that they are questioned about their own experience that will yield efficient description of working with this population. Literature suggests that "qualitative methods facilitate the study of issues in details and in depth." (Patton, 2002, p. 14). Therefore, a qualitative research method approach seemed the most appropriate for this project. A brief (10 question) open-ended questionnaire (See Appendix C) was created and provided to participants. The questionnaire was provided via email rather than in person interviews due to the COVID-19 pandemic (see ethical concerns for further detail).

Sample

Participants were selected based on their predetermined criteria. That is, for this sampling, participants were initially selected only if they were a licensed psychologist (Patton, 2002). Initially, participants were individually recruited from Eastern Kentucky University Psychology Department (EKU) and Eastern State Hospital (ESH) based on their expertise in the field of psychology. Participants were contacted via email to determine their interest the in present study. Additionally, after consulting with research advisor, a mass email was sent to the EKU Psychology Department to gain additional participants. Criteria for the research participant included being a licensed psychologist or a student trainee under the supervision of a licensed psychologist. The final participants were 15 clinicians, including 10 licensed psychologist and 5 student trainees under the supervision of a licensed psychologist.

Participants

As noted, a total of 15 (N=15) participants responded to the questionnaire, 10 of whom were licensed psychologist and 5 student trainees. Their practicing experience ranged from 4 to 25 years, having experience in both psychotherapy and assessment. Their work settings included college/university counseling centers, private practice, forensic assessment, inpatient hospitals and prisons.

Ethics

Due to this study involving human participants, the project required approval by the institutional review board (IRB) of EKU. Additionally, since ESH is affiliated with the University of Kentucky (UK), the UK IRB was also consulted. Per their request, a letter of support provided by ESH was obtained to have full UK and EKU IRB approval. For confidentiality purposes, the participants identities were identified with pseudonyms and all electronic files were kept in a password protected file on a password protected computer. No printed records were obtained during this study, though a plan to keep records in a fireproof filing cabinet with the research advisor on EKU’s campus was in place. The author emailed informed consent to the participants and gave them opportunity to ask questions prior to completing the questionnaire if needed. The participation in this study was entirely voluntary, and the participants were able to withdraw their involvement at any time or elect to not answer questions they did not feel comfortable doing so. There was no direct incentive for participating in this study. With regard to risk, there was the possibility of some discomfort related to sharing information about personal experience as well as the inconvenience of completing the questionnaire. Additionally, due to the small size of the sample (N=15), it is possible that other members may identify other’s responses. Although these risks were minimal, steps to maintain

confidentiality were enforced. No participant expressed any distress or concern in participating in the questionnaire.

Data Collection

To organize the data, the author noted information that was consistently endorsed by the participants. Examples included experiencing countertransference, witnessing others avoid or comment about Cluster B PD patient's and importance of professional development. The data analysis relied on content analysis as the framework. A first step was to carefully examine each response to the questionnaires breaking down data into categories and themes. To analyze the data, the author used a code to assign to each unit of endorsement to the open-ended questions (e.g., yes, I've experienced…). This code allows the author to easily identify number of endorsements from each participant and to easily identify the number of endorsements to themes. Based on the recommendations of Hill et al.(2005), each theme was categorized by the number of endorsements. These authors advised that out of 10 to 15 cases, a minimum of 3 cases should endorse the same theme in order to assert that there is a connection between the themes. Data was organized based on the participant endorsement to allow consistent themes to emerge. Based on the number of participants, only the themes that were endorsed by at least five participants were kept. The themes, participant pseudonyms, codes and number of endorsements were recorded in a password protected excel spreadsheet.

Results

After data analysis was completed, a total of 4 categories and 11 themes were revealed. Each category and theme are discussed below. To emphasizes this study, deidentified direct quotes from participants will be used.

Challenges in Treatment of Cluster B PD

Theme 1: Therapy Interfering Behaviors. All 15 participants reported personally experiencing therapy interfering behaviors from their patients. Some participants noted that while these therapy interfering behaviors were often distracting, they used these opportunities of pattern to see the patient's real-world behaviors.

> One clinician described numerous therapy interfering behaviors that they experienced:
> "Therapy interfering behaviors (TIB) range based on the type of setting, but with a lot of commonalities. Being late or no-showing for appointments settings, nonpayment of bills are more typical in outpatient settings whereas refusing inpatient sessions or leaving prematurely or abruptly are more common in inpatient settings. Anger/hostility to the therapist and contingent suicidal threats are common across settings as is homework noncompliance, off-task comments/hyper and hypo-talkativeness, and not answering or unresponsiveness to direct question at times. In my setting (inpatient psychiatry), inappropriate boundary crossing by patients also occurs perhaps more frequently due to the acuity of psychiatric symptoms (e.g., inappropriate language, verbal abuse, sexualized comments, and at time nudity)."
>
> (Walt Disney)
>
> "I routinely experienced/experience therapy interfering behaviors from patients. With borderline, they usually present as individuals with a history of chaotic relationships and I begin to notice they can be volatile in the therapeutic relationship."
>
> (Stephen King)

Theme 2: Manipulation. 9 participants endorsed that they felt manipulated by their patients with Cluster B PD. It should be noted that the term *manipulated* is specifically used in this questionnaire

to mimic the language in the current literature. Findings were interesting in that some participants reported they felt they had been *manipulated* by their patients, while other clinicians viewed it as symptomatology.

> “Manipulation is not a term that I use. What others may see as manipulative behaviors, I see as just being a part of symptom presentation showing the client getting in the way of their own progress. Such behavior is an attempt to regain control when they think it is slipping and should be looked at as a sample of how they combat increased stress related to the struggle to reach life and therapy goals.”
>
> (Dorthea Dix)

> “I have experienced this with some of the people I have evaluated who have ASPD. They will try and dominate the conversation and turn it towards what they want to discuss instead of my evaluation questions. I also get the sense that some attempts at malingering in forensic evaluations is motivated by attempts to manipulate me into form a certain opinion.”
>
> (Marty McFly)

Negative Reactions from Other Mental Health Providers

In this particular category, clinicians and student trainees reported witnessing other mental health providers experiencing stigma or countertransference.

Theme 3: Witnessing Comments. 13 participants endorsed witnessing other mental health providers engage in inappropriate comments regarding Cluster B PD patients.

> “I have heard colleagues make comments about the challenges of working with individuals who have BPD. They sometimes make disparaging comments like “she’s so borderline.”
>
> (Marty McFly)

> "I have found staff (this includes medical and mental health providers, other disciplines, non-patient care individuals who may interact with the patients) frequently make derogatory comments, avoiding particular patients, and/or having lower frustration tolerance with certain patients when they were not provided certain patients when they were not provided support and/or education regarding how to work with these behaviors from their managers and/or administration, breaks from working with patients on the unit."
>
> (George Washington)

Theme 4: Witnessing Avoidance. Corresponding to the previous theme, 10 participants reported witnessing other mental health providers purposefully avoiding working with Cluster B PD individuals.

> "I belong to several therapist groups on social media and the most common diagnosis that people say they cannot work with is Cluster B, specifically Borderline PD."
>
> (Elvis Presley)

> "Many times, I have observed the stigma that mental health professionals experience working with Cluster B personality disorder clients. This stigma has often included wanting to avoid them because of how draining they can be in and sometimes out of the sessions."
>
> (Jack Sparrow)

Countertransference

Theme 5: Personally Experiencing Countertransference. 13 participants endorsed the theme indicating that they have personally experienced countertransference, bias, or stigma when working with Cluster B personality disorder patients. On clinician recounted an incident in which they experienced countertransference in treatment.

> "I frequently feel countertransference when I'm working with someone who fits this profile [Cluster B PD] especially those with features of Narcissistic Personality Disorder, sometimes mixed with Borderline Personality Disorder. They frequently do not engage in treatment, despite my hard work, and they are sometimes insulting, despite my demeanor or respect. I had a patient who had features of Borderline and she was often incredibly insulting. I was relieved when she fired me."
>
> (Dolly Parton)

> "I have often experienced countertransference/negative thoughts when working with patients with cluster B personality disorder. For me it can feel like irritation that the patient isn't doing what I want them to do, or they are "too emotional," or they keep making the same poor decisions over again."
>
> (King Kong)

Theme 6: Negative Therapy Outcomes. One clinician reported how this experience affected their evaluation.

> "In a couple of cases, I ended up providing the evaluation services free of charge after a long conflict. I will not be willing to see these clients in my practice or at EKU again. So their future access to services from me with me curtailed. I had another case in which the person was so verbally aggressive that we had to shorten the assessment feedback session, so the mother missed the opportunity to learn about their child."
>
> (Darth Vader)

> "I would say they could affect treatment outcomes by limiting the therapist's engagement, willingness, and efforts made to do the work overall."
>
> (Jack Sparrow)

Professional Development

Clinicians noted how they have personally combatted countertransference and how they have approached their own biases in therapy and evaluations. The participants attributed this professional development to a variety of ways.

Theme 7: Self-Care. 8 research participants noted that they engage in self-care to keep them grounded in their work. Some participants were descriptive in their personal self-care strategies that they partake in. For instance, one participant reported the following:

> "I aggressively engage in self-care, including therapy (when needed), a practice of faith, exercise with my dog, meditation, and doing what I enjoy. These are not optional activities, but necessary to keep my vessel health and available to others."
>
> (Dolly Parton)

> "Engage in self-care before, during, and after work."
>
> (Walt Disney)

Theme 8: Engaging in supervision. Majority of participants endorsed that they engage in supervision in order to combat countertransference. One clinician noted the importance of supervision for new clinicians. For instance, when asked directly about advice for new providers, the responded,

> "Don't be bashful about bringing them [concerns or barriers] up and maintaining active dialogues with supervisors."
>
> (Stephen King)

> "My advice for new therapist working with this population is to be patient and seek regular supervision no matter how long you've worked with this client population."
>
> (Jack Sparrow)

Theme 9: Importance of consultation.

> "I have sought consultation with other therapists who have experience in working with clients diagnosed with PDs. Processing my thoughts and feelings with these veteran therapists has always been helpful."
>
> (Dorthea Dix)

In addition to general consultation, one clinician emphasized specific consultation:

> "I consult with other colleagues, especially DBT experts, when I am stuck with someone, because I do believe that the DBT principles are the best roadmap in working with these difficult to treat individuals."
>
> (Dolly Parton)

Theme 10: Awareness of own biases. 7 participants admitted that they believe becoming aware of one's own bias is a large part of professional development and how to contest countertransference. One clinician reported that this is a continuous process for them:

> "I remind myself that these individuals have difficulties and learning histories that support the current behavior. That they are not behaving in these ways out of malice. I work to respond in a calm, and measured fashion, working to de-escalate rather than escalate stress."
>
> (Darth Vader)

> "Most often, I remind myself that the behaviors I'm seeing are part of the disorder, likely developed as normal response to an abnormal situation, and attempt to move my countertransference into a more empathic place."
>
> (King Kong)

Theme 11: Continuing Education. 6 participants emphasized the importance of continued education. They noted that in the field of psychology, learning is continuous. One clinician noted:

> "Get trained in DBT. This is not kids play and these participants are some of the most difficult to treat individuals in the world. Constantly training and improving clinical skills is critical. So, get used to being in a state of lifelong learning to be a competent clinician."
>
> (Dolly Parton)
>
> "Engage with NAMI or other consumer-oriented groups to learn more about first person and lived experience to provide a wider and more informed viewpoint and contextualization of behavior. For me, ACT and DBT and Trauma Informed approaches are essential for having a therapeutic lens/orientation that is based in mindfulness and allows for acceptance and change strategies and has a substantive evidence base. Good training in suicide focused interventions such as CAMS also really helps with being a human, validating the lived experience, and collaborating to develop alternatives to suicide and lives worth living."
>
> (Walt Disney)

Discussion

In an effort to expand on the current literature and to help fill the gap, this study explored the lived experiences of licensed psychologist and student trainees under supervision who work or have worked with Cluster B PD patients. The results suggest that those who work with Cluster B PD often experience challenging interfering behaviors that is likely to cause countertransference, as well as revealing how these thoughts and feelings can interfere with their own therapeutic work. Further, the participants provide insight and advice for future clinicians who work with this population.

Challenges in Treatment of Cluster B PD

All participants endorsed experiencing therapy interfering behaviors in their work with Cluster B PD. Majority of clinicians spoke on directly addressing and identifying these behaviors, as they commonly can impact treatment, although not all. Similar to previous studies discussed (Ingenhoven et al., 2010; Weinberg & Ronningstam,2020; Allen, 1997) common therapy interfering behaviors noted by participants were disruption behavior, suicidal behavior, terminating therapeutic services early.

The findings from this research are also consistent with the existing literature on the factors relating to addressing therapy interfering behaviors. While all participants endorsed experiencing this phenomenon, they differ in that some participants noted to addressing these issues, while others reported ignoring these behaviors. One participant reported that they address therapy interfering behaviors in the following way:

> "Often my first course of action is to address the safety concerns, as those are most pressing. Minimizing harm allows us time to then look what the functions of the therapy interfering behaviors are and begin addressing the drivers of those behaviors. Another aspect we often address is meeting with the individual in common areas or on a 2:1 basis to minimize the ability of the patient to use staff splitting/allegations. Setting limits and maintaining firm boundaries utilizing a DBT perspective is also often helpful."

This clinician's perception is consistent with the findings of Allen (1997) in that utilizing a DBT approach to address safety is a primary concern and is something that should be done in a direct manner, making this primary goal of the treatment when working with Cluster B patients. Additionally, setting firm limits of boundaries and setting a contract (i.e., not missing sessions, therapy is not unconditional, etc.) with the patient is an appropriate method. It should be noted that

while these DBT paradigms do not eliminate the specific interfering behaviors, it has been empirically demonstrated to reduce these behaviors (Allen, 1997).

In addition, 9 out of 15 participants revealed feeling manipulated by this population. Consistent with current literature, majority participants reported a sense of boundary violations (e.g., personal favors, overtaking conversation, splitting staff, etc.). However, 2 out of 15 participants revealed that they prefer not to use the term manipulative as this further enhances the pejorative language surrounding Cluster B PD. They simply report feeling that these boundary violations are rather part of the symptomatology. This resonates with many other theories in the literature that manipulation can be an unconscious act (Kernberg, 1984) or illogical intent from the patient (Linehan, 1993).

Negative Reactions from Other Mental Health Providers

Majority of participants reported witnessing colleagues or other mental health providers experience stigma when working with Cluster B PD patients, such as purposefully avoiding or making negative comments about patients with a Cluster B PD diagnosis or traits. These findings are consistent with other studies (Black et al., 2011; Bodner et al., 2015; Kling, 2014) revealing that it is common for mental health providers to purposefully avoid or to experience negative reactions when working with this population. Additionally, simply the label of having a Cluster B PD may initiate initial stigma and countertransference. The label of a PD has shown to correlate with automatic negative connotation, staff reacting in a less therapeutic way, and a sense of blameworthiness to the patient. (Bonnington & Rose, 2014; Freestone, 2015).

The question becomes, how can we eliminate or minimize this idea of stigma around labels of a PD? Since the DSM-III (American Psychiatric Association, 1980) and what we currently use today, the DSM-5 (American Psychiatric Association, 2013), utilizes an approach that explicitly

looks at diagnostic criteria and emphasizing observable characteristics (Kotov et al., 2021). There are many limitations to this as categorizing all mental disorders is not supported by data, as studies consistently have found evidence in stability between psychopathology and normality (Krueger et al, 2018; Haslam, et al., 2020). Additionally, this categorical nomenclature leads to a loss of information, reduced reliability, a view of these disorders as independent disorders, though comorbidity is common, diagnosis are heterogenous (including symptoms that have little in common), and many participants fall short of meeting full criteria and are determined as Unspecified (Kotov et al., 2021). Research is clear that psychopathology can be characterized by dimensions (Kreuger et al., 2018). In 2015, the Hierarchical Taxonomy of Psychopathology (HiTOP) was formed as an effort to address the limitations of traditional nosolgies (Kotov et al., 2021). Briefly described, this model consists of a hierarchically organized dimensions identified in covariation of psychopathology features, starting with basic building blocks of signs, symptoms, and maladaptive behaviors are grouped into specific dimensions: symptom components and maladaptive traits (e.g., performance anxiety, separation insecurity) (Kotov et al., 2021). See Appendix D for a detailed graphic of the dimensions of the HiTOP model. Additionally, the HiTOP model is focused on psychological dysfunction rather than consequences of functioning in society.

In relation to personality traits and the HiTOP model, Kotov et al. (2021), argue that personality and psychopathology may be related because they share etiology (spectrum model), one plays a casual role in the development of another (predisposition) and one influences the presentation of another. Research has shown that the HiTOP corresponds with the previously mentioned FFM model and the AMPD (Brandes & Tacket, 2019; Watson et al., 2019; Widiger & Crego, 2019). Kotov et al. (2021) argues that if personality includes the predisposition to psychopathology, then perhaps personality should itself become the focus of intervention before

dysfunction develops. The authors go on to declare that it is most appropriate to target personality itself on a dimensional scale and target general personality traits (Kotev et al. 2021). This HiTop model approach, while the research itself still continues to grow, would likely minimize the label of Cluster B PD, and allow the clinician to focus on treating the general personality traits itself.

Countertransference

Almost all participants (13) reported personally experiencing countertransference. Those who did, also reported that this experience negatively impacted their treatment. Consistent with many other findings (Treloar, 2009; Gabbard, 2009 & Tranzilli et al., 2017), clinicians are likely to experience countertransference when working with this population. Additionally, the findings from this present study are similar to the study by Treloar (2009) in that while therapist endorsed experiencing countertransference when working with Cluster B PD, they are able to recognize that due to their own countertransference, they are able to have a sympathetic understanding that they are negatively impacting the proper care to their patients. However, counteracting this, literature has also suggested that countertransference may be out of the awareness to some clinicians (Rosenbluth & Yalom. 1997).

Furthermore, the current results indicate that those who are more in a treatment role with this population, reported experiencing countertransference at a higher rate than those who work more in an assessment role. The pattern of experiencing countertransference was reportedly due to dealing with therapy interfering behaviors (not showing for appointments, difficulty in setting goals, disruptive and aggressive behaviors). As noted previously, some participants noted that they address these issues, while others noted they ignore these behaviors. In regard to improving this countertransference, literature suggests not addressing patient's interfering behaviors, particularly frequent and frustrating instances, will likely negatively impact the clinician, the patient, and the

overall therapeutic alliance (Kirby, 2009). Directly addressing these issues will strengthen the therapeutic relationship and can reduce treatment interfering behaviors within in the treatment and in the patient's day to day life (Kirby, 2009). Other ways to decrease countertransference will be described in the next section.

Professional Development & Advice

The findings in this category are consistent with many studies that highlight the importance of support in working with this population. Specifically, findings are consistent in supervision (Rosenbluth & Yolam, 1997), consultation (Linehan, 1993), and continuing education (Cleary et al., 2002; Rosenbluth & Yolam, 1997). Additionally, participants noted the importance of self-care and awareness of clinician biases.

Participants endorsed consultation as what they rely on most to reduce countertransference. These findings resonate with other studies (Hellman et al., 1986 & Linehan, 1993) indicating that DBT consultation team plays a key role in improving therapist motivation, emotion regulation, adherence to the DBT model and decreasing burnout. While DBT was originally developed to work with those with BPD, this DBT consultation team can be expanded to in working with all Cluster B PD (Linehan, 2015). Similar to consultation, ten participants stressed the importance of supervision. Additionally, 8 participants emphasized the importance of self-care. Again, parallel to Linehan's (1993) original work, she emphasized that those without pro-active self-care and adequate support, even those with the most skilled therapist who work with Cluster B PD may be prone to falling into a pattern of distancing behaviors (Linehan, 1993).

7 participants in the present study stressed the significance of being aware of their own biases. They believed that without having this knowledge of their own bias, these biases would

likely to interfere with their own therapeutic work with patients. Additionally, 6 participants endorsed that continuing education is essential in learning skills to combat experiencing countertransference when working with this population. Those who endorsed trainings, highlighted the emphasis on becoming prepared for therapy interfering behaviors and recognizing initial countertransference. Specific trainings that the participants endorsed were DBT (Linehan, 1993), Acceptance and Commitment Therapy (ACT) (Hayes et al., 2012), Trauma informed care approaches, and Collaborative Assessment and Management of Suicidality (CAMS) (Jobes, 2006). Current research points to that majority of basic trainings in personality disorder(s) in mental health environments (i.e., hospitals and prisons) are typically a half day to a full day (Brown & Vollm, 2013). It is not difficult to imagine, that this might cause fear and anxiety in working with this population without proper training. Literature is also suggestive that clinicians show an interest in continuing education and that 95 % of clinicians are willing to spend at least one hour or more per month participating in continued education (Cleary et al., 2002). Expanding on basic training in personality disorders utilizing these specific approaches, such as the ones described above, will likely give clinicians a better understanding of this population, as well as a better idea of interventions, tactics, and knowledge.

Response Differences Between Licensed Psychologist and Student Trainees

While there was a significant difference between participants who were licensed psychologist (N=10) and those who were student trainees (N=5), similar results were endorsed. Student trainees indicated that while they have fewer experience with this population, all student trainees endorsed experiencing treatment interfering behaviors from their patient(s), observing other colleagues or mental professionals use pejorative language surrounding this population, personally experiencing countertransference. It is not surprising that all student trainee

participants endorsed supervision as a way to overcome countertransference and without supervision, this would likely impact their treatment outcome. Interestingly, a significant difference between more experienced licensed psychologist and student trainees was the endorsement of self-awareness of biases. These findings resonate with Rosenbluth & Yalom (1997) that some clinicians may be unaware of their own biases and label them as challenging to work with.

Limitations and Future Direction

While this study provides many strengths, this study is not without limitations. Data was collected in a limited work environment, whereas majority of participants primary work setting was an outpatient clinic, private practice and inpatient hospital setting. While 2 participants had experience working with an inmate population, no correctional psychologist completed the study. Due to the high statistics of Cluster B PD in this population, around 70% (Feinberg & Greene, 1997), experience from correctional psychologist may be vastly different from those in other settings. Additionally, some mental health providers may feel awkward or embarrassed to share their experiences (Rosenbluth & Yalom, 1997). Therefore, it is possible that the clinicians who agreed to participate in this study may not have fully revealed their internal experiences of their encounters with Cluster B PD out of fear of being perceived as incompetent, holding stigmatizing biases towards personality disorders, or overly critical. Lastly, while this project looked at mental health providers with many years of experience, it also looked at graduate students with at least four years of experience in providing psychological services. This study was not narrowed to clinicians who strictly work with Cluster B PD. Results of clinicians who work strictly with this population may yield different results and should be further explored.

Implications and Conclusions

The present literature review and data yielded in depth information about experiences working with Cluster B PD in a variety of settings. This project helps inform providers of challenges that can be involved in working with this population and raises awareness in how this can impact the therapeutic work with their patients. Further, this project raises awareness how this can impact the providers own well-being and creates suggestions in how to address this issue.

First it is clear that there are challenges in working with this population such as interfering behaviors and at times, unreasonable requests. It is the authors hope that this present project will bring awareness that this is a common phenomenon in working with this population and that it is important to utilize appropriate paradigms to address this issue in psychological services. Additionally, bringing attention to that this population may likely be unintentionally be participating in these interfering behaviors. These findings may help clinicians increase their empathy and patience in working with this population.

Second, negative connotations from providers and the label itself of a PD further give into the stigma surrounding these disorders. By stepping away from a categorical approach and treating the personality rather than simply the specific symptoms, a dimensional model approach is likely to take away the stigma that surrounds the label or a personality disorder.

Third, we see that based on this data as well as existing literature, countertransference continues to be an issue in clinicians, particularly those who work with PDs. We also see how this is impacting the therapeutic work with this population. Therefore, it is imperative that providers implement self-care, engage in supervision regularly, consult with other professionals, become educated on their own biases, and are encouraged to engage in continuing education on

this population. By being able to openly discuss these challenges and have support, it is likely that this will decrease bias and stigma in working with Cluster B PD.

While it is clear in the current literature that this population remains stigmatized, it is the author's hope that this project will raise awareness and educate those who work with Cluster B PD patients. Clinicians are advised to partake in these suggestions to help increase their overall therapeutic work and their own mental health. Despite challenges, working with this population can be valuable and rewarding.

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Table 1

Experience of Clinicians and Cluster B PD

Categories and Themes	Number of endorsements
Challenges in Treatment of Cluster B PD	
1. Therapy Interfering Behaviors	15
2. Manipulation	9
Negative Reactions from Other Mental Health Providers	
3. Witnessing Comments	13
4. Witnessing Avoidance	10
Countertransference	
5. Personally Experiencing Countertransference	13
6. Negative Therapy Outcome	13
Professional Development & Advice	
7. Self-Care	8
8. Supervision	10
9. Consultation	13
10. Self-Awareness of Bias	7
11. Continuing Education	6

Note: N=15; licensed psychologist (N=10); doctoral trainee under the supervision of a licensed psychologist (N=5)

APPENDIX A:
Demographic Form

[Assessing Biased Attitudes Towards Clients with Cluster B Personality Disorders: A Literature Review]

Your responses to the following questionnaire are very much appreciated. Please complete the following demographic information followed by a set of 10 open ended questions relates to your experience working with patients diagnosed with Cluster B Personality Disorder(s). The term *patients* refers to individuals you have worked with in a mental health professional manner who have Cluster B Personality Disorder. Further, the term Cluster B Personality Disorder refers to individuals who have been diagnosed or possess characteristics of the following: Antisocial Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder, and Histrionic Personality Disorder).

Demographic Information

Date: ___________________________

Initials: ____

Education: Please describe your level of education

______High School/GED
______Bachelors
______Masters
______Ph.D.
______PSY.D.
______Other

If other, please explain_____________________________________

Employment: Place of employment _________________________

Type/Title of Work__________________________

Please describe the setting you work/practice in: _______________________

How long have you been practicing clinical psychology?
____

Appendix B:
Consent Form
Eastern Kentucky University

[Assessing Biased Attitudes Towards Clients with Cluster B Personality Disorders: A Literature Review]

I am conducting a literature review about the experience of therapists when conducting psychological services to patients/clients with Cluster B Personality Disorder (e.g., Antisocial Personality Disorder, Borderline Personality Disorder, Narcissistic Personality Disorder). I invite you to participate in this project. You were selected as a possible participant because you have worked with or been exposed to Cluster B Personality Disorders in your practice as a mental health professional. Please read this form and ask any questions you may have before agreeing to participate.

This project is being conducted by Samantha England, M.S. under the supervision of Dr. Dustin Wygant, Dr. Melinda Moore, and Dr. Michael McClellan, Clinical Doctoral Psychology Program at Eastern Kentucky University.

Background Information:

The purpose of this project is to explore the experience of the clinician when working with Cluster B PD patients/clients in search for how to address clinician bias and countertransference if encountered. In the literature, many studies have been conducted to understand why clinicians may experience such countertransference. The findings of this proposed project will attempt to create a better understanding of clinician personal experiences when working with Cluster B personality population and fill the gap in the literature in how to best address countertransference and bias issues.

Procedures:

If you agree to be in this project, you will be provided an open-ended questionnaire which can be completed on your own time. The questions will pertain to your experience with Cluster B personality disorder patients/clients. In light of COVID-19, in person interviews will not be permitted.

Risks and Benefits of Being in the Study:

The project has some minimal risk. For example, there is a possibility of some discomfort related to sharing information about your personal experiences. There also may be some inconvenience associated with taking time to complete the questionnaire. In order to reduce inconvenience risks, the questionnaire will be brief and can be completed on the clinicians' own time and provide the clinician with completing the questionnaire in the privacy of their own environment. It should be noted that the pool or participants for this project is rather limited and small.

Although measures will be taken to maintain confidentiality (see below), it is possible that other members may identify your responses within the final literature review. If you feel uncomfortable answering any questions on the questionnaire you are permitted to terminate the project at any time. There are no direct benefits to you for participating in this project.

Confidentiality:

The questionnaire of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. A character name will be used to identify you rather than your name or initials. I will not include any other identifying information such as gender, place of employment, date of birth, etc. The types of records I will create include strictly the questionnaire via email or a hard copy of the document. The digital documents of the questionnaires that are sent via email will be kept on a password protected computer with a password protecting the individual document itself. Any printouts of hard copy questionnaires will be kept in a locked fireproof filing cabinet in my faculty advisor's office on EKU's campus. Only I and my project advisors Dr. Wygant, Dr. Moore, and Dr. McClellan, if necessary, will have access to the data.

Voluntary Nature of the Study:

The participation in this project is entirely voluntary. Your decision whether or not to participate will not affect your current of future relations with Eastern Kentucky University. If you decide to participate, you are free to withdraw at any time. Should you decide to withdraw data collected about you, please inform me in writing prior to May 2021 so that your data will not be included in this project. You are also free to skip any questions on the questionnaire.

Contacts and Questions:

My name is Samantha England. If you have questions about the questionnaire or informed consent, you may contact me at (303) 437-1861. I am conducting this project under the supervision of Dr. Dustin Wygant whom you can contact at 859-893-7204. I am in the process of receiving IRB approval for this project but have gained the permission of my supervisors to collect data while waiting on IRB approval. You may also contact Eastern Kentucky University Institutional Review Board at 859-622-3636 with any questions or concerns.

You will be emailed a copy of this form to keep for your records.

APPENDIX C:

[Assessing Biased Attitudes Towards Clients with Cluster B Personality Disorders: A Literature Review]

Questionnaire

1. Please describe your experience working with Cluster B Personality Disorder patients/clients.

2. Have you experienced therapy interfering behaviors from your patients? If so, how did these present? How did you address them?

3. Have you ever felt your patients were trying to manipulate you in anyway? If so, please explain.

4. Have you observed colleagues or other mental health professionals experience stigma or countertransference when working with Cluster B personality disorder (e.g. comments, avoidance, stress)?

5. Have you personally felt countertransference, bias, or stigma when working with Cluster B personality disorder? Please explain.

6. Have you experienced burnout due to working with Cluster B personality disorder patients?

7. If any, how do you believe these thoughts or feelings affected or could have affected the outcome of treatment.

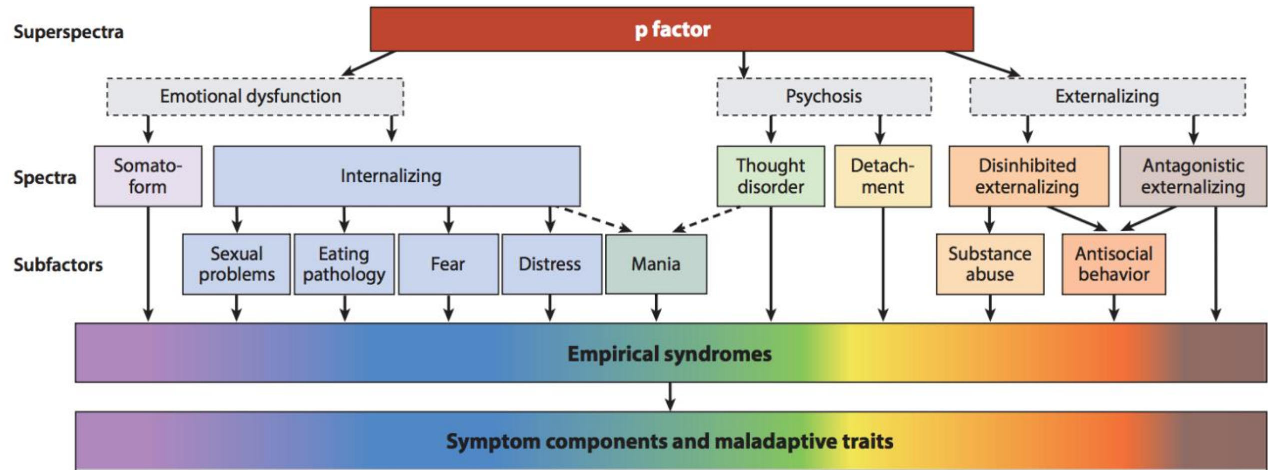
8. What have you done to overcome these barriers and manage these emotions and/or thoughts?

9. What advice do you have for new therapists working with Cluster B personality disorder?

10. What are additional comments you would like to add?

Appendix D

HiTop Figure



(Kotov et al., 2021)