Minor Thesis: Research Project Reports and Exegesis

Personality Disorders in Clinical Practice: Axis I Comorbidity, Management/ Treatment, Psychologist Boundary Issues and Self-Care

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Three Thematically Linked Placement Project Reports and an Exegesis Addressing Professional/ Ethical Issues in the Practice of Clinical Psychology

Submitted in March, 2003, in partial fulfilment

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School of Behavioural and Social Sciences and Humanities

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AUSTRALIA

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Statement of Authorship

Except where explicit reference is made in the text of the minor thesis, this thesis contains no material published elsewhere or extracted in whole or part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgment in the main text and reference list of the thesis.

Signature: _____

Date: _____

Foreword

Looking back to the start of my clinical psychology doctoral studies, unifying themes pertaining to the placement research reports – working with personality disorders (PDs), therapeutic boundaries and self-care in clinical practice – were set at around the same time that I enrolled as a student in the course. I had just started correctional officer training at a newly opened, privately operated maximum security correctional facility, envisaging that the shift work on offer would enable me to devote most week days to undertaking a higher degree. Several months later, shortly after I had started the first semester of study, I was re-contracted to work as a probationary psychologist at the prison after obtaining clinical supervision. My change in role from correctional to clinical work was fast-tracked by a shortage of mental health staff in relation to the burgeoning number of inmates being housed at the new facility.

Suicide and self-harm prevention was a primary focus and a significant proportion of the inmates referred to me suffered from mood, anxiety and adjustment disorders. However, I also noticed that most inmates – hardly surprisingly – met the criteria for one or more Axis II PDs. Largely by virtue of their history of imprisonment and recidivism, a majority of inmates were diagnosable with Antisocial PD (APD). It also became apparent that, among the inmates deemed to be at high risk of suicide, acute suicidal thinking was frequently transient and depressive episodes were often amenable to treatment. Furthermore, adjustment problems and reactions to incarceration commonly improved simply with the passage of time. However, the inmates' personality traits were relatively intractable and certainly challenging, but intriguing, from a psychological perspective.

The first fifty day clinical doctorate placement was a six-month (two days per week) post at an inner suburban Adult Community Mental Health Service. Perhaps as a result of my ongoing, albeit limited, prison experience and the therapeutic unpopularity of certain psychiatric conditions (e.g., somatoform and PDs) with many mental health practitioners, several patients with these presentations were referred to me. My first research project consists of a detailed description of the assessment and initial treatment of two men, one middle-aged and another aged 19 years, with primary diagnoses of Bipolar and Schizoaffective Disorder. There was an absence of psychotic features in both patients at the time of referral. One man had a two-decade history of Body Dysmorphic Disorder (previously Dysmorpho-

phobia), with several Cluster C personality traits (Obsessive-Compulsive, Dependent and Avoidant; DSM-IV, 1994) and Social Phobia. The younger man met partial criteria for APD. My observations involving these patients paralleled widespread clinical reports that multi-axial disorders often co-occur in individuals and that the existence of discrete psychological problems, in isolation from other major diagnostic criteria, is unusual.

During the next clinical placement, which incorporated the private practice of clinical psychology corresponding with my continuing employment at the prison, several publicly documented local cases of patient-therapist sexual contact (PTSC) involving psychologists were researched in relation to the study of ethical matters, self-care issues and therapeutic boundary violations in clinical practice. Boundary behaviours specifically relating to PTSC were appraised and are presented with a review of the literature and practical guidelines regarding therapist conduct developed to assist in establishing protocols with a view to avoiding ethical violations and transgressions leading to PTSC.

A simultaneous clinical placement at a Post-Traumatic Stress Disorder (PTSD) Clinic attached to a public hospital was also undertaken, during which I was engaged in the individual and group therapy of an intake of Vietnam War Veterans. Other activities included reviewing the PTSD literature and compiling data relating to the psychological appraisal of successive intakes of veterans in the preceding decade. The PTSD clinic experience was invaluable, but less relevant to the theme of PDs.

After completing these placements and acquiring full registration as a psychologist on the basis of supervised employment, I resigned from my prison role, accepting a position as a psychologist with the newly established Adolescent Forensic Health Service (AFHS), which services the Juvenile Justice Units in metropolitan Melbourne. A fourth clinical placement corresponded with the first fifty days of my AFHS role. The case study reported recounts the conceptualisation, assessment and initial treatment of an adolescent diagnosed with ADHD, Oppositional Defiant Disorder and Conduct Disorder. An apparent trajectory towards APD was only precluded by the young person's age (13 years), with strong evidence of fledgling psychopathic processes. Successful aspects of his treatment included positive reinforcement of pro-social behaviours, sometimes linked to his narcissistic desire to stand out from his peers, and the establishment of a supportive network of positive male figures around the young person.

Acknowledgments

The author expresses sincere appreciation for the considerable time, expert contributions and learning opportunities afforded by the talented and dedicated psychologists who were involved in supervising the practical requirements of each of the clinical psychology placements undertaken. These people were, in chronological order; Ms. Lynda Katona, senior clinical psychologist and manager of the Adult Community Mental Health Service, Mr. Bernard Healey, consultant clinical and forensic psychologist to the Office of Corrections and in private practice, Mr. Tony McHugh, senior clinical psychologist and coordinator of the PTSD Clinic, Ms. Andrea Phelps, senior clinical psychologist at the PTSD Clinic, Mrs. Kerri Rhodes, forensic psychologist and team leader at the AFHS, and Mrs. Felicity Dunne, consultant clinical and forensic psychologist to the AFHS and other public agencies.

Special thanks are in order for Mr. Bernard Healey – a long-time consultant to numerous private and government sector organizations – who has provided regular, ongoing clinical supervision for the author since early 1998, when probationary psychology registration was commenced, through to the time of full registration in 2000, and beyond. His insight, generous approach and methodical, supportive style of practice, whether involving patient treatment, student supervision, primary, secondary or tertiary consultation is invariably effectual, ethical, compassionate and inspirational. Bernard has been and continues to be a professional adviser, mentor and role model for the author and other students of psychology aspiring to the highest standards of clinical practice.

Research Project 1

Two Cases Referred for Psychological Intervention at a Community Psychiatry Clinic Service

Paul L. Grech. B.Sc. (Hons.)

Minor Placement Report, submitted in March, 2003, in partial fulfilment

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Abstract

Case studies of two patients referred for psychological intervention at a community psychiatry clinic service are presented. Each patient had primary diagnoses of Schizoaffective and/ or Bipolar Disorder. There was an absence of psychotic features in the case of both patients at the time of referral. Case One (Steve) recounts the author's involvement in the care of a 39 year old man with primary diagnoses of Bi-Polar Affective and Schizoaffective Disorder, presenting with a preoccupation with his physical appearance, especially his nose, ears and hairline. Perusal of his psychiatric records revealed a reference to "dysmorphophobia" (now known as Body Dysmorphic Disorder; BDD since 1987) almost two decades earlier, with several other psychiatric conditions periodically noted, including reference to Cluster C personality traits (Obsessive-Compulsive, Dependent and Avoidant; DSM-IV, 1994) and Social Phobia. There was no evidence on his file (or provided by the patient) of any systematic psychological treatment of his BDD, anxiety or Social Phobia during previous hospital admissions and community management. A request was made by his case manager for an assessment of his level of anxiety and an evaluation of the nature of his BDD, leading to eight sessions of cognitive-behaviour therapy (CBT). Case Two (Joel) had a primary diagnosis of Schizoaffective Disorder (Manic Type) and Cannabis Dependence and a differential diagnosis of Cannabis Induced Psychosis. He was referred to the author for investigation of his level of intellectual functioning and personality assessment, in relation to an "odd affect", schizoid trend and cluster B personality traits. A clearer understanding of his possible cognitive problems, educational ability/ potential and personality traits was sought. To address these questions, the BDI-II, WAIS-III and MMPI-2 were administered during the course of four fifty minute sessions. These cases highlight the not infrequent existence of comorbid Axis 2 pathology with Axis I disorders, including somatoform disorders. Personality disorders are regarded as less amenable to psychiatric or psychological treatment. A great contrast between each patient's motivation for and acceptance of treatment was also partly attributed to their personality differences, notwithstanding their similar primary psychiatric diagnoses.

Brief Reviews of Primary and Secondary Psychiatric Diagnoses in Case Studies

Schizoaffective Disorder

In the DSM-IV, Schizoaffective Disorder is characterised as "an uninterrupted period of illness during which, at some time, there is a Major Depressive, Manic or Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia" and "there have been delusion or hallucinations for at least 2 weeks in the absence of prominent mood symptoms..." (p. 292). Furthermore, "symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness" (p. 296). A less severe and chronic course is generally observed in Schizoaffective Disorder compared to Schizophrenia, with the prognosis about midway between Schizophrenia and mood disorders. The disorder "may be preceded by" certain Personality Disorders, including the cluster C disorders Schizoid, Schizotypal, or Paranoid Personality Disorder and the cluster B disorder, Borderline Personality Disorder (DSM-IV, p. 294).

In each case presented, the Bipolar Subtype of Schizoaffective Disorder was noted, with a Mixed Episode in Case One (Steven), who also had a comorbid diagnosis of Bipolar Disorder, and a Manic Episode in Case Two (Joel).

Bipolar Affective Disorder

The Bipolar Disorders are a family of manic-depressive illnesses marked by "extreme affective dysregulation, or the swinging of mood states from extremely low (depression) to extremely high (mania)..." with the mood during manic episodes described as "euphoric, elevated...or irritable" (Miklowitz, 2001, p. 523). There is a very high rate of completed suicide in Bipolar Disorder (approximately 10-15%) and raised coexistence of other disorders, especially substance abuse or dependence and Axis II (personality) disorders, although estimates of the prevalence of the latter diminish to around one in four during remission of Bipolar Disorder (see Miklowitz, 2001).

Axis II: Cluster B and C Personality Disorders Axis II

In each case study, Axis II pathology was relevant to the presentation at referral. The Axis II disorders, especially Borderline and Cluster C (i.e., Avoidant, Dependent, Obsessive-Compulsive) Personality Disorders are often comorbid with Bipolar Disorder, as alluded. In Case One (Steve), prior reference had been made to each of the three Cluster C Personality Disorders, each of which appeared highly pertinent to the patient's ongoing functioning, while in Case Two (Joel), partial criteria were met for Antisocial Personality Disorder, itself not infrequently comorbid with the other Cluster C Disorders, including Borderline Personality Disorder.

Case One (Steve): Reason for Referral and Presenting Problem

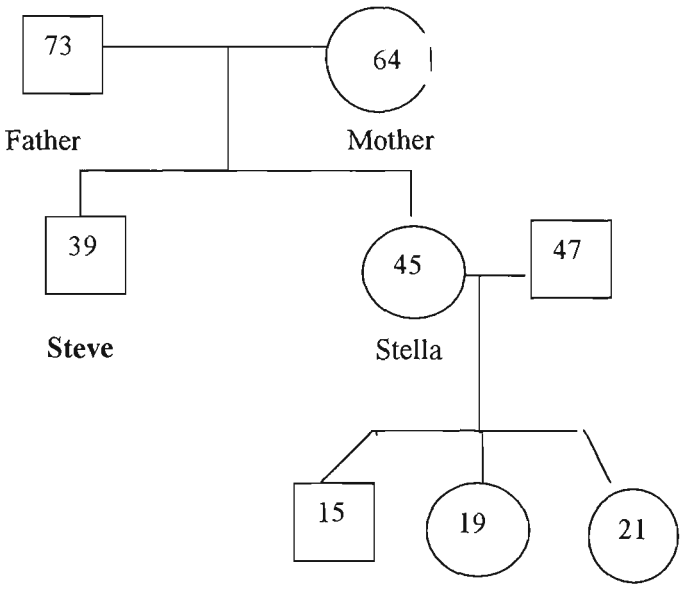
Steve (pseudonym) was referred to the author for "psychological services" by his social worker, who had been case-managing his Community Treatment Order (CTO) at a community mental health service, following his discharge from the attached psychiatric inpatient unit. His case management had consisted of fortnightly meetings, based on improving community integration and everyday living skills (e.g., cooking classes). Compliance with medication was monitored via ongoing monthly reviews with a psychiatric registrar (psychiatrist in training). The problem to be assessed was described as an ongoing preoccupation with his physical appearance, especially a 1984 rhinoplasty with undesirable results, and receding hair. Steve's "fixation" with his nose was noted in relation to him blaming his mental illnesses on the ongoing distress of the outcome of his 1984 rhinoplasty. Other issues mentioned were his social anxiety, ritualistic behaviour such as his inability to leave the house for 24 hours after washing his hair and other symptoms of anxiety, including agoraphobia, related to his appearance. Steve was compliant with his medications (two mood stabilisers and a neuroleptic) and there were no psychotic features at referral. The author's primary goal was to assess the nature of Steve's anxiety and preoccupation with his appearance, with a view to implementing a treatment plan, if agreed to by the patient, whose CTO was due to expire just prior to referral. As the request for psychological help did not come from Steve himself, his motivation to engage in treatment and stage of change also needed to be addressed.

Personal and Psychosocial History

A thirty-nine year old, single disability pensioner without children, Steve has always lived with his now elderly seventy-three year old father and sixty-three year old mother in a converted shop at the back of their house, which he refers to as a "prison". He was born in Greece, of Macedonian extraction, and his family migrated to Australia in 1965 when he was five years old. His mother has one sister who still lives in Greece and he said that his father has "heaps" of brothers and sisters, in Greece and the United States, but Steve could not name any of them or remember their ages. There is no history of psychiatric disorder on either parent's side. He has one sister, Stella, who is married with three children, with whom Steve has minimal contact. Steve's family's genogram is shown in Figure 1.

Figure 1

Steve's Family Genogram (pseudonyms used)



Steve reported that he had attained normal development milestones throughout his infancy and childhood. There was no recollection of significant birth complications, early traumas, abuse, or unusual psychosexual or aversive experiences during his school years. He said that he had endured occasional teasing about his "jumbo ears" – about which he was very self-conscious – with later inquiries revealing he had grown his hair long to cover them. Steve also mentioned having always been quite shy with girls, but developing confidence in this area by his late teens. After finishing Year

10 at the age of 16 years, Steve had worked as a sign writer apprentice until that business was sold and subsequently as a graphic artist, from a bungalow at the rear of his parent's home that he converted into an office in his early twenties. Steve recalled going to nightclubs and meeting girls, but said he had not formed any substantial relationships. He acknowledged illicit drug use throughout his mid-twenties, culminating in successful treatment for heroin dependence. Only one significant sexual relationship, formed in his late twenties, was noted; a long standing casual relationship with "Sandra" (pseudonym), who Steve said has a history of leaving him for other men then "coming back" on the pretext of being "just friends". He said that he tolerated her behaviour because he had never regarded her as a "soul mate" and also felt unable to sustain a long-term, stable relationship with anyone following a nose operation when aged 24 years. However, he spoke of always enjoying the physical side of their liaison.

Steve said that a rhinoplasty he had in 1984 (the year of his first admission) had "ruined his life". That year he elected to have surgery on his nasal passage, damaged by a blow received in a fight, to assist him with breathing. He also decided to have a bump on his nose filed down, apparently at the surgeon's suggestion. This procedure left him with a slightly upturned bridge from the side profile, akin to "ski slope", that he said had made him look "weak" and lacking in "character". As a result he described feeling very embarrassed in the company of others in almost any social situation. According to Steve – as later verified by his family – he was successfully running his own business prior to the operation, mixing well socially and meeting his "fair share" of women. Ever since, he said that he has not worked and had been unable to come to terms with his new appearance, describing his life as "a mess".

Forensic History, Drugs and Alcohol

Steve received a Community-Based Order in 1990, when aged 30, for stealing a television to pay for cannabis. This Order included 250 hours of community work, which he completed. Steven said that this incident occurred shortly after he fell off his bicycle, hitting his head and being knocked out. He met the only woman he has ever had a significant relationship with, Sandra, while doing community work. She was completing an order for drug related matters.

Steve acknowledged previous marijuana abuse and intravenous drug (heroin and speed) use prior to 1990. He claimed to be a non smoker, an occasional social drinker and infrequent (once fortnightly) cannabis user at assessment. He said that of his two current friends, both of whom were mentally ill, one had given up cannabis, while the other was trying to do so. Although Steve's nine year on-off girlfriend Sandra was positive for Hepatitis C and he had been exposed to various risk factors, Steve recently tested negative for Hepatitis A, B, C and HIV. Steve said that he had almost always used safe sex practices (i.e., condom use).

Medical History

Steve's medical history was unremarkable, with no reported allergies, chest conditions, broken bones, sensory impairment, or operations, except for his rhinoplasty in 1984, when aged 24 years, and five minutes of unconsciousness in 1989 as a result of his bicycle accident. He said that the rhinoplasty was undertaken several years after he had had his nose broken in a nightclub brawl, after which he had been unable to breathe through his nasal passage. Steve reported that the surgeon had suggested to him that he could actually improve the appearance of his nose, in addition to restoring nasal breathing. In Steve's view, it was the greatest mistake of his life to consent to the procedure, which he said had "ruined" his appearance and his life. Steve said that he had considered legal action against the surgeon, but had been advised to abandon this course.

In view of the passage of time it was not straightforward to retrospectively assess Steve's premorbid personality. However, it appeared that the emergence of his psychiatric history was confluent with his perception of the aesthetic outcome his nose operation. It was considered significant that, from the perspective of his 1984 diagnosis of dysmorphophobia, a random event (Steve's nightclub brawl and broken nose), general health concerns on Steve's part (restoration of nasal breathing) and the surgeon's suggestions of cosmetic improvement pre-dated his rhinoplasty, as opposed to preoccupations on *his* part of *improving* his appearance. At first glance, it appeared that Steve's dysmorphophobic symptoms, as well as his major psychiatric disorders, post-dated his rhinoplasty.

Psychiatric History

As noted, Steve had a diagnosis of Bipolar Affective Disorder (Mixed) and Schizoaffective Disorder at referral. He had been discharged from the inpatient ward of the hospital psychiatric unit several months earlier on a Community Treatment Order, which had expired one month prior to referral to the author, at which time he was a voluntary patient. Steve was medicated with two mood stabilisers; Lithium (1,000 mg) and Sodium valproate (1,200 mg), a neuroleptic; Haloperidol (which was changed to Risperidone, 1 mg, at the time of referral), an anti-cholinergic agent; Procyclidine (15 mg) and diazepam (10 mg nocte). During the third therapy session, Steve disclosed that he had also been taking Proscar (and previously Propecia, the same anti-baldness medication), for about 12 months, although this medication is not believed to have psychotropic effects.

Steve's full psychiatric history was perused prior to his first appointment with the author, from his psychiatric file and computer records, and discussed in conjunction with the referral for psychological intervention with his case manager and treating psychiatric registrar. In summary, nine prior hospitalisations were recorded, including three involuntary admissions. These were a two week informal admission in 1984 (Primary diagnosis [Dx] of Dysmorphophobia, the pre-1987 term for BDD) six weeks after his rhinoplasty, a three-week involuntary admission in 1988 (Dx: Schizophrenia, Somatic Delusions, and Social Deterioration), a one-week involuntary admission in 1989 (Dx: Mania), three brief informal admissions in 1992 (Dx: Mixed Affective Episode, Manic Episode), with reference to "writing off" his car, and a further three brief admissions in consecutive years between 1997 and 1999, including his most recent involuntary admission six months ago.

The inpatient intake summary referred to paranoia regarding his neighbours spying on him and keeping him under electronic surveillance, thoughts of attacking neighbours with a machete and chronic insomnia. Occasional non-compliance with anti-psychotic medication was also noted, with irritable mood and paranoid thoughts, manic episodes, culminating in involuntary detention due to threatening behaviour and refusal to take medication.

Assessment (Sessions 1-2)

Mental State Examination

At the first meeting Steve presented as despondent and very pessimistic about likely success of any treatment, as well as own future. He was a tall man, at about 6'1", of Mediterranean appearance, with black, partially receding hair, yellowish teeth and lean build. When entering the corridor leading to the interview room and leaving the building afterwards, Steve's posture seemed stooped and his movements stereotyped and somewhat hurried, but his gait was otherwise normal. No extrapyramidal symptoms (e.g., pseudoparkinsonism, dystonia or akathisia) were evident. He was adequately groomed, dressing in a dull coloured grey shirt, well-worn trousers and unpolished black shoes. The author explained the psychologist's role in a potential treatment program, should Steve consent, and outlined confidentiality (including its limits) and other matters pertinent to establishing a collaborative, therapeutic relationship. Steve's initial motivation to partake in psychological assessment and/ or therapy appeared ambivalent.

At interview, Steve's affect was flat, blunted and rather guarded, albeit cooperative and appropriate. He tended to slouch in his seat and eye contact was minimal. Steve's speech was generally taciturn and monotonic, but coherent. His mood in the weeks preceding interview was depressed, with his gloomy outlook also pervading all discussions of past, present and future. Steve indicated that his recent mood was characteristic of the preceding months and, in general, the last fifteen years since his 1984 rhinoplasty. When the topic changed to his appearance, Steve became slightly more talkative. He was at all times well placed in time, place and person. There were no indications of psychotic processes or formal thought disorder, or any apparent abnormalities of attention, concentration or memory and his general intellect was suspected to be within or close to the average range, although his cognitive functions were not formally assessed. His insight about his psychiatric illnesses appeared limited, but he was able to name them and volunteered certain views, such as the importance of being compliant with his medications. His attitude to his pharmacologic treatment was that it "bombed" him out and slowed him down, but had never altered his core sense of despair since his rhinoplasty.

Reasonable rapport was established during the first meeting and Steve agreed to further assessment and an initial arrangement of weekly 60 minutes sessions, but expressed doubt about whether any form of psychological approach or treatment would change his outlook. He acknowledged having heard of cognitive-behaviour therapy (CBT) via friends with psychiatric illnesses and the recent suggestion of his case manager, saying that he understood its purpose was to "change people's thinking", but denied being offered this form of treatment previously. There was no evidence on his psychiatric file of the involvement of a psychologist, or application of formal CBT, in his previous treatment.

Anxiety and Depression

The Beck Depression Inventory – 2nd Edition (BDI-II; Beck, Steer, & Brown, 1996) and the State-Trait Anxiety Inventory (STAI; Spielberger, Gorusch, Lushene, Vagg, & Jacobs, 1983) were administered during the second session with Steve. His total BDI-II score of 35 placed him within the Severe Depression range (29-63). Five out of 21 items were fully endorsed (i.e., a rating of 3). Only three items were not endorsed. Equal elevation was observed across both the Cognitive and Somatic-Affective dimensions of self-reported depression. Steve said that he believed that his mood at assessment was actually "a little better than average", giving himself a general score of 6 out of 10, where 0 would equate with his lowest ever and 10 his best ever mood and 5 his typical mood.

Steve rated himself a 2 on item 9 ("I would like to kill myself") and said that at some stage in most other two week periods or on bad days "I would kill myself if I had the chance". He denied the existence of any suicide plans at time of assessment, but disclosed vague thoughts of shooting himself "if I had a gun", which he did not have access to, nor was he endeavouring to obtain. The extent of his suicidal ideation and acknowledgement of chronic suicidal impulses lead to the routine assessment of his risk at each session, as part of a brief mental status examination. Steve agreed to his BDI-II results being discussed with his psychiatric registrar and case manager. In relation to the final item of the BDI-II, whic was endorsed as "0", Steve stated that his libido had, in his view, noticeably increased in the year he had been taking Proscar, an unexpected effect given that the most common side effect of this medication is

decreased libido. There was no change in interest in sex in the two week BDI-II reference period.

Although no change was noted on Appetite item, Steve acknowledged often missing meals, never eating breakfast and rarely lunch, preferring a coffee or hot chocolate most days. His daily caffeine intake was limited to about two or three normal strength coffees. Although he occasionally ate well-balanced dinners in the company of his parents made by his mother, it seemed that his fresh fruit and vegetable intake was quite limited. The possibility that Steve's questionable nutrient and low protein/ calorie intake, missed meals and erratic meal times were contributing to his mood state was noted.

Steve's medication regime included several drugs with sedating effects as a possible side effect (Sodium valproate and Risperidone) or intended action (diazepam), which needed to be considered as potential contributors to his depressive state, in addition to his primary diagnosis of Bi-polar Depression. As sedation is often most pronounced at the initiation of antipsychotic medication therapy, his change to Risperidone also needed to be monitored in that regard. It was also noted that Steve had been prescribed benzodiazepines for the majority of the preceding decade in relation to anxiety problems and difficulty sleeping. There were no indications that Steve had ever misused benzodiazepines. However, given that his current, moderate prescription of diazepam had been maintained for several months at the same level, the possibility of tolerance was considered, with development of subtle withdrawal symptoms and inadvertent dependence despite maintenance a full therapeutic dose occurring in a significant percentage of patients (Trickett, 1991).

On the STAI, Steve scored 68 for State Anxiety, out of a total possible total score of 80, equivalent to T score of 81, where 100% of adult males without a psychiatric illness (aged 19-39 years) would score lower. He also scored 80 for Trait Anxiety (the maximum possible score), placing him at the 100^{th} percentile. Given this clear evidence of severe short and long-term anxiety, Steve was further assessed to ascertain whether he met the criteria for any anxiety spectrum disorders. It was established that Steve often suffered from subthreshold panic (several times weekly), but only occasional panic attacks (once bimonthly), marked by a pounding heart, sensations of smothered breathing, heaviness in the chest and abdominal discomfort. These were almost always situationally bound or predisposed,

being associated with a perception that he was being evaluated in certain social situations (e.g., during grocery shopping). Therefore, an essential criterion for Panic Disorder was not met. Criteria for three other anxiety disorders, Agoraphobia Without History of Panic Disorder, Generalized Anxiety Disorder and Social Phobia, were each concurrently met, with Social Phobia best accounting for Steve's anxiety-related distress and impairment in everyday functioning.

Other Initial Diagnostic Considerations

Steve's feelings of inadequacy and hypersensitivity to negative evaluation, and his preoccupation with being criticized or rejected in social situations, was prominent in discussions of his day to day life. Partial criteria were also met for Obsessive-Compulsive Disorder (OCD) in relation to Steve's preoccupation with his "feminine" nose, "receding" hair and "jumbo" ears, in particular his ritualistic activities based upon hiding or modifying his appearance (e.g., his hair washing and straightening, with the aim of camouflaging his ears). However, ongoing assessment during the second and third sessions established that Body Dysmorphic Disorder[1] (BDD) – called dysmorphophobia before 1987 – better accounted for Steve's anxiety-related symptoms. It should be noted that "the best way to differentiate [hypochondriasis and BDD] from OCD is to examine for content specificity of the fear-provoking thoughts" (Barlow, 2001, p. 213), with most BDD patients "singly obsessed" compared with OCD sufferers, who typically have multiple obsessions. There was no evidence of post-traumatic sequelae in relation to the nightclub fight which eventually lead to Steve's operation, nor the surgical procedure itself.

Although BDD was ultimately considered to be of utmost diagnostic relevance to Steve's clinical dysfunction, as will be demonstrated, his high baseline levels of anxiety prompted the immediate inclusion of psycho-education about anxiety, over-breathing, panic attacks and behavioural management techniques, including a standard, controlled abdominal breathing exercise (see Bourne 1995) in Steve's initial therapy sessions, as will be outlined.

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[1] In ICD-10 BDD is coded under F45.2 Hypochondriacal disorder if criterion A.(2) is met (World Health Organization, 1993)

Since partial criteria for OCD were met, further inquiries were made about Steve's daily routine. It was discovered that he habitually washed his hair every second day and did not permit himself to be seen in public unless his hair was flat. If it rained when he was out and his hair became wet he said that if he did not remove himself from public view he experienced extreme anxiety and feared suffering a panic attack. He displayed good insight about his obsessive behaviours but acknowledged finding it almost impossible to break his patterns, as they had been established years ago. It was determined that Steve did not meet the full criteria for Obsessive-Compulsive Personality Disorder, nor another Cluster C Personality Disorder, Dependent Personality, although several criteria were again met (e.g., he has difficulty initiating activities because of a lack of self-confidence). Although sufficient criteria were met for Avoidant Personality Disorder, the remaining Cluster C Personality Disorder, Social Phobia seemed to better account for his pervasive pattern of social inhibition, especially in the light of his relatively outgoing premormid personality, prior to his rhinoplasty. In view of his forensic history, involvement in nightclub violence, illicit drug use and violent content and themes noted in his delusions during his previous inpatient admission, as well as the reported association of BDD with narcissistic personality traits (see Phillips & McElroy, 2000), Steve was also screened for Cluster B Personality Disorders. However, very few criteria were met. Notwithstanding Steve's diagnosis with Schizoaffective Disorder, none of the Cluster A Personality Disorders matched his personality functioning.

In view of Steve's diagnosis with Bipolar Mood Disorder, his high level of baseline anxiety and depression and his change in medication at referral, he was asked to complete a daily, self-rated record of his mood, hours of sleep, social activities, and any other significant life events. The mood scale was based on the Social Rhythm Metric (Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990), an instrument which uses self-ratings and ranges of daily mood on a ten-point scale from -5 (depressed) to +5 (euphoric/ activated). Steve completed his mood chart as homework and brought it to each session, so that fluctuations in mood and their possible association with other factors could be checked and discussed, as well as to encourage self-monitoring on Steve's part as a means of developing insight and identifying triggers to changes in mood.

Body Dysmorphic Disorder (BDD)

Perusal of Steve's psychiatric history and referral/ service request to the author, combined with preliminary discussions with his case manager, treating psychiatric registrar, author's clinical supervisor and the patient himself (during sessions 1-3), indicated that all criteria for BDD (DSM-IV, p. 468) were met. Furthermore, BDD was determined to be the most clinically meaningful descriptor and explanation of his everyday functioning and associated anxiety, in conjunction with his pre-existing diagnoses of Bipolar Affective Disorder (Mixed) and Schizoaffective Disorder. These were established at the time of his most recent hospitalisation six months earlier.

The primary criteria for BDD is a "preoccupation with an imagined defect in appearance. If a slight anomaly is present, the person's concern is markedly excessive" (DSM-IV, p. 468). Clinically significant distress or impairment in functioning was added in the DSM-IV criteria, updated from DSM-III-R, while the term "dysmorphophobia" was used in nomenclature prior to the DSM-III-R definition (APA, 1987). In adults, BDD is a fairly common, but often secret and therefore hidden, disabling disorder (Phillips, Nierenberg, Brendel, & Fava, 1996) affecting up to 2% of the population (Phillips, 1996). It is "characterised by painful and time-consuming obsessions about the perceived defect" (Albertini & Phillips, 1999, p. 454) and compulsive behaviours such as mirror-checking and excessive grooming (Hollander, Cohen, & Simeon, 1993). Patients with BDD have been described as "highly rejection sensitive" (Phillips et al, 1996, p. 125). In addition, "insight is generally poor and a significant percentage of patients are delusional" (Albertini & Phillips, 1999, p. 454). Those authors also noted "considerable morbidity, such as social, educational, and occupational impairment, being housebound, psychiatric hospitalization, suicide attempts, and completed suicide" (p. 454).

Although BDD is classed as a Somatoform Disorder in DSM-IV, many believe that from both an aetiological and treatment perspective, BDD should be "classified with obsessive-compulsive disorder, whatever the intensity of symptomatology, rather than with somatoform or delusional disorder" or "hypochondrial psychoses", as in Europe (Filteau, Pourcher, Baruch, Bouchard, &

Vincent, 1992, p. 503). Indeed, there is general concurrence that BDD "may respond preferentially to serotonin reuptake inhibitors" (Phillips et al, 1996, p. 127), typically utilised in the treatment of comorbid depression and OCD. The use of cognitive-behaviour therapy in the treatment of BDD, although rarely reported in the literature, appears promising. Exposure, response prevention, and cognitive therapy (all used in treating OCD) have been successfully employed with BDD (Marks & Mishan, 1988; Neziroglu, Yaryura-Tobias, 1993; Rosen, Reiter, Orosan, 1995), although placebo-controlled studies are lacking (Phillips, 1996). Practical aids in the assessment of BDD include the Body Dysmorphic Disorder Examination (BDDE; see Rosen & Reiter, 1996), which was designed for use in developing CBT programmes for treating BDD.

Goals of Psychological Intervention

Following liaison with Steve's case manager, psychiatric registrar, the author's clinical supervisor, the initial meetings with Steven, and a thorough examination of the use of CBT in BDD, OCD and bipolar depression, six preliminary goals of psychological intervention were framed in the context of eight 60-90 minute sessions, once/ weekly, with homework tasks:

1. Having confirmed the existence of BDD in consultation with Steve's psychiatric registrar, based on Steve's prior diagnosis of dysmorphophobia and ongoing symptomatology, a BDDE was planned during sessions 3-4, in order to frame a CBT intervention involving self-monitoring, and later graduated exposure and response prevention (sessions 6-10).
2. Preliminary psycho-education about CBT, anxiety, breathing-retraining, panic attacks, relaxation, and behavioural management strategies (including a standard, controlled abdominal breathing exercise) was planned for sessions 3-5, to reduce Steve's high baseline anxiety.
3. Instruction in, ongoing use and session-by-session review of the Social Rhythm Metric was initiated in order to encourage self-monitoring, to chart Steve's treatment progress and as a therapeutic exercise, to calibrate any mood changes against situational events. Its use has been recommended in the treatment of Bipolar Disorder (Monk et al., 1990).

4. Introduction to/ implementation of exposure and response prevention training (sessions 6-10).
5. Ongoing mental-state assessment, especially in regard to suicidal ideation, in conjunction with case manager and psychiatric symptoms/ medication compliance, in liaison with psychiatrist.
6. Assessment of treatment progress, including psychometric re-assessment of depression and anxiety levels at end of session 8.

Body Dysmorphic Disorder Examination (BDDE)

Use of the 33 item BDDE, a semi-structured clinical interview procedure, assisted in identifying the internal/ external cues associated with Steve's BDD behaviours and in framing a CBT program. A brief description of his responses to items 1, 2 and 3-33 (summarised) obtained during sessions 3-4 follows.

1. Subject's description of the defect(s) in physical appearance

Steve's main perceived defect is his nose (side profile "ski sloped" since rhinoplasty operation in 1984), followed by his ears ("too big"), and finally his receding hairline (which is increasingly revealing his ears). On a task where Steve was asked to rate different parts of his body in terms of his satisfaction with their appearance on a scale from 0 (the most unacceptable possible) to 5 (average) to10 (perfect) Steve provided the following ratings (specific problem areas in bold):

Table 1 *Body Part Aesthetic Evaluations*

Body Part	Rating/10	Comments
General appearance:	5	
"Neck up"	0	* Literally could not see past his
"Neck down"	6	perceived defects
Nose	**0**	* Unable to provide higher rating
Ears	**2**	* "Jumbo" ears, in Steve's words
Eyes	7	
Mouth	6	
Hair	**4**	* In relation to receding hairline
Arms	6	
Legs	7-8	* Has received positive comments
Chest	6	
Shoulders	7-8	
Height	9	* Self-rated best feature (he is 6'1")
Weight	7	

2. Interviewer's rating of subject's physical appearance

The writer would not have noticed (nor selected) Steve's defect, but upon having it pointed out and described could, in a small way, understand Steve's view that the slightly upturned nose may not quite fit with the generally strong, coarse Macedonian facial features (i.e., the prominent jaw line, broad face and large ears). The writer agrees that Steve's ears are quite large but they seem to match his relatively large head and big features generally.

His slightly receding hairline is comparable to 50% of the male population of his age. Steve's treating psychiatrist was in somewhat stronger (private) support of Steve's contention that his "nose does not fit his face" and is slightly "feminine" in appearance, another of Steve's beliefs).

Full responses to items 3-33 are contained in Appendix A (p. 50). In summary, Steve did not present with significant somatic complaints other than those involving specific aspects of his appearance, which for him, was extremely important.

He acknowledged that many other men had his type of nose shape, but said that what was different in his case was that his nose was altered without regard for the "character" of his other facial features. Steve said that he checked his ears several times daily to make sure that his hair was covering the upper half of them. Although his nose bothered him more he checked it less often because he believed that there was nothing he could do on daily basis to alter it. He mentioned examining the noses of others, including public figures (on television and in magazines) and washing and drying his hair obsessively once every two days in order to maximize the covering of the upper half of his ears and keeping his hair at a specific length to achieve this.

In general, Steve reported a constant, ongoing and upsetting preoccupation with his nose, ears and hair throughout his waking hours and frequent suicidal ideation regarding his nose dating back to the time since his rhinoplasty in 1984. However, Steve sought minimal reassurance from others and rejected assurances regarding his appearance, especially in relation to his perceived faults.

Steve said that he completely avoided almost all public situations and had not worked in the sixteen years since his operation. He worried that women would find his nose unattractive or unmanly and that men would regard him as "wimpy" (i.e., weak looking). When in the company of others, Steve acknowledged having these thoughts constantly and stated that the thought of others paying attention to his defects was unbearable. Apparently, the only people to have commented on Steve's nose were his family, relatives, friends and on-off girlfriend. Most believed that his new nose was "fine" or an "improvement", although several had said Steve was better off without the operation.

At school Steve said that he was teased about his "jumbo" ears. Although the onset of Steve's BDD dated to his rhinoplasty (when 24 years old), adolescence is typically the time of onset of the disorder. In hindsight, Steve's self-consciousness about his ears may be viewed as either a precursor of his vulnerability to BDD, or as an early symptom.

Steve said that he rejected positive remarks about his perceived faults and agreed with negative comments he thought were well-intended. Notwithstanding the teasing Steve had endured at school about his "jumbo" ears, he found it difficult to decide whether he had been treated differently since his nose operation but assumed that everyone noticed the change and believed that he was perceived in a different way.

In summary, Steve's "defects" caused him heartache because he felt that he had lost his "character". He reported deliberately punching himself on the nose, arranging appointments over the years with plastic surgeons with a view to undertaking further surgery and using Propecia for head hair growth.

Graded Exposure: Initial Ratings of Situations

On a task where Steve was asked to rate different situations in terms of the degree of distress he experiences (or believes he would experience) on a 10-point scale ranging from 0 (no distress at all), to 5 (moderate distress), to10 (the most distressing) Steve provided the following ratings. They have been listed overleaf from least to most distressing in approximate order, using a Situational Distress Rating Hierarchy.

Table 2 *Situational Distress Rating Hierarchy*

Situation	Rating	Comments
Being at home alone	0-2	
Being at home with parents in same room	2-4	* Fears criticism
Being at home with relatives present	5-6	
Visiting mail box in driveway	1-2	* House in quiet street
Going to milk bar across the street	5	
Visiting a friend Chris' flat in Ormond (by car)	5	
Visiting Junction Clinic	7	* Will only visit clinic
Visiting beach on own	7	on "good" days
Going to cookery classes at Prahran Mission	7	
Visiting gym	8	* Started going during
Using public transport	8	therapy
Walking length of Chapel street	8-9	* Always avoids this
Grocery shopping at a supermarket with trusted companion	8-9	* Went several times
Grocery shopping on own	8-10	during therapy
Eating at a café or restaurant	10	* "Impossible"
Going to a pub, bar or nightclub	10	* "I just won't do it"

Introduction to CBT (Sessions 3-5)

As well as completing the BDDE and situational distress ratings as a prelude to exposure therapy in sessions 3-4, Steve was also gradually introduced to the general principles of CBT. He expressed a strong aversion to this therapeutic approach, including exposure and especially in vivo protocols, from the outset of initial discussions. It emerged that he had learned second hand of several CBT approaches via other patients who had received it and Steve was worried about confronting his fear of venturing into certain social situations. The author reassured Steve that exposure therapy was just one of a number of treatment options and that he would not be forced to do anything that would cause him severe anxiety, with the goal always being to reduce his distress in the long term. Basic information (handouts) and explanations were provided about anxiety, breathing-retraining and the underlying causes of panic attacks. Feedback was also provided about his BDI-II and STAI results from the preceding session.

Steve was asked about how he normally relaxed or dealt with anxiety. His standard approach was to withdraw to the sanctuary of his room at home, or a closed toilet cubicle if in public. At home, Steve

said that he tended to either pace in his room, or lie down, close his eyes and attempt to sleep. He also mentioned listening to music and occasionally taking extra diazepam, or smoking a joint. However, Steve apparently rarely smoked by himself nowadays, usually doing so in the company of a friend with schizophrenia whom Steve said he had first met in hospital in 1997. The pros and cons of each approach were touched on, with Steve encouraged to generate these.

A practical behavioural management strategy discussed, demonstrated and rehearsed with Steve was a standard, controlled abdominal breathing exercise, which Steve said was similar to a technique he had been "shown years ago that hadn't worked". When given the opportunity to demonstrate his recollection of this exercise, Steve clearly over-breathed, inducing mild hyperventilation. After rehearsing the correct method several times, Steve acknowledged feeling more relaxed and agreed to practice controlled breathing each morning and evening, as part of a relaxation strategy, until he had mastered the technique, with a view to being able to use it in anxiety or stress-provoking situations.

At the conclusion of Session 3, a pleasant activities schedule that detailed a list of relaxing, enjoyable and self-nurturing experiences (e.g., taking a hot bath) was presented to Steve, with the task of undertaking one activity not part of regular routine in the week prior to his next session. Steve noticed that "cooking yourself your favourite meal" was on the list and asked whether that could be his activity, as he had been attending a cooking class.

At the start of session 4, Steve reported that he had cooked eggplant stuffed with rice and meat-balls, as well as vegetable soup, each of which he had learned to prepare in his cooking class. He said that it had "turned out really well" and that both he and his mother had loved it. Normally, Steve's mother was solely responsible for preparing evening meals. Evidently, she was shocked that he had prepared what amounted to two meals. Even more significantly, Steve reported actually shopping for the ingredients himself at the local supermarket for the first time in about two months. He said that he had visited the supermarket late at night, when it was relatively quiet, but had still found the experience to be quite an ordeal. Steve stated that the store he had chosen to shop at was in proximity to housing commission flats. He found the locals who tended to use this store less threatening than the "posh"

customers (who frequented a nearby "upmarket" delicatessen) who Steve said made him feel uncomfortable. Nevertheless, it was pointed out to Steve that he had inadvertently undertaken exposure therapy! This lead to further discussions about Steve's intention to remain involved in group activities after his cooking classes finished, such as those run at the local mission for mentally ill people, around whom he described feeling "comfortable". Since there is a small gymnasium attached to the mission, the author encouraged Steve to use the facility, as he had reported a previous interest in weight training. Although Steve said that he had reservations about using the gym, given that the idea of wetting his hair by showering afterwards was too anxiety-provoking, he agreed that he could begin by showering at home afterwards. It was anticipated that, by using the gym, Steven's exposure to social situations could be increased and he would add vigorous, physical exercise to his weekly routine, which has known antidepressant and calming effects (Bourne, 1995).

During session 4, the BDDE was completed. With the diagnosis of BDD firmly established and following prior consultation with Steve's psychiatric registrar, education about BDD and the types of treatments that had been used was provided. Examples of other cases reported in BDD literature were discussed. With Steve's input, the author devised a Situational Distress Rating Hierarchy, as displayed earlier in Table 2. A 10-point subjective unit of distress scale was used. Given Steve's diagnosis with Bipolar Mood Disorder, his high level of baseline anxiety and depression and his change in medication at referral, he was also asked to complete a daily, self-rated record of his mood, hours of sleep, social activities, and any other significant life events between sessions. This scale was based on the Social Rhythm Metric (Monk et al., 1990), which uses self-ratings and ranges of daily mood on a ten-point scale from -5 (depressed) to +5 (euphoric/ activated). Steve agreed to complete the mood chart as homework and bring it to his appointments, so that changes in mood and possible associations with other factors could be checked and discussed, in addition to encouraging self-monitoring, as a way of developing insight and identifying triggers to changes in mood.

Session 4 was concluded with a rehearsal of the controlled abdominal breathing technique, which Steve performed admirably. Importantly, he reported having found the strategy useful several hours

earlier, when he felt anxious soon after getting up and getting ready to come into the clinic. He said that he always worried about whether his hair would remain straight and cover his ears on days he had to go out. He was especially concerned about the appointment because rain had been forecast. Although Steve acknowledged that controlling his breathing had taken the "edge" off his anxiety, he also insisted that he still felt depressed everyday. However, he said that he had not had thoughts of suicide as often in the preceding week.

On session 5, Steve was praised for completing five out of seven days of his mood chart, which he remembered to bring along. It was noted that his mood had fluctuated several points above and below the baseline, which was discussed in the context of his assertion in the previous session that his mood was always low. Another positive step taken by Steve was visiting the gym the afternoon following the previous week's session. Steve said that he used the opportunity of "gearing himself up" for that day's appointment to change into a tracksuit and visit the gym. He said that he had used the stationary bike and lifted light weights using several of the machines. It was notable that the greatest elevation in his mood for the week (a "3") had occurred the day after doing his workout. Steve recalled that he had felt relatively relaxed the next day but had not attributed it to his workout.

He agreed to visit the gym again.

A pattern that was revisited was Steve's habit of often eating little, if anything, until the mid-afternoon, as a result of simply not feeling hungry, or feeling "jittery" in the stomach. After discussion about the overall quality of his diet and the potential effect of missed meals on mood, Steve agreed to experiment with eating a light snack, like yoghurt or fruit, with his coffee, within the first two hours of waking on alternate days during the next week, to test whether his mood changed.

Further CBT approaches, including the principles underlying graded exposure to feared social situations (in reference to Steve's Situational Distress Rating Hierarchy completed in the preceding week) and response prevention, in relation to Steve's BDD symptoms and behaviours, were also discussed. Graded exposure, as opposed to flooding, was determined to be the most appropriate exposure strategy, in view of Steve's extreme levels of anxiety and depression and his preconceptions

about and general aversion to the technique. It was decided that Steve would visit the beach on his own between sessions during the mid-afternoon, when it is relatively quiet and that the following week's session would involve visiting a coffee shop with the author mid-morning. Steve felt very apprehensive about the latter task, but reluctantly agreed. His worries were discussed in detail and it transpired that one of his major fears was being observed by young waitresses who would judge his appearance. The author resisted the temptation of either allaying Steve's concerns by acceding to his choice of coffee shop, or insisting on visiting a busy, trendy café. Instead, a compromise was reached by pre-selecting an espresso bar located at the quieter end of a busy street, in proximity to the clinic. Raising the bar to this intermediate level between challenging and excessively distressing was anticipated to be more anxiety-provoking than visiting the supermarket on his own, but offset somewhat by the author's presence. Steve was encouraged to practice his controlled breathing on the morning prior to his appointment and consider using a relaxation tape given to him later by the author.

In the final 15 minutes of the session, the author took Steve through a full muscle relaxation procedure, with a view to Steve practicing the procedure at home. He was provided with a relaxation tape, using a voiceover providing guidance through the entire procedure, which had proven effective and popular with prison inmates learning relaxation as part of an anger management program used by the author.

Cognitive Therapy, Exposure and Response Prevention (Sessions 6-8)

The first half of Session 6 consisted of a detailed exploration of the links between Steve's beliefs, assumptions about others, automatic thoughts, feelings and BDD behaviours, as a prelude to visiting a café, about which Steve was clearly quite apprehensive. Steve's uneasiness about the café visit actually assisted the cognitive therapy in preventing it from becoming an intellectual discussion. In early sessions Steve's highly elevated baseline anxiety had been more than sufficient in itself to fulfil this purpose. However, the author's impression was that Steve's anxiety, at least in sessions, had gradually diminished. Therefore, the emotional arousal created by Steve's apprehension was harnessed while delving into his BDD-related cognitions, aiding identification of erroneous thought processes linked

with his anxiety. These included overgeneralisation of Steve's fears (e.g., "the young women *always* notice my jumbo ears"), mind reading ("you'd be surprised how many people pick up on the fact my nose doesn't match my face"), exaggeration and catastrophising (e.g., "I don't want to sit next to the coffee machine because all the staff will stand together gazing and laughing at me") and dichotomous (black and white/ all-or-nothing) thinking (e.g., "the only result today is that I will feel humiliated").

After allowing Steve to practice his controlled breathing in the presence of the author, a list of these and other BDD-related negative, underlying automatic thoughts stereotypical of Steve ("I have Jumbo ears") and unrealistic core beliefs ("If I don't hide my ears people will laugh at me") was generated. In their place, an alternate list of possible replacement thoughts was developed during a brainstorm, with considerable input from the author (e.g., "I have many positive physical attributes, like my height" and "It is unlikely that most people would actually notice my ears, or think less of me as a person, whether they are big or small"). Initially, Steve found this task not only difficult, but bizarre. However, after several humorous moments, during which he actually laughed heartily for the first time in the author's presence in 6 sessions, Steve involved himself in the exercise. A copy was given to Steve, with a homework task of writing down all his persistent, stereotypical, negative thoughts, challenging them himself and writing down an alterative, more realistic attitude or thought.

Session 7 consisted of the trip to a local café in proximity to the community clinic. Upon arrival Steve was clearly highly anxious and had been sweating profusely, as evidenced by damp spots on his shirt under his armpits and the small of his back. His excessive use of aftershave on that day was notabl in that that body odour had never been problematic, but he expressed concerns in relation to his increased perspiration and had apparently overcompensated by drenching himself in the cologne that he had carried with him to the appointment. An even greater worry expressed by Steve was that the sweat emanating from his forehead may wet his hair and flatten the desired effect regarding his hair which he had carefully created to camouflage his ears as much as practicable. Ever prepared on this occasion, Steve had brought a handkerchief to wipe his brow and, to the writer's surprise, requested a moment to go to his care and change into a fresh, dark shirt he had brought that he believed would look more

"manly", as well as conceal any sweat. This request was obliged. After a discussion of homework tasks, automatic thoughts and brief, controlled-breathing relaxation exercise Steve performed well and assisted in calming him. During this session Steve's heart rate was monitored throughout. At arrival it was 120 beats/ minute, dropping to 98 prior to leaving the building after changing shirts.

Steve seemed to relax further during the walk to café, with conversations specifically geared to pleasant thoughts using a schedule provided to Steve to assist in falling to sleep. At arrival at the café, which was reasonably quiet, a waiter directed us to a table just inside the front door, which was not Steve's inner preference, but Steve accepted this placement without question. Once seated, he made the insightful observation that he had fully expected all the waiting staff, including the person who seated us, to be female, based on his fears of physical evaluation by females. His pulse five minutes after arrival was 102, but a degree of elevation was attributed to the walk down. The author instructed Steve to engage in as much conversation as possible with whoever served us.

A waitress appeared shortly afterwards. Steve was relived by the fact she was middle-aged and deliberately asked her to describe several items on the menu, leading to light, casual conversation. Towards the end of the café visit, more people had started to arrive, but Steve described feeling relatively relaxed by this stage, which came as a surprise to him. On the trip back to the clinic he said that he found the exercise very useful and actually requested more!

Anxiety/ Depression Re-Assessment and Feedback (Sessions 8-9)

Steve came to session eight with a newfound purpose following the café visit, believing the exercise to have been worthwhile and demonstrating to himself that he could manage certain social interactions that he had been doubting he could ever face again. He reported a mixed week, with two gym visits, but a bad day on the weekend during which he punched himself in the nose and broken a mirror. However, he had written down his thoughts and emotions afterwards and these were discussed in detail. Steve was able to describe, unaided, the sequence of events leading to the perseveration of his BDD behaviours, which he identified as a de facto anxiety-reduction technique such as his *relative*

relief as an end-result of hair washing and preparation a day prior to leaving the house.

During the session, Steve's anxiety and depression were re-evaluated using the STAI and BDI-II. Moderate but clinically important reductions were noted on each scale. His total score on the BDI-II fell from 32 (severe) to 26, placing him in the moderate range. On the STAI, Steve's state anxiety score also dropped to 65 (from the maximum score of 80) and his trait anxiety changed from 80 to 72.

The author was involved in a review meeting concerning Steve's medication, with a decision made to reduce his anti-psychotic medication and include a serotonin-selective reuptake inhibitor (SSRI) antidepressant, on the basis of the support of this medication in the BDD literature, which the author had discussed with the psychiatric registrar. Arrangements were made for Steve's psychiatric registrar and case manager to continue to assist Steve with his CBT program and monitor his homework activities. The author's clinical placement ended with Steve's last session and the case conference meeting, but further correspondence with Steve's psychiatric registrar indicated that he was continuing with most aspects of the therapy offered and looking forward to catching up a trendy café!

Discussion of Case One in Reference to BDD Literature

Steve was an extremely depressed, highly anxious man referred for psychological intervention by his community psychiatry clinic case manager. Confirmation of the existence of BDD was made in liaison with Steve's case manager and close consultation with his psychiatric registrar, based on Steve's prior diagnosis of dysmorphophobia and ongoing symptomatology. Mutually agreed upon treatment goals were established and he undertook eight sessions of CBT with the author, after initial reluctance and pessimism on his part about the possibility of change. At the conclusion of therapy there was clear evidence of significant general reductions in mood disturbance and BPD-related behaviours, as well as other indicators of improvement in his clinical picture, although he still harboured thoughts of cosmetic surgery at the conclusion of therapy.

Since "no biopsychosocial models for the development and maintenance of BDD exist" (Veale et al., 1995, p. 717) and patients "are generally regarded as difficult to treat or to engage in psychological

therapies" (p. 724), in part as a result of frequent coexistent depression, PD and avoidance behaviour, the case was perceived by the author's clinical supervisor as especially challenging. Steve's pre-occupation with his nose and hair represented the most common foci of disturbed bodily perception reported in BDD (Neziroglu & Yaryura-Tobias, 1997). Studies of effective treatment protocols in BDD, including appropriate psychological interventions, remain limited, but the combined use of cognitive therapy, exposure and response prevention during eight 60-90 minute once/ weekly sessions, as described in this case study, effected a modest relief of BDD symptoms, depression and anxiety, even prior to the subsequent addition of SSRI antidepressant therapy, which reportedly enhanced treatment gains, according to both Steve and his treating psychiatric registrar. In hindsight, earlier initiation of SSRI therapy may have facilitated and potentiated the effect of CBT, as reported in the BDD literature (Phillips, 1996). The results obtained agreed with previously reported research supporting CBT in BDD treatment, based primarily on case reports or small series of BDD patients.

Steve's assessment as severely depressed at referral was typical of BDD sufferers, the majority of whom fall into this range of depression pre-BDD treatment, as measured on the BDI (Phillips, 1996). Social Phobia is also very common, affecting 26% (current) to 36% (lifetime) BDD patients, but "this rate applies only to "primary" social phobia – that is, social phobia that does not appear to be largely due to BDD. If social phobia due to BDD were included, the percentages would be much higher" (Phillips, 1995, p. 336). Although Steve met the criteria for Social Phobia, this was viewed as secondary to his BDD, but improved significantly via CBT targeting his BDD.

It has been previously proposed by Veale et al. (1995) that BDD patients "are more sensitive in their aesthetic perception..." (p. 719). An interesting post-study finding has been the recent report of an apparent association between BDD and occupations or education in art and design (Veale, Ennis, & Lambrou, 2002), given Steve's interrupted career as an apprentice sign writer (business sold) and then a graphic artist (prior to his first admission), plus his recent interest in pottery. Whether aesthetic interests predispose towards, contribute to or stem from BDD – or an underlying factor affecting both entities – remains to be determined. In hindsight, it was notable that Steve had acknowledged that

many other men had his type of nose shape, but he said that what was different in his case was that his nose was altered without regard for the "character" of his other facial features. Steve's sense of the overall gestalt of his facial features clearly underpinned his perception of a "defect" and, in this case, the association with an aesthetic predisposition seems relevant to the psychological aetiology of his BDD.

Quality of life is significantly reduced for patients with BDD compared to the general population, especially in the mental health domains, even compared to patients with depression, diabetes, or a recent myocardial infarction (Phillips, 2000). That author also reported that more severe BDD symptoms and a history of psychosis, as observed in Steve, are associated with even poorer QOL. However, Steve's case highlights that gains made in BDD-related areas of dysfunction, such as social phobia, agoraphobia, general anxiety levels and cognitive misattributions, can build the patient's confidence while tackling the core cognitive schemata and ingrained behaviours underlying complex, distressing and disabling psychological problems, such as BDD.

At the end of 10 weeks of CBT and a change in medication, Steve's BDD and social avoidance behaviours had abated considerably and his inner torment regarding his nose and ears had receded, but by no means disappeared. Significantly, Steve's perception of CBT had changed favourably and his outlook for the future had improved. Subsequent contact with Steve's treating psychiatric registrar indicated that these changes had been maintained three months post-therapy.

Postscript: Steve has not been admitted as an inpatient in the two years since psychological intervention and has been discharged from his CTO.

References

Albertini, R., & Phillips, K. (1999). Thirty-three cases of body dysmorphic disorder in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 38* (4), 453-459.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. Rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barlow, D.H. (1993). *Clinical handbook of psychological disorders.* (2nd ed.). New York: Guilford Press.

Barlow, D.H. (2001). *Clinical handbook of psychological disorders.* (3rd ed.). New York: Guilford Press.

Barlow, D.H., Craske, M.G., Cerny, J.A., & Klosko, J.S. (1989). Behavioral management of panic disorder. *Behavior Therapy, 20*, 261-282.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Beck Depression Inventory* (2nd ed.). San Antonia, TX: The Psychological Corporation.

Bourne, E. (1995). *The anxiety and phobia workbook. A step-by-step guide for curing yourself of extreme anxiety, panic attacks, and phobias* (2nd ed.). New York: MJF Books.

Cohen, L.J., Kingston, P., Bell, A., Kwon, J., Aronowitz, B., & Hollander, E. (2000). Comorbid personality impairment in body dysmorphic disorder. *Comprehensive Psychiatry, 41* (1), 4-12.

Hollander, E., Cohen, L., & Simeon, D. (1993). Body dysmorphic disorder. *Psychiatric Annals, 23*, 359-364.

Marks, I., & Mishan, J. (1988). Dysmorphophobic avoidance with disturbed bodily perception: A pilot study of exposure therapy. *British Journal of Psychiatry, 152*, 674-678.

Miklowitz, D.J. (2001). Bipolar disorder. In D.H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders* (pp. 523-561). New York: The Guilford Press.

Monk, T.H., Flaherty, J.F., Frank, E., Hoskinson, K., & Kupfer, D.J. (1990). The Social Rhythm Metric: An instrument to quantify daily rhythms of life. *Journal of Nervous and Mental Disease, 178*, 120-126.

Neziroglu, F.A., & Yaryura-Tobias, J.A. (1993). Exposure, response prevention, and cognitive therapy in the treatment of body dysmorphic disorder. *Behavioral Therapy, 24*, 431-428.

Neziroglu, F.A., & Yaryura-Tobias, J.A. (1997). A review of cognitive-behavioural and pharmacological treatment of body dysmorphic disorder. *Behavior Modification, 21* (3), 324-340.

Rosen, J.C., & Reiter, J. (1996). Development of the body dysmorphic disorder examination. *Behaviour, Research and Therapy, 34*, 755-766.

Rosen, J.C., Reiter, J., & Orosan, P. (1995). Cognitive-behavioral body image therapy for body dysmorphic disorder. *Journal of Consulting & Clinical Psychology, 63* (2), 263-269.

Phillips, K.A. (1996). *The broken mirror: Understanding and treating body dysmorphic disorder*. Oxford: Oxford University Press.

Phillips, K. (2000). Quality of life for patients with body dysmorphic disorder. *The Journal of Nervous and Mental Disease, 188* (3), 170-175.

Phillips, K., Nierenberg, A.A., Brendel, G., & Fava, M. (1996). Prevalence and clinical features of body dysmorphic disorder in atypical depression. *The Journal of Nervous and Mental Disease, 184* (2), 125-129.

Schmidt, N.B., & Harrington, P. (1995). Cognitive-behavioral treatment of body dysmorphic disorder: A case report. *Journal of Behavior Therapy & Experimental Psychiatry, 26* (2), 161-167.

Spielberger, C.D., Gorusch, R.L., Lushene, R.,E., Vagg, P.R., & Jacobs, G.A. (1983). *State-Trait Anxiety Inventory for Adults.* Palo Alto, CA: Consulting Psychologists Press.

Trickett, S. (1991). *Coming off tranquillizers and sleeping pills.* Wellingborough, England.

Veale, D., Gournay, K., Dryden, W., Boocock, A., Shah, F., Willson, R., & Walburn, J. (1995). Body Dysmorphic Disorder: A cognitive Behavioural model and pilot randomised controlled trial. *Behavior, Research & Therapy, 34* (9), 717-729.

Veale, D., Boocock, A., Gournay, K., Dryden, W., Shah, F., Willson, R., & Walburn, J. (1996). Body Dysmorphic Disorder: A survey of fifty cases. *The British Journal of Psychiatry, 169* (2), 196-201.

Veale, D., Ennis, M., & Lambrou, C. (2002). Possible association of body dysmorphic disorder with an occupation or education in art and design. *American Journal of Psychiatry, 159* (10), 1788-1790.

World Health Organization (1993). *The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research.* Geneva: Author.

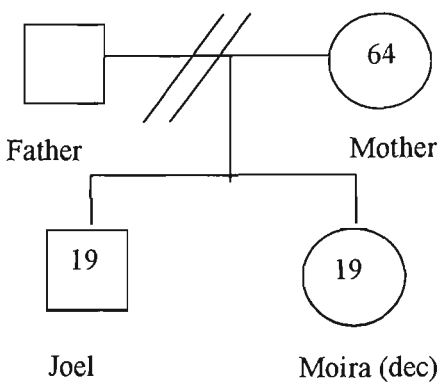
Case Two (Joel): Reason for Referral and Presenting Problem

Joel Lamont (pseudonym) was referred for psychological assessment, based on observations of an "odd" affect, notable incongruence between Joel's expressed emotions and outward presentation at the time of (and since) admission to a psychiatric in-patient facility and questions of possible longstanding cognitive impairment or personality disorder, There was also evidence of depressive themes in his presentation. A clearer understanding of his possible cognitive problems, educational ability/ potential and personality traits was sought. To address these questions the BDI-II, WAIS-III and MMPI-2 were administered during the course of four fifty minute sessions.

Personal and Psychosocial History

Joel said that he had been living out of home for the past three years. He was disinclined to discuss his relationship with his family, with whom he was alienated and was unable to provide any details regarding his extended family. Joel denied knowledge of any complications associated with his birth or early development, said that he had always been quite healthy and indicated that had reached developmental milestones within or ahead of expected parameters. At assessment he was living on his own above a Fish and Chip shop at which he was employed full-time. He reported "pulling out" of his final year of high school (Year 12) three quarters of the way through, during 1998, due to the distractions of living with others and supporting himself financially, which prevented him from giving full attention to his studies. Joel also reported poor motivation, a lack of career goals and cannabis use.

Figure 2 *Joels's Family Genogram (pseudonyms used)*



As a result of working in the Fish-n-Chips shop, Joel stated that he had decided he did not want to be a "blue-collar worker" and planned to embark on university studies via the "Open Leaves" learning entry program linked with Monash University.

Forensic History, Drugs and Alcohol

Joel reported that, prior to his hospitalisation, he had been using cannabis daily for the preceding two to three months, but had reduced his frequency and amount of use considerably since his release from hospital on a CTO. He denied regular use of other illicit substances, but acknowledged having "experimented" over the years with ecstasy and amphetamines during raves and parties. Joel said that alcohol, even spirits, did not "do it for him" and he did not like the taste of beer or wine, and so his alcohol intake had been very limited in the last few years. This was positive in light of his mother's history of alcoholism.

Medical and Psychiatric History

There was no history contained in the intake and discharge summaries in Joel's hospital file of early behaviours indicative of childhood distress (e.g., bedwetting) or significant illness or injury. Joel's anamnesis was one of consistent physical health, no chest conditions, broken bones, medicinal therapies or surgical procedures. However, he indicated that the pressures of his final two years of high school had overwhelmed him and his cannabis use had escalated as his stress levels rose. The impression was Joel had been rudderless since failing to complete his final year of high school the preceding year, with his lack of direction and inner disappointment leading to progressive deterioration.

Following a recommendation by the Community Assessment Team, who had interviewed Joel following friends' extreme concerns about his mental state, he was admitted for two weeks, in a psychotic state, as an in-patient to Alfred Psychiatry during May, 1999, which included substance (cannabis) abuse prior to admission. The diagnosis was Axis 1: Acute Psychotic Episode (Drug induced). His sister committed suicide (aged 19) two years ago; Joel indicated that they had not been especially close. He appeared to have had a traumatic childhood, being parented by a mother who

suffered from alcoholism, with whom he has only occasional contact, and a physically abusive stepfather he refused to acknowledge. At the time of initial referral to Alfred Psychiatry Clinic Service (June, 1999) Mr. Lamont was medicated with Risperidone (antipsychotic), Zoloft (Sertraline; SSRI for depression), Diazepam (10 mg daily for anxiety) and Cogentin (Benztropine; for antipsychotic-induced extrapyramidal symptoms, principally akathisia in Joel's case). When seen by the writer six weeks later he was being prescribed a new regime consisting only of Zoloft and Risperidone, but reported compliance only with the antidepressant.

Presentation at Assessment

Mental State Examination

Joel presented as a lightly built, pale-skinned, young man, aged 19, with slightly receding light brown hair, although his appearance and demeanour most closely resembled mid- rather than late-adolescence or early adulthood. He dressed in sneakers, baggy jeans, a T-shirt and sweater. No problems were apparent regarding hygiene or self-care, but he was a little dishevelled during his second appointment, saying he had to rush to get to the clinic after sleeping in. No cuts, bruises, evidence of intravenous drug use, tattoos, body piercing, or other distinguishing attributes were observed.

Although difficult to pinpoint, Joel indeed presented as somewhat odd, as suggested the referral notes. A sign of this was lack of continuity and congruence in his expressed affect, thought content, and demeanour, which all seemed slightly out of sync on occasions, yet below a threshold indicating obvious psychotic processes, which were calmly denied. The flow, rate and form of speech was generally normal, but sometimes delayed and slowed, with no evidence of thought blocking, but a degree of defensiveness and at other times apparently belated comprehension. Joel's affect was, to an extent, guarded and suspicious, at times labile, but generally euthymic and reactive at interview. He rated his mood between 6 and 7, on a scale of 0-10, with 0 = lowest ever mood and 10 = best ever.

At each 50 minute assessment session Mr. Lamont presented as hesitant but intrigued by the assessment process and seemingly motivated to give his best. Initially he was somewhat sceptical

about the purpose of each of the tests (BDI-II, WAIS-III and MMPI-II) administered. However, he quickly availed himself fully to all necessary procedures. Although the sessions were focused on test administration, several features of Mr. Lamont's personality were evident in the limited time he and the writer were engaged in general conversation. One of these features was a general lack of maturity in terms of his conversational style, self-described behaviours, palpable lack of direction and underachievement in his life to date. Also prominent was a psychopathic trend evidenced by Mr. Lamont's delight in describing stories about having been involved in attempted car insurance fraud and the activities of a "good friend", whose favourite hobby involved torturing animals, including swinging cats by their tails and throwing them around. It did not appear that Joel's intention in detailing these stories was a secondary gain (e.g., a reaction of disdain or other emotion by the author) but simply delight in describing what was to him "hilarious". Joel broke into laughter when recounting how his friend swung a cat over a fence and they watched it attempt to land upright, skidding across grass in a neighbour's garden. This was the most animated he appeared during the four sessions with the author. When asked about the animal's risk of injury, Joel seemed taken aback, stating "it's only a cat".

There was also a shallowness, superficiality and general dearth of emotional depth in Mr. Lamont's descriptions of his life experiences. His marked detachment from his family was highlighted by a complete denial of any paternal involvement in his childhood/ adolescence. His plans for the future seemed somewhat grandiose and supercilious, as distinct from healthy self-confidence or genuine intentions to better himself. However, this impression is tentative and guarded in light of the limited time spent engaging with Mr. Lamont separate from each of the test administrations. As mentioned, Joel denied the existence of recent delusional phenomena/ psychotic processes and there were no indications of formal thought disorder, tangentiality, religiosity, obvious post-traumatic sequelae, obsessive-compulsive ideation or behaviours, dysmorphophobic or hypochondriacal beliefs, bizarre, major suicidal or homicidal ideation, but off-beat, antisocial themes certainly permeated his perception of the world.

Anxiety and Depression

Joel denied the existence of symptoms of anxiety or any history of panic attacks and did not present with any signs of worry, nervousness or increased physiological arousal or psychological agitation, so detailed interviewing/ psychometric assessment of anxiety was not undertaken. The Beck Depression Inventory – 2nd Edition (BDI-II; Beck, Steer, & Brown, 1996) was administered during the first session with Joel as a screen for depressive symptoms, given the referral request, his use of antidepressant medication, sister's suicide, estrangement from his family and ongoing, albeit reduced cannabis use, known to contribute to depression and psychosis (Walters, 1993). As noted psychotic symptoms were denied by Joel but an in depth analysis of his personality constellation using the MMPI-2 was planned, enabling indirect investigation subtler signs of impaired perception and any signs of PTSD emanating from traumatic early life experiences.

Results: BDI-II

Mr. Lamont's total score on the Beck Depression Inventory (Second Edition) was 14, which placed him in the mild range of depression (14-19), as specified by Beck, Steer and Brown (1996) in the BDI-II Manual. His score of 14 compares with mean scores of 7.65 (SD =5.9) for a non-depressed University of Pennsylvania sample; 19.14 (SD=5.7) for a mildly depressed sample. 27.44 (SD=10.0) for a moderately depressed group and 32.96 (SD = 12.0) for those severely depressed. No items were fully endorsed and only two items received ratings of "2". These were Loss of Pleasure and Loss of Energy. Given that Mr. Lamont's sister suicided at age 19 and there were depressive themes in his initial admission, suicidal ideation should be carefully monitored in his case in future. At assessment he acknowledged thoughts of killing himself but said that he would not carry them out. He is currently prescribed with Zoloft and said that his mood had lifted somewhat since being medicated. It could be expected that Mr. Lamont's mild self-reported depression may have impacted slightly on his performance on the WAIS-III, primarily in terms of his level of attention and concentration, although these faculties appeared intact throughout assessment. No evidence of neurological signs or

impairment existed on his psychiatric file in relation to a full organic work up, mini-mental status exam at admission, or psychiatric review.

Results: WAIS-III

A full scale IQ (FSIQ) of 114 placed Mr. Lamont at the 82nd percentile where only 18 percent would do better. His FSIQ is in the middle of the high average range and comparable to many university undergraduates, which suggests that study at this level is not beyond his ability. Joel's Verbal IQ of 119 was significantly higher than his Performance IQ of 106. All of his Verbal Scale scaled scores ranged between 12 and 15, with the exception of the Working Memory task Letter-Number Sequencing on which he had a scaled score of 9. He performed at a consistently lower level on the Performance subtests, his scaled scores ranging from 9-11, with the exception of the untimed Perceptual Organization task Matrix Reasoning (14).

There were also prominent differences across Mr. Lamont's four Index scores. These ranged downwards from a high of 118 (Verbal Comprehension; VC) to 111 (Perceptual Organization; PO) to 108 (Working Memory; WM) to 96 (Processing Speed; PS). Each decrement in index scores was statistically significant with the exception of Perceptual Organization and Working Memory. Also of note is the observation that his pattern of index scores (VC>PO>WM>PS) most closely fits the profile of a schizophrenic sample, among samples of people from a range of neurological, alcohol-related and neuropsychiatric groups, as documented on pp. 166 to 168 in the WAIS-III Technical Manual (1997). It is possible Joel's cannabis and prescribed medication use may have impacted on his intellectual functioning, but this could not be determined on the basis of one testing occasion.

Results: MMPI-2:

Joel's MMPI-2 results were regarded as comprising a valid profile, given that six key validity indicators (L, F, K, VRIN, TRIN and Back F) were within normal or acceptable limits. Furthermore, Joel only omitted one item (# 425; which refers to one's childhood father figure). Overall, 232 items were endorsed as true, 335 as false. Joel's K scale score ($\underline{T} = 49$) suggests a healthy balance between

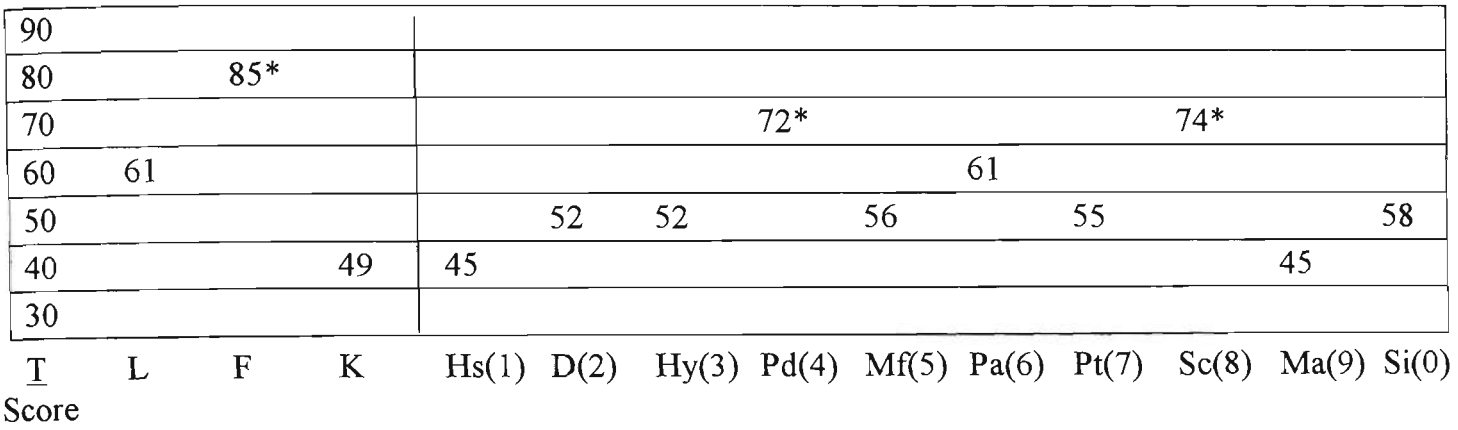
positive self- evaluation and self-criticism, while his L score (T = 61) is reflective of an honest approach and an absence of either over- or under-emphasizing pathology (i.e., faking neither bad, nor well-adjusted).

Amongst the validity indicators only Joel's F (Infrequency) scale was unusually elevated (T = 85), with sources of such an elevation including malingering, significant psychopathology (especially psychotic processes) or all-true/ random responding.

In Joel's case, both random/ indiscriminate and all-true responding are clearly ruled out, given that his VRIN (T = 50) and TRIN (T = 57F) scores were normal. In addition, his normal F Back score (T = 59) indicates that he maintained a valid response set throughout the inventory. Given that his K (T = 49) and L (T = 61) scales were also within normal limits (diminishing the likelihood of malingering/ faking bad or good), the presence of significant psychopathology (usually psychotic processes) seem the most likely source of his elevation on the F scale. Related interpretative possibilities include a plea for help, a current adolescent identity crisis and a confused state accompanied by severe psychopathology. Although Joel did not present as actively psychotic or confused during testing his MMPI-2 results indicate that his personality structure is most comparable to psychiatric patients manifesting various forms of schizophrenic disorder and also to law breakers who are not from underprivileged backgrounds (See MMPI-2 Manual). At a basic, intuitive level, his elevated F score was probably also highly reflective of his odd, quirky presentation, in that high F (Infrequency) scores are a simple direct result of frequent endorsement of infrequently endorsed items in the general population.

Joel's clinical code, using the Welsh system, was 7' 4' 0/ 5/ 7/ 2/ 3/ 1: 9: F" L- K:, with his results on the basic scales presented in Figure 3. Two of three validity indicators, namely the Lie (L) scale and Defensiveness (K) scale, were within normal limits and the Infrequency (F) scale was highly elevated, but not unacceptable so, especially in the context of Joel's diagnosis with schizoaffective disorder and recent in-patient status.

Figure 3. *Basic MMPI-2 Profile of Joel*



Key: Clinically significant elevations are marked with an asterisk (*)

Joel's high-point clinical scale score (Schizophrenia; Sc) is the least frequent peak score in the MMPI-2 normative sample of men, occurring in only 4.7% of the cases. Furthermore, only 2.6% of the sample had Sc as the peak score at or above a T score of 65. However, given Joel's similarly high score on Pd (= 72) and lack of significant elevation on the other clinical scales (Pa was 61), Sc and Pd were considered concurrently. Indeed, a two-point code type seems the most appropriate and parsimonious configurational interpretation of Joel's MMPI-2 basic scale scores.

Two-Point Code: 8-4

Two-point code types tell us which two clinical scales are the highest ones in the profile. Given that in Joel's case Pd and Sc are clearly the highest two and almost identical numerically it makes most sense to focus on what his 8-4 code type usually means (and making the assumption this code type is interchangeable with 4-8). The literature reports that 48/ 84 individuals are perceived by others as odd, peculiar or queer (Graham, 1993), with the first two qualities certainly noted on admission and consistent with the writer's observations. Individuals with this profile also tend to be nonconforming and resentful of authority, moody, deceptive and manipulative and lacking in impulse control. They have poor self concepts, lack basic social skills, have impaired empathy, harbour strange or unusual thoughts, display poor judgment and experience erratic, irritable or angry moods. Joel's two-point

code is also the most common MMPI profile among rapists of adults using the inventory's previous version (Armentrout & Hauer, 1978). However, no concrete signs of paraphilic ideas or a sexual offending history emerged in Joel's case and his Mf scale score (T = 56) was certainly normal. That aspect of his MMPI-2 profile may of course be entirely incidental in relation to his specific risk of aberrant or violent sexual behaviour and given the extreme – and utterly justifiable – stigma associated with these crimes, this observation was not included in his clinical psychological file report. In general, the background of 48/ 84 individuals is also common among women with a sexual abuse history (Griffith, Myers, Cusick, & Tankersley, 1997), substance abusers (Donovan, Soldz, Kelley, & Penk, 1998), prison inmates (Duncan 1989) and offenders in general (Fraboni, Cooper, Reed, & Saltstone, 1990), with the code-type usually marked by underachievement, uneven performance and marginal adjustment. These elements were certainly apparent in Joel's life.

Psychiatric patients with the 48/ 84 code type tend to be diagnosed as schizophrenic (paranoid type) or as having an antisocial, schizoid, or paranoid personality disorder. Given that Joel's third highest scale score was in fact Pa (T = 61) this makes sense. Furthermore, on the Goldberg Index (= L + Pa + Sc – Hy – Pt using T scores), used to discriminate neurotic from psychotic profiles, Joel scored 96, in which scores of greater than 45 suggest a psychotic diagnosis. The writer's observations were that any paranoid or psychotic components of Joel's personality were not particularly prominent during general interactions throughout testing but antisocial/ psychopathic elements certainly surfaced on several occasions. Nevertheless, it is notable that Joel was refusing his antipsychotic medication (Risperidone) at the time of assessment, but compliant with his antidepressant (Zoloft).

Antisocial Trend

Given Joel's elevation on scale 4, his self-reported illegal activity and his drug use, the writer examined his score configuration in the context of a comprehensive system of classifying criminal offenders based on the MMPI profiles developed by Megargee, Bohn, Meyer and Sink (1979; cited in Megargee, 1984). Joel's profile is relatively common in various forensic settings and most frequently

presents among rapists, as noted. Given Joel's elevations on scales 8, 6 and 4, he fitted the "Charlie" Megargee type very closely (see Zager, 1988).

This type was described by Megargee and his associates as "hostile, misanthropic, alienated, aggressive, antisocial, and as having an extensive history of poor adjustment, criminal convictions and mixed substance abuse" (Graham, 1993, p. 213). With the exception of known legal censure, overt hostility or aggression during assessment, all of these elements are applicable to Joel, including his involvement in attempted car insurance fraud, which came to the attention of police.

For this reason Wiener-Harmon subtle-obvious subscales for Psychopathic Deviance (Pd-S and Pd-O) were checked. Joel scored 15 for Pd-O, against a male mean of 6, giving him a T score of 74 for obvious psychopathic deviance, similar to his Pd clinical scale score. On Pd-S, Joel scored 11, yielding a T score of 52 and somewhat allaying alarm about the magnitude of elevation on Scale 4. Regarding four items related to problematic anger on the Lacher-Wrobel Critical Item Set (Hathaway & McKinley, 1993), Joel scored in the affirmative on two items; 134 ("At time I feel like picking a fist fight with someone") and 213 ("I get mad easily and then get over it soon").

Two other scales related to asocial functioning were examined. On Antisocial Attitude (also from the Lacher-Wrobel Set) Joel endorsed six out of nine items, reflecting an eye-for-an-eye philosophy (item 27), school suspensions and visits to the principal (84, 105), trouble with the law (266) and 324: "I can sometimes make other people afraid of me, and sometimes do for the fun of it".

Joel endorsed 13 out of 22 items on the Supplementary scale, Antisocial Practices, in comparison to a male mean raw score of 8 (SD = 4), placing him a little above average. Many items on this scale also loaded onto Antisocial Attitude, and it was noted that Joel did not tend to endorse items reflecting action, as opposed to attitude.

The DSM-IV Manual was checked in relation to Joel's antisocial personality features, with clinical criteria displayed overleaf.

Table 3 *DSM-IV Criteria: Antisocial Personality Disorder (American Psychiatric Association, 1994)*

Pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
2. Deceitfulness, as indicated by repeated lying, use of aliases, or coning others for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. Reckless disregard for safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honor financial obligations
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

Furthermore, the person must be aged at least 18 years, there must be evidence of Conduct Disorder with onset before age 15 years and the occurrence of antisocial behaviour is not exclusively during the course of Schizophrenia or a Manic Episode.

Although Joel's estrangement from his family, treatment by his father, ongoing cannabis use, elevation on Scale 4 of the MMPI-2, two-point code type and individual item responses were a cause for concern, it was doubtful, especially in the absence of more detailed interviewing, investigations of collateral sources of information (e.g., family member, school, employer, etc.) and a criminal records check, that he fulfilled the minimum of three – if any – of the criteria for APD. Antisocial ideation, attitude and beliefs, as opposed to actual repeated conduct, seemed more pertinent to Joel's functioning, as far as could be ascertained at assessment. Furthermore, his full-time employment and plans for future study augured against current relevance of further inquiries regarding this diagnosis.

As a result of potential post-traumatic repercussions related to Joel's experience of violence in childhood supplementary PTSD scales (PK and PS) whose validity has been well-supported in research (Munley, Bains, Bloem, & Busby, 1995) were perused. Joel scored 17 on PK, giving him a T score of 65, considered clinically relevant. On PS, Joel scored 19, resulting in a less elevated T score of 58.

Several Harris-Lingoes subscales were checked in relation to other impressions at mental state assessment. On Naïveté (Pa_3) Joel's score of 5 placed him at the normative mean. He endorsed only four items on Ego Inflation (Ma_4; 9 items), against a mean of three in the normative sample, reducing the suspicion of a narcissistic inclination. On Amorality (Ma_1) Joel endorsed just one item, against an average of two for normative males.

In a fifth and final session with Joel, the author provided feedback about the results of mood, personality and intellectual assessment. His responses to items on Scale 8 were discussed in the context of his denial of ongoing, florid psychotic processes, his cannabis use and the social stigma regarding schizophrenia and related disorders. Materials provided to Joel ("Learning to control voices" handout developed by Melbourne clinical psychologist, Ilona Zágon; Appendix B (p. 55), and psychological aspects of cannabis use) were reviewed and the option of future psychological intervention was offered in the context of his CTO. Joel indicated that he planed to study at a Technical and Further Education facility in the following year, with a view to commencing higher studies in future.

Conclusion/ Treatment Considerations

Joel Lamont was referred for cognitive and personality assessment eight weeks after an acute psychotic episode, believed to be drug induced, which resulted in a two week admission at Alfred Psychiatry. At assessment, Joel presented as an immature young man, initially suspicious about the purpose of testing but fully compliant, and, according to his account, free of active psychotic symptoms, although refusing to take his anti-psychotic medication and top-scoring on Scale 8

(Schizophrenia) of the MMPI-2. A handout outlining psychological approaches for dealing with auditory hallucinations was provided, the subject of managing possible feelings associated with the stigma attached to experiencing a major mental disorder was raised and the perils connected with even modest but regular cannabis use (including psychosis, depression and long-term cognitive effects) and individual susceptibilities was referred to. His score of 14 on the BDI-II indicated a mild level of depression, otherwise reasonably well controlled by antidepressant medication (Zoloft). Given the suicide of his sister at age 19 years and the presence of depressive themes upon admission it is recommended that his degree of depression and any evidence of suicidal ideation be monitored closely in future. Currently Joel acknowledges having thoughts of killing himself but does not plan to carry them out.

WAIS-III testing revealed a full scale IQ of 114, placing him at the 82nd percentile and corresponding to the high-average range. His Verbal IQ of 119 was significantly greater than his Performance IQ of 106. This "cognitive imbalance" is the opposite pattern often "posited as an antecedent condition in relation to antisocial behaviours" (Snow & Thurber, 1997, p. 351), with this aspect of Joel's neuropsychological profile therefore not supportive of an APD hypothesis. His Processing Speed index score of 96 was significantly lower than his three other index scores. His overall pattern of index scores (VC; 118 > PO; 111 > WM; 108 > PS; 96) was most typical of that displayed by a schizophrenic sample (which was one of 16 clinical groups with various neurological, psychiatric and developmental disorders in the special group studies cited in the WAIS-III Technical manual).

Joel's high-point clinical scale score on the MMPI-2 (Sc: $\underline{T}$ = 74) also corresponded to the scale most elevated among psychiatric patients manifesting various forms of schizophrenia. His score on Pd ($\underline{T}$ = 72) was the only other clinically elevated score, giving him a 8/ 4 or 4/ 8 two-point code-type, the most parsimonious and appropriate interpretation of Joel's MMPI-2 profile. Psychiatric patients with the 48/ 84 code type tend to be diagnosed as schizophrenic (paranoid type) or as having an antisocial, schizoid, or paranoid personality disorder. It was evident upon his admission, during

his stay as an inpatient and at assessment that Joel demonstrated symptomatology and personality traits suggestive of all of these diagnoses, but at the present time, did not appear to meet APD criteria.

When observed during the course of general interactions throughout cognitive/ personality assessment Joel's psychotic and paranoid features were less pronounced (although clearly evident in his MMPI-2 results). Joel acknowledged having been a regular cannabis user and it probable that his substance use has had a significant impact on his mental functioning and emerging personality structure during the last few years.

Joel has a history of law breaking, having boasted to the writer about his involvement in attempted car insurance fraud, and he delighted in recounting a story about mistreatment of a cat by a friend. However, further psychological appraisal of any concerns about psychopathic tendencies may not be indicated, in view of his unremarkable endorsement of MMPI-2 items relating to amoral ideation and behaviour, ego inflation and problematic anger. It is more likely the concerns that emerged at mental state assessment may be more closely connected to early emotional deprivation, social dislocation, unfulfilled needs and interpersonal immaturity (as opposed to naïveté).

Having withdrawn three quarters of the way through Year 12 in 1998 Joel expressed a desire to pursue university entry via the Open Leaves program next year, indicating that life as a "blue collar" worker did not appeal to him. It appears that he will need considerable help to realize this goal, given his lack of family support, impulsive and immature personality traits and recent hospitalization, probably resulting from his history of substance abuse. His IQ of 114 and consistent performance across all subtests (none < 9) suggest that intellectually he is capable of completing Year 12 and undertaking higher studies. However, his high-average intellect will not be enough to offset his considerable psychiatric, emotional and psychosocial difficulties without consistent professional support and treatment and his willingness to commit to this assistance over the medium to long term.

References

Armentrout, J.A., & Hauer, A.L. (1978). MMPIs of rapists of adults, rapists of children, and non-rapist sex offenders. *Journal of Clinical Psychology, 34* (2), 330-332.

Donovan, J.M., Soldz, S., Kelley, H.F., & Penk, W.E. (1998). Four addictions: The MMPI and discriminant function analysis. *Journal of Addictive Diseases, 17* (2), 41-55.

Duncan, D.F. (1989). MMPI scores of tattooed and untattooed prisoners. *Psychological Reports, 65* (2), 685-686.

Finn, S.E. (1996). *Using the MMPI-2 as a therapeutic intervention.* Minneapolis, MN: University of Minnesota Press.

Fraboni, M., Cooper, D., Reed, T.L., & Saltstone, R. (1990). Offense type and two-point MMPI code profiles: Discriminating between violent and nonviolent offenders. *Journal of Clinical Psychology, 46* (6), 774-777.

Graham, J.R. (1993). *MMPI-2. Assessing personality and psychopathology.* New York: Oxford University Press.

Griffith, P.L., Myers, R.W., Cusick, G.M., & Tankersley, M.J. (1997). MMPI-2 profiles of women differing in sexual abuse history and sexual orientation. *Journal of Clinical Psychology, 53* (8), 791-800.

Hathaway, S.R., & McKinley, J.C. (1993). *Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Manual for administration and scoring and User's guide for the Minnesota Report: Adult Clinical System-Revised.* Minneapolis, MN: University of Minnesota Press.

Megargee, E. (1984). A new classification system for criminal offenders: VI. Differences among the types on the Adjective Checklist. *Criminal Justice and Behaviour, 11* (3), 349-376.

Munley, P.H., Bains, D.S., Bloem, W.D., & Busby, R.M. (1995). Post-traumatic stress disorder and the MMPI-2. *Journal of Traumatic Stress, 8* (1), 171-178.

Pope, K.S, Butcher, J.N., & Seelen, J. (2000). *The MMPI, MMPI-2, & MMPI-A in court. A practical guide for expert witnesses and attorneys* (2nd ed.). Washington, DC: American Psychological Association.

Snow, M., & Thurber, S. (1997). Cognitive imbalance and antisocial personality characteristics. *Journal of Clinical Psychology, 53* (4), 351-354.

Walters, E. (1993). *Marijuana. An Australian crisis* (2nd ed). Moorabbin, Australia: Associated Printers.

Zager, L.D. (1988). The MMPI-based criminal classification system: A review, current status, and future directions. *Criminal Justice and Behaviour, 15*, 39-57.

Zágon, I. (1998). "*Coping With Voices*" *Handout.* Compiled at Alfred Psychiatry, Melbourne, Australia.

Appendix A

Steve's Body Dysmorphic Disorder Examination in Case Study 1

As noted, use of the 33 item BDDE, a semi-structured clinical interview procedure, assisted in identifying the internal/ external cues associated with Steve's BDD behaviours and in framing a CBT program. A full description of his responses to items 3-33, summarised in text (p. 19-20) follows.

3. Presence of other types of somatic complaints other than appearance

None that seemed exaggerated (they included occasional headaches and mild GI symptoms)

4. Perceived abnormality of the defect (extent to which subject believes the defect is common or rare)

Steve acknowledged that many other men had his type of nose shape, but he said that what was different in his case was that his nose was altered without regard for the "character" of his other facial features.

5. Frequency of body checking

Steve checked his ears (in particular) several times daily to make sure that his hair was covering the upper half of them. Although his nose bothered him more he checked it less because there is nothing he can do on daily basis to alter it.

6. Dissatisfaction with appearance defect

Steve has experienced ongoing suicidal ideation regarding his nose ever since his 1984 rhinoplasty.

7. Dissatisfaction with general appearance

Other than his nose, ears and receding hair Steve is quite accepting of his general appearance.

8. Frequency of seeking reassurance about appearance from other people

Steve seeks little, if any, reassurance from others and actually rejects any reassurance about anything to do with his appearance, especially his perceived faults.

9. How often subject experiences *upsetting* preoccupation with appearance

Steve has a constant, ongoing, upsetting preoccupation with his nose, ears and hair throughout his waking hours.

10. Self-consciousness/ embarrassment about appearance in *public* situations (e.g., city streets, restaurants)

Steve completely avoids almost all public situations, in particular restaurants, cafes, shops and main streets.

11. Self-consciousness/ embarrassment about appearance in *social* situations (eg. at work)

Steve sold most of the equipment he used as part of his home business following the operation and has not worked in the 16 years since

12. How often subject thought other people were scrutinizing his/ her defect

Steve worries that women would find his nose unattractive or unmanly and also worries that men would regard him as "wimpy" (i.e., weak looking). Whenever Steve is in the company of others in a social situation he has these thoughts constantly.

13. Distress when other people pay attention to the defect

Steve indicated that the thought of others paying attention to his defects is unbearable.

14. How often subject received comment(s) from others about his/ her appearance

The only people who have commented on Steve's nose are his family, relatives, friends and on-off girlfriend. Most have said that his new nose was fine or an improvement, while several have said he was better off without the operation. At school Steve said he was teased about his "jumbo" ears. Although the onset of Steve's BDD dated to his rhinoplasty (when he was 24 years old), adolescence is typically the time of onset of the disorder. In hindsight, Steve's self-consciousness about his ears may be viewed as either a precursor of his vulnerability to BDD, or as an early symptom.

15. Distress when other people comment about his/her appearance

Steve rejects positive remarks (e.g., "Your nose is normal") and agrees with negative comments he believes are well-intended (e.g., "Yes, your hair is receding"). It is not so much the comments but rather the focus of attention on his perceived defects that Steve finds distressing.

16. How often subject felt treated differently due to his or her appearance

Apart from the teasing at school about his "jumbo" ears Steve finds it difficult to decide whether he has been treated differently since his nose operation but assumes everyone notices.

17. Distress when other people treat him or her differently due to appearance

Steve assumes he is treated differently. For him it is not a case of "when", but rather to what extent. Even more so, Steve's defects primarily cause him internal heartache because he feels he has lost his character. It is as much what he has lost as what he has become as a result of the operation.

18. How important is physical appearance in self-evaluation

For Steve physical appearance is extremely important.

19. Extent of negative self-evaluation in a non-physical sense due to the appearance defect

Difficult to ascertain with certainty.

20. Extent of negative self-evaluation in non-physical sense by others due to the appearance defect

Unclear about this item.

21. Perceived physical attractiveness

Steve regards himself as being reasonably attractive apart from his nose, ears and hair, which he feels completely ruin his appearance.

22. Degree of conviction in physical defect

Steve is 100% certain that his nose is totally out of character with the rest of his face, his ears are too big and his hair is gradually receding (there being valid grounds for all three beliefs, especially the latter two, depending on the observer).

23. Avoidance of public situations due to appearance (e.g., restaurants, restrooms, city streets)

Completely avoids almost all public situations, except going from A to B for the purpose or medical appointments, pottery/ cooking classes, the gym and occasionally on a Sunday the local milk bar for a newspaper.

24. Avoidance of social situations due to appearance (e.g., parties, speaking to authority figures)

Completely avoids almost all social situations, except the gym (once/week), pottery/ cooking classes or other situations where the only people present are psychiatric patients, mental health care professions and occasionally close relatives.

25. Avoidance of close physical contact due to appearance (e.g., hugging, kissing, dancing close, sex)

Steve has had an on-off relationship with "Sandra" for about 10 years, but for the most part avoids the possibility of relationships.

26. Avoidance of physical activities (eg. exercise or outdoor recreation) due to appearance

Recently started going to the local gym once/ weekly for a weights workout on the writer's suggestion.

27. How often subject camouflages or hides appearance defect with clothes, make-up and so forth

Washes and dries hair obsessively once every two days in order to maximize the covering of the upper half of his ears. Keeps his hair at a specific length to achieve this.

28. How often subject contorts body posture in order to hide defect (e.g., keeping hands in pocket)

Walks and sits hunched forward but posture is probably a result of Steve's general anxiety and unconscious intention to skulk out of sight than a conscious attempt to hide his face from view.

29. Inhibiting physical contact with others (changes body movements or posture during contact in order to hide defect, e.g., doesn't let partner touch certain body area)

Steve will not let anybody touch his ears or hair near his ears in case his ears are uncovered. He reluctantly let the plastic surgeon examine his ears and does not have a problem with having his nose touched.

30. Avoidance of looking at own body

Steve does not spend inordinate amounts of time checking his appearance, with the exception of covering his ears with his hair and making sure that it's in place. He does not particularly avoid looking at his body.

31. Avoidance of others looking at body unclothed

Steve does not seem to have a particular aversion to being observed naked, but rather a general aversion to having people notice his nose or ears.

32. How often subject compares his or her appearance to that of other people

Very often Steve examines the noses of others, including people in public, on television and in magazines.

33. Remedies that the person has attempted to alter the appearance defect

Steve has deliberately punched himself in the nose (not causing significant damage), arranged several appointments with doctors for surgery (only to withdraw) and always covers his ears with his hair. He takes Propecia for head hair growth.

COPING WITH VOICES

The voices that you hear are technically called AUDITORY HALLUCINATIONS. They are voices or sounds heard in the ears or the mind.
They are real experiences that you can hear but other people can not hear.

Voices can be:

-Nasty or critical
-Bossy or demanding
-Angry
-Happy and positive
-Male, female or genderless
-Of one or hundreds of voices
-Familiar or unknown
-Helpful or unhelpful
-Loud or soft.

Voices seem to live of attention given to them. People often find that the more that they listen to them the more frequent, loud or persistent they become. They may do their best to get your attention by commenting on sensitive issues or by persisting until you respond to them.

People can find benefits in continuing to hear voices and in NOT hearing voices. Some people find their voices reassuring in the things that they say, some people find that the voices help them to feel less lonely and some people have had voices for a long time and see them as having become part of their identity. When people want to have more control over their voices there are a number of strategies that can be very effective in coping with and managing voices. When you manage your voices more successfully or no longer hear voices you may find that you:

-Have better concentration
-Find it easier to relate to people
-Feel less stressed
-Have more stable moods or emotions
-Feel more in control of yourself/life
-Feel less stigmatised.

GETTING IN CONTROL OF VOICES

Most people notice that their voices tend to be better or worse in certain situations, or when they are in particular frames of mind. By avoiding or managing these situations it is sometimes possible to prevent the voices from occurring at all. Examples of triggering situations are:

-Feeling down, stressed or anxious
-Isolation or inactivity
-Low levels of auditory stimulation
-Expecting to hear the voices ("tuning in")
-Physical health problems (e.g., flu)
-Alcohol or drug use.

The following strategies may assist in reducing or stopping the voices once they have begun.

STRATEGIES TO HELP CONTROL AND COPE WITH VOICES

At least a couple of the following strategies will help you. However, it is recommended that you try a few and persist with trying for some time; they may not work completely and/or immediately. Like learning any skill, using any of these strategies will require practice. Some people find a combination of techniques the most effective. The only way to know if it will work for you is by giving them a try!

It is very often helpful to begin by self-monitoring and keeping a diary of when the voices occur (what time of day, what situation you were in), how you felt when they began, what they said, what you did and how long they lasted. This may determine that particular strategies may be more helpful for you than others.

- *Distraction*

Deliberately shift your attention away from the voices to things that take up your attention completely. Some of the other strategies outlined below can be used as distractors. Anything from focusing on the small details of something you see, to reading, to talking to someone can be helpful.

- *Contact With Others*

Some people find that too much social stimulation and noise can be stressful and make the voices worse. In this situation temporarily withdrawing until your voices improve can be helpful. For others it is the opposite; they find that increasing their social stimulation helps them to generally feel better and this can positively impact on their voices. Telephoning, writing or talking to someone should be considered to increase or decrease the level of stimulation you feel.

- *Physical Stimulation*

Increasing or decreasing your level of physical stimulation may affect your experience of voices. To decrease you physical stimulation you can do relaxation exercises (talk to your workers if you do not know how to do these), sleep, listen to soothing music, sit or lie quietly, meditate, imaging a peaceful scene, etc. To increase your physical stimulation you can walk, jog, etc. These measures can be used to prevent the voices or manage them once they have begun.

- *Vocal Activity*

There is quite a lot of research and a lot of people have reported that when they use their vocal chords (their "voice box") by speaking, singing, humming, reading aloud, even yawning their voices stop altogether. To some extent this is a distractor, but the research suggests that there is a connection between the vocal chords and voices. When people heard voices in laboratory tests it was found that their vocal chords were moving.

- *Improving Self-Esteem*

If you feel better about yourself and your life, if you feel less guilty, unworthy or inadequate, your negative voices can be prevented. Self-esteem can be boosted via assertiveness training, general counselling, doing activities that you enjoy and help you feel good about yourself, and so on. Again, talk to your worker.

- *Dismissal*

Some people have found that firmly ordering voices to go away or telling them to keep quiet may sometimes help. It is best to either do this in private or in your mind so that others do not think that you are talking to them or behaving strangely. For example, say "Go away and leave me alone!" said loudly and clearly while stamping your foot. If necessary, repeat several times.

- *Aversion*

Some people have found that pairing the voices with some negative event reduces their occurrence. For example, flicking a rubber band on your wrist as soon as a voice appears has reduced the appearance of voices.

- *First Person Singular Therapy*

Start to think of the voices as things you are telling yourself. For example, one person heard voices telling her she will never get better. When she saw these voices as her own thoughts (i.e., "I am telling myself I will never get better"), she reminded herself of the things that she was doing to get better and of the ways in which she had made some improvements in her life. Her voices significantly improved.

- *Auditory Stimulation*

Auditory stimulation can be very effective in managing voices. Try using a walkman or a portable radio with earplugs. This tends to work best when what is being listened to is meaningful and grabs your attention. Some people find that they get messages from radios or particular songs or music. In this case experiment with talk-shows, music with words and music without words. Another interesting bit of research has shown that for some people using earplugs can stop or reduce their voices. Try both ears or one, then the other ear. Some have found that the voices may stop AFTER rather than during wearing them. This is as yet unexplained.

- *Thought Stopping*

As soon as you become aware that you are hearing voices, say to them out loud "STOP!!". Immediately think of something pleasant or turn your attention to something in your environment and do something to occupy your mind as much as you can. If they persist, say again out-loud "STOP!!" and again create a pleasant image or distract yourself. As this becomes effective and after a while, you can say STOP in a softer and softer voice until you whisper it, and then you will be able to say it in your mind with the same effect. The key to success is to use your mind constructively once you have ordered the voices to go. This technique can also be used with negative or stressful thoughts you want to stop.

Research Project 2

Psychologist-Patient Intimacies: Boundary Issues and Recommendations for Ethical Practice

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Minor Placement Report, submitted in March, 2003, in partial fulfilment

of the requirements for the degree of:

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Abstract

Discussions between the author and his clinical supervisor (B. Healey, personal communication, 1999) regarding psychologists' sexual liaisons with patients prompted the development of materials presented in the present paper. The author's supervisor had respectfully declined a request from one such psychologist for formal collegial support, as a result of the transgressing psychologist's substantial history of unethical practice, which contributed to eventual action taken by the local statutory body to reprimand and subsequently revoke that psychologist's licence to practice. This case, and five vignettes presented, demonstrate the utility of the concept of boundary crossings and violations preceding overt psychologist-patient sexual contact (PTSC) in the context of a slippery-slope hypothesis proposing that attention to subtle boundary crossings and ethical violations may help prevent PTSC. Section B of the Australian Psychological Society (APS) Code of Ethics (1997) outlines twenty-one principles pertaining to relationships with clients, five of which are concerned with sexual relationships (B8-12). The clear messages in these principles form the basis of the present paper's contention that PTSC is almost invariably unethical and deleterious to the patient and profession, with the onus being on the psychologist "to establish that the client was not vulnerable to exploitation as a consequence of the prior professional relationship" (APS Code of Ethics, Revised edition, 1999, p. 4) in cases where sexual intimacies ensued more than two years after termination of the professional relationship, which corresponds to the minimum currently accepted prohibitive time frame. Increased contemporary awareness of the extent of PTSC in mental health fields has generated considerable debate about emerging boundary guidelines and standards advocated by professional bodies such as the APS and American Psychological Association. Many practitioners fear that rigid ethical codes demanding absolute therapist neutrality and anonymity impede or stifle the possibility of therapeutic movement, depriving patients of creative, intuitive and expert care. The argument will be presented, that far greater harm to patients, psychologists and the profession has occurred as a result of ignoring or overriding the guiding principles and commonsense expectations ethical boundary guidelines embody, than by adhering inflexibly to their canonical edict.

"Sexual contact with a patient...is considered by many to be one of the most egregious acts possible for a health care professional" (Plaut, 2001, p. 7). Two decades ago, an experienced Australian clinical psychologist's opinion was sought in relation to an inquiry to determine whether a fellow professional was guilty of conduct discreditable to a psychologist. The case in question involved the use of "body therapy" by a psychologist, which had lead to a complaint requiring collegiate advice to be provided to the Victorian Psychological Council (see Healey, 1984).

In legal correspondence, it was noted that "it is unacceptable for a psychologist to engage in body...or related therapy if it means touching a client, dressed or undressed, particularly any form of genital touching. Such touching or exploration should be the domain of the client/ patient or partner, if desired by the client. Physical examination of the body by a professional is the domain of medicine and any genital exploration should be done with the client's consent by a qualified medical practitioner with fully controlled hygiene and other procedures, preferably by a medical specialist with appropriate detailed knowledge of anatomy, physiology and accompanying sensitivity to problems physical and emotional" (Healey, 1984, p. 3).

The clinical psychologist concluded that the behaviour of the psychologist under investigation constituted "conduct discreditable to a psychologist", assuming the complainant's account was accurate. In further correspondence, questions were raised regarding therapist motives and self-gratification, as opposed to patient welfare, in the use of such "risky procedures" (see LoPiccolo & LoPiccolo, 1978, p. 520). An absence of any theory or data supporting the use of patient/ therapist touching, nudity, sexual activity or relations was highlighted, with explicit Ethical Guidelines relating to procedures/ assessments that involve psychologist-client physical contact published by the APS (4th ed.; Dec. 2002; see Appendix C, p. 104-108) and available to APS members, complementing the APS Code of Ethics.

Since the time of the abovementioned body therapy case, the "issue of intimate or sexual contact between helper and client has become the most widely discussed ethical question in counselling, psychotherapy and clinical psychology" (Belkin, 1988, p.51). Unfortunately, this is still the case in Victoria another decade on; in fact throughout the world wherever psychology is practised, as

demonstrated by comparative surveys (Wincze, Richards, Parsons, & Bailey, 1996), notwithstanding cross-cultural variation in awareness of sexual misconduct among psychologists, as noted by those authors.

Garrett (1998) noted that, in a large scale anonymous survey of clinical psychologists in the United Kingdom, under 4% reported having sexual contact with their patients. However, 22.7% had treated clients who had been sexually involved with prior therapists, most commonly private psychiatrists, nurses and social workers. However, "over 38% of the respondents knew, through sources other than their own patients, of clinical psychologists who had been sexually involved with their patients" (p. 227), an experience also reported in psychiatry (Gartrell, Herman, Olarte, Feldstein, & Localio, 1987). It was a discussion between the author and his clinical supervisor about sexual liaisons with patients involving mutually known psychologists that prompted the development of materials presented in the present paper. The author's supervisor had declined a request from one such psychologist for formal collegial support, as a result of that psychologist's history of unethical practice, which contributed to eventual action taken by the local statutory body to reprimand, then revoke that psychologist's licence to practice.

Patient-Therapist Sexual Contact: Complaints Against Health Practitioners

Schoenfeld, Hatch, & Gonzalez (2001) noted that "as many as 11% of psychologists may have to respond to a complaint during their careers" (p. 491). Among disciplinary proceedings handled during the two year period 1998-99 by the Victorian Psychologists Registration Board, ten (of 99) have been cases involving "sexual impropriety", to be referred in this paper as patient-therapist sexual contact (PTSC). Of the cases heard in 1999, "sexual relationship with a client" was proven in two cases, leading to cancellation of registration in one case and suspension of registration for 5 years in another. A third psychologist had been convicted by the criminal courts for sexual offences against children, committed while a teacher prior to psychological registration, which was subsequently cancelled.

Perusal of the Annual Report of the Medical Practitioners Board of Victoria (1999) revealed that

of 414 complaints received in the 1998/ 99 financial year 21 cases involved "sexual misconduct" with a selection of the formal hearings included in pages 25-27 of that report. Findings and determinations in the proven cases ranged from suspension to cancellation of registration, with conditions including supervision and restricted practice conditions being imposed on those permitted to continue working. A subsequent section of that report was devoted to how the Medical Board monitors "impaired practitioners", including those with drug or alcohol dependence, psychiatric or physical illnesses determined to have impacted on professional capacity.

In the United States, PTSC became the most common reason for actions taken against mental health care professionals more than ten years ago (Brodsky, 1989), with sexual misconduct constituting 44% of complaints in the 1998 annual report of the American psychological Association Ethics Committee (1999). A similar trend has been observed in Australia (Quadrio, 1996). As there were 3907 currently practising psychologists, and a further 1217 probationary psychologists, in Victoria in 1999, 10 matters involving PTSC (and a reportedly small number of un-investigated complaints) in the preceding two years may not seem to be a cause for concern. Such figures, though, are not only an inappropriate index of the reported incidence of PTSC and the harm it wreaks but also a reflection of the under-reporting, by knowing colleagues of perpetrators as well as victims, of unethical conduct by therapists that is either clearly abusive, ultimately traumatic, or even fatal for the patient (Stake & Oliver, 1991). A lack of exposure by colleagues aware of PTSC involving fellow professionals also opens up a related debate concerning the ethical obligation of confidentiality and the issue of mandatory reporting (see Aikin, 1960; Gartrell et al., 1987; Stone, 1983; Vinson, 1987; Zoller & Miller, 1973).

Awareness of PTSC

According to Kroll (2001), "a backlash against the self-actualizing psychotherapy movements of the 1960s and 1970s in concert with recent concerns about professional sexual misconduct has led some forensic psychiatrists to redefine many routine components of therapy as boundary behaviours" (p. 274). Contemporary awareness of the extent of PTSC was attributed by Zelen (1985) to the "rise of feminism,

consumerism, and a humanistic-egalitarian therapeutic orientation" (p. 178) within the helping profession. The change in awareness, according to Sherman (1993), is largely a "testament to the cultural impact of feminist consciousness raising" (p. 65), in that women are no longer disbelieved when they allege abuse by those entrusted with their care. However, this is not be taken to imply that females, although statistically the most likely client of an exploitative male therapist, are the only victims of PTSC, or males the only perpetrators. (Bates & Brodsky, 1989).

In the author's placement and employment experiences at forensic and clinical mental health settings a number of verified cases of PTSC have involved female allied health and correctional personnel, including a probationary psychologist whose details will not be presented. Indeed, instances of female-female PTSC (Sherman, 1993), female-male PTSC (e.g., Treen, Avery-Brown, & Haederle, 1992), male-male PTSC (Sherman, 1993) and, tragically, minor-therapist sexual contact (Bajt & Pope, 1989), have all been well documented. Morrison & Morrison (2001) found that of 75 psychiatrists disciplined by a state medical board in a 2.5 year period (who were proportionately more likely than non-psychiatric physicians to be disciplined for PTSC), the "disciplined group included more psychiatrists who claimed child psychiatry as their 1st or 2nd speciality" (p. 474).

The issue of informed consent and collaborative approaches in medicine and mental health fields is more prominent than in previous decades (Abel, Barrett, & Gardos, 1992; Barlow, 2001). A parallel rise in both consumerism and the egalitarian psychotherapeutic orientation (Blatt, 2001), emphasising informed consent in which the "client" has a right to know what to expect in therapy (and the choice to agree to all procedures), underpinning a homoeostatic shift away from the awesome, distant, "Freudian" analyst to the open, warm, embracing therapist or "helper", has also raised awareness of PTSC. On the other hand, the emergence of the egalitarian psychotherapeutic orientation may itself be exploited to downgrade or depreciate one of the strongest arguments against PTSC – that an inherent power differential underlies the patient-therapist relationship. Power differentials underlie the majority of professional, vocational and personal relationships and the increasing popularity of the collaborative, client-centred approach (Barlow, 2001) should not in any way diminish responsibility on the part of the

psychologist to adhere to professional boundaries.

Kroll (2001) in fact described the "backlash against the self-actualizing psychotherapy movements" (p. 274) precipitated by increased awareness of PTSC in an article critiquing overly rigid therapist boundary behaviours in the "richly diverse practice of psychotherapy" (p. 274). Simon (2001) counters by arguing that "for every harm done by therapists who have misconstrued boundary guidelines as inflexible boundary standards, I submit that many more therapists have harmed patients, themselves and their professions by not following generally accepted boundary guidelines" (p. 289). Several case examples of such harm involving PTSC follow in order to illustrate

Vignettes

Although case reports are typically idiosyncratic, five vignettes illustrating PTSC may serve as a starting point for examining possible consequences of patient exploitation incumbent upon the abovementioned power differential, the violation of subtle boundary conditions usually preceding overt exploitation (see Celenza, 1998; Simon, 1999; Gabbard, 1997, 2001), the relevance of contextual factors (e.g., practice in small communities) and also the dual vulnerability of patient and practitioner.

Case 1. "A single male colleague of yours... is having trouble with one of his female clients, whom he is very much attracted to. He finds himself willing to run overtime in the sessions, and if she were not a client, he would like to ask her out on a date. He feels somewhat guilty about his feelings. He is wondering if he should terminate the professional relationship and begin a personal one. He has shared with his client that he is sexually attracted to her, and she admits finding him attractive. Your colleague comes to you for suggestions on how he should proceed..." (Corey & Corey, 1989, p.191).

Sexual attraction to patients by therapists is common (Stake & Oliver, 1991). Lamb, Catanzaro, and Moorman (2003) recently noted that, among practicing psychologists in the United States who had "engaged in prohibited sexual relationships with clients, supervisees, and students" (p. 102), "84% were male psychologists, and the majority of relationships were with female clients after the therapist-client relationship ended" (p. 102). In the case example above, objectivity appears to have been lost and the

practitioner is strongly contemplating a personal relationship prior to even terminating therapy, which raises the grave scenario of therapists' actually grooming patients for PTSC (Epstein, 2002). Several boundary violations have already occurred (e.g., running overtime, sharing sexual feelings). Fortunately, he has shared his feelings with a colleague, which may consolidate his tenuous grip on his options and prevent PTSC.

Case 2. (manufactured by author). During the first session of therapy with a handsome, familiar looking man, the psychologist, a young single woman, realised that he was the same older boy she remembered having a crush on in school. He had returned to live in the small country town where she lived and, as it turned out, he was having relationship problems with a woman she knew well, her cousin! Towards the end of the session he mentioned remembering her face and looking forward to seeing the psychologist at the local church and reception hall where they were both attending a wedding the following weekend.

This case example shows that managing dual or multiple relationships in regional and small, rural (or ethnic) communities is clearly an unavoidable dilemma faced by health care practitioners (Faulkner & Faulkner, 1997; Schank & Skovholt, 1997), without even beginning to unravel the added complexity of feelings of sexual attraction.

Case 3. "A woman and her husband saw the psychologist for marriage counselling. Their marriage ended and she continued alone. A year and a half later, the doctor declared her therapy ended, introduced her to his wife as 'his friend', and invited her to spend a day with the family at Cape Cod. When he came to her apartment the following week and silently began to undress her, she felt paralysed, powerless to resist. Their relationship went on for six years. Later she became depressed enough to be hospitalised" (Sherman, 1993, p.65).

Nonsexual post-therapy associations, friendships and other types of relationships may be a seductive precursor to transgressions of the type described in Case 3 (see Anderson & Kitchener, 1998). The APS Code of Ethics (1997, revised 1999) outlines clear principles (B 10-12; p. 3-4) relating to the period of prohibition following termination of the professional relationship:

B10. No member may engage in a sexual relationship with a former client when less than two years have expired since the ending or termination of the professional relationship.

B11. In circumstances where more than two years have elapsed since the ending or termination of the professional relationship between the member and former client, in determining whether a sexual relationship between the member and former client is unethical, the following matters will be taken into consideration: a) the length of the professional relationship; b) the nature of the professional relationship; c) the client's mental state at the time he or she commenced the sexual relationship with the member, d) the circumstances in which the professional relationship ended or was terminated; and e) the duration of time that has expired since the ending of the professional relationship. Additionally, any other salient matters may be taken into consideration when evaluating the conduct of a member who has engaged in a sexual relationship with a former client.

B12. Where it has been established that a sexual relationship existed between a member and a former client after the expiry of 24 months from the ending or termination of a professional relationship, the onus shall be on the member to establish that the client was not vulnerable to exploitation as a consequence of the prior professional relation.

In Case 3, less than the minimum requisite two years had elapsed. However, more importantly, the doctor in question was still married to his wife, it would appear that the patient was "vulnerable to exploitation as a result of the prior professional relationship" (p. 4) and the patient's emotional and mental state was obviously disregarded by the doctor who embarked on the sexual relationship, leading to the woman receiving inpatient psychiatric treatment.

Five key factors underpinning the rationale for the prohibition are outlined in the APS Ethical Guidelines (see Appendix C of this paper). In summary, these are; 1. Clients' vulnerability to exploitation in the context of therapeutic, teaching, consulting and supervisory relationships, 2. The adverse effect on clients, 3. Impairment of the proper provision of services, 4. Sexual relationships are

not a legitimate part of therapy, and 5. Power differentials operate within psychologist-client relationships and these tend to remain post-therapy.

Case 4. "After years of therapy with a world famous analyst, she was more than just a patient. He took her sailing on his boat; she came along when he addressed an international conference in Paris. Throughout, he was 'courtly and kind ... a gentleman'. Then one nightmarish afternoon, she abruptly awakened from a drug he had assured her would 'help the therapy along' to find he was raping her. After her charges became public, a dozen more women came forward with similar tales" (Sherman, 1993, p.64-65)

This narrative sketch draws attention to several issues, including the boundaries between different relationships, professional/ personal and patient/ friendship/ acquaintance. Also, "the single biggest predictor of exploitation in therapy is a therapist who has exploited another [client] in the past" (Bates & Brodsky, 1989, p.141). Epstein (2002) noted that "psychiatrists who permit themselves to justify that a sexual relationship with a particular patient after termination would ever be acceptable are likely to engage in preparatory planning to "groom" a patient for a future liaison" (p. 877).

The final vignette presented is a real case arising from a complaint made to the Psychologists Registration Board of Victoria, Australia. Although a matter of public record, identifying details are deleted.

Case 5. "The complainant, Ms O, had been subjected, during 1992, to sexual advances by an ordained member of the Catholic Church. Some years later she took up an offer made on behalf of the Church to obtain psychological counselling at the Church's expense. Ms O selected the psychologist and counselling sessions took place over a three month period. Subsequently Ms O lodged a complaint about the psychologist, Mr B. She alleged that, during the professional relationship between them, Mr B had engaged in sexual acts with her.

In the Board's view it was abundantly clear from the evidence that Ms O had been in an emotionally vulnerable condition when she consulted Mr B and became dependent professionally on him. It was also clear that, ignoring the well-established boundaries maintained between a prudent psychologist and his or her client he had commenced an inappropriate relationship, including sexual intercourse, with her.

The board concluded that Mr B had been guilty of infamous conduct in a professional respect. His registration was suspended for five years. (Case 13 published in the1999 Annual Report of the Psychologists Registration Board of Victoria; http://www.psychreg.vic.gov.au).

This final case example, a real one, illustrates the commonness of sexual abuse as a background factor in patients of psychologists and the not infrequent referral of a patient because of such abuse, sometimes by a previous health care practitioner or member of the clergy (Parsons & Wincze, 1995; Pope, 1994). Merely feeling safe in the company of a mental health professional is of paramount importance to patients with an abuse history, in which case even minor boundary crossings such as minor, benign or incidental touch of any kind may be quite detrimental to engendering a sense of trust and security and a "heightened sensitivity to various forms of touch" may exist (Gabbard, 1997, p. 323).

Case 3 illustrates the harm often wreaked on the client by PTSC, while the first vignette is intended as an inchoative extrapolation towards benign ends of hypothetical continuums where philosophical exceptions undoubtedly abound and beg a number of questions:

Is PTSC always overtly abusive or can some therapists justifiably argue "my case is different?"

Is PTSC always harmful to the client?

Is there a point during or beyond therapy that PTSC can be argued to be ethical?

How can the unquestionable harm arising from many and probably most instances of PTSC be balanced against its seemingly inevitable existence (to be examined), the innocuous exceptions, and, perhaps most importantly, the therapists who genuinely believe PTSC is not specifically unethical in all circumstances?

In this paper, the argument presented is that PTSC is deleterious to the well-being of the patient, whether during or after therapy, and always potentially harmful to the wider helping profession (see Orr, 1997). Although this may seem an ethical but perhaps impractical view, given the high incidence of PTSC, and even flawed philosophically, considering any of many exceptions that can be generated, it will be demonstrated that it is the stance most likely to protect and advocate for the welfare of most clients, and psychologists.

Since the anti-PTSC viewpoint is rarely challenged in the literature, there is a paucity of informed debate regarding several of the stronger and more frequent counterarguments, especially regarding extrapolations from PTSC to boundary theory. Instances of dissent will be seriously considered, especially in relation to Kroll's (2001) proposition that boundary violations are "a culture-bound syndrome" (p. 274), in which "highly controversial claims about what is ethical and proper behavior in psychotherapy gain a mantle of incontrovertibility when linked to predictions that ignoring published boundary guidelines will result in damage to the patient and litigation against the therapist" (p. 274).

Australian and American Professional Body Psychologist Ethics Codes

The 1997 APS Code of Ethics principles relating to the period of prohibition following termination of the professional relationship was outlined earlier in relation to the third case vignette. In the preceding Code of Professional Conduct (operational from 1986-1996), the APS stated:

B5. "Psychologists must avoid dual relationships that could impair their professional judgement or increase the risk of exploitation".

This principle was embodied in Section B7 of the 1997 APS Code of Ethics, which further noted that "examples of such dual relationships include, but are not limited to, provision of psychological services to employees, students, supervisees, close friends or relatives" (p. 3). It is further stated:

> "Psychologists must not exploit their professional relationships with clients sexually or otherwise" (Section B8, p. 3) and "Sexual relationships with between members and current clients must not occur. When a therapeutic procedure entails some level of physical intimacy with a client, informed written consent must be obtained from the client or the client's legal guardian prior to introduction of that procedure" (Section B9, p. 3).

Valuable additional cautions were contained in the Appendix of 1986 Code of Professional Conduct: "It is unethical for the psychologist to engage in any form of activity with the client which could be construed as sexual and which reduces professional objectivity" (Appendix B5) and "If a psychologist,

engaged in a therapeutic role with a client, identifies personal feelings suggesting physical attraction of such magnitude as to threaten loss of control which could lead to physical intimacies, the psychologist should terminate therapy and take steps to refer the client elsewhere immediately" (B6).

In addition to forbidding sexual intimacies (SIs) with current clients, a previous Ethics Code of the American Psychological Association (APA), adopted prior the current APS Code, had already explicitly outlawed therapy with clients with whom previous SIs have been shared and, akin to the present APS Code, prohibited SIs "for at least two years after cessation or termination of professional services" (Ethical Standards 4.054.07, Reports of the Association, 1992, p.1605).

Furthermore, Section 4.07(b) of the APA Ethics Code also stated further that "psychologists do not engage in [SIs] with former [clients] even after a two-year interval except in the most unusual circumstances..." with such a psychologist bearing "the burden of demonstrating that there has been no exploitation, in light of all relevant factors..." (p.1605). These factors included the patient's current mental status, personal history, and the nature and duration of the therapy. Gabbard (2002) recently insisted that posttermination sexual relations "insidiously subvert the therapeutic relationship" (p. 593), at best increasingly the likelihood of further treatment being required, with "marriage between psychiatrists and patients [not a rare phenomenon] ... not relevant to the ethics of post-termination sexual relationships" (p. 593).

Shavit (1997) holds the view that "the ethics of psychotherapists engaging in sexual contact with former patients remain controversial and confusing, especially as time passes after termination (p. 2078), although all clinicians interviewed in his study "agreed that the potential harm resulting from post termination sexual involvements was great" (p. 2078). In a review of posttermination boundary issues, Epstein (2002) went further, stating that those "who permit themselves to justify that a sexual relationship with a particular patient after termination would ever be acceptable are likely to engage in preparatory planning to "groom" a patient for a future liaison" (p. 877; see also Epstein, Okasha, & Kay, 2003; MaImquist & Notman, 2001).

Although the APA and current APS Code of Ethics is explicit about unethical nature of PTSC under

almost all circumstances, prevalence research indicates that 5-10% of psychologists and psychiatrists disagree with, disregard, or otherwise fail to comply with this ethical position, including at least one researcher "whose pioneering work helped document the extent and harm of sex in therapy" (Sherman, 1993, p.70) but who was expelled from his psychiatric association for having an affair with a patient.

Prevalence of Patient-Therapist Sexual Contact

Housman and Stake (1999) noted that the prevalence of reported PTSC ranged from .5% to 3% among female therapists and 3% to 12% among male therapists (see Garret & Davis, 1994; Gartrell, Herman, Olarte, Feldstein, & Localio, 1986; Holroyd & Brodsky, 1977; Lamb et al., 1994; Pope, Levenson, & Schover, 1977; Rodolfa et al., 1994; Pope, Tabachnick, & KeithSpiegal, 1987). Half of 1,320 respondent psychologists in one study reported assessing or treating at least one patient who had been sexually intimate with a prior therapist (Pope & Vetter, 1991). Of major concern, 22.9% of a sample of APA Psychotherapy members regarded PTSC with former clients as "neither ethical or unethical" and 8.5% regarded PTSC with former clients as "somewhat or highly ethical" (Akamatsu, 1988). Belkin (1988) suggested what many psychologists suspect; that "some of the most notable psychotherapists had (or *probably* had) sexual contact with their patients" (p. 51).

An unequivocally disconcerting study alluded to was conducted by Bajt and Pope (1989), who reported that 24% of respondent psychologists, albeit members of the APA's Child, Youth and Family Services Division or publishers in the area of PTSC, declared encountering instances of sexual contact between therapists and minor patients. A reluctance to report such seriously criminal behaviour obviously limits research in this area but Brodsky (1989) also cites reluctance to report PTSC as the factor implicated in "falling numbers of male therapists admitting to sexual intimacies, undoubtedly due to increasingly negative professional and community attitudes" (Quadrio, 1992). Therefore, future findings of a reduced prevalence of PTSC (which may of course be counterbalanced by an increased rate of psychologists reporting the transgressions of other psychologists) will need to be qualified against contextual factors and reporting methodologies.

Related PTSC Continuums

A strong consideration to be drawn from a thorough review of the PTSC literature is that erotic behaviour by psychologists may be regarded as a phenomenon that emerges at one pole of many related continuums, as previously identified by the author (Grech, 1992) and others (e.g., Coleman and Schaefer, 1986). This paradigm may serve as a useful framework for subsequent debate. Four continuums may be envisaged which occur within the realm of the psychologist-patient *relationship*:

1. Countertransference issues and the fine line spanning requisite therapist empathy and rapport, which may be encroached by familiarity-friendship and ultimately close friendship-sex (Bonasia & Slotkin, 2001; Gabbard, 1995/ 1997; Hillman & Stricker, 2001).
2. Merging or superseding of patient needs with those of the psychologist, sometimes leading to a sexualisation of the fiduciary relationship that may result in PTSC, akin to Coleman and Schaefer's (1986) psychological-covert-overt abuse continuum (see also Celenza, 1998; Gabbard, 1997).
3. Any physical contact during therapy – as opposed to specific therapies that are subsumed within continuum 4 – that range from encouraging pats, hugs or a greeting peck to longer embraces, massage, or affectionate/ erotic touching (Bond, 1998; Holroyd & Brodsky, 1980; Orr, 1997).
4. Physical examination and any of the "body therapies" referred to earlier (Healey, 1984; see also Pattison, 1973), albeit more often relevant within the field of psychiatry, or desensitisation procedures requiring nudity, may become, or even begin, as a source of sexual gratification for the practitioner, thus necessitating strict ethical guidelines (see Section B9, 1997 APS Code of Ethics).

Coleman and Schafer's (1986) psychological-covert-overt continuum may also be interpreted in terms of sexual misconduct being viewed along a range of behaviours beginning with subliminal events and escalating to gestures, remarks and eventually actual sexual acts (see Celenza, 1998). Importantly, it appears that "sexual misconduct need not be flagrant to do substantial harm" (Sherman, 1993, p. 70). In a study cited by Sherman (1993), it was found that conversation about either the therapist's or one's own sex life, long full-body hugs and flirting aroused the same intense feelings as those experienced by

clients whose therapists engaged them in actual sexual acts. With regard to the female client-male therapist relationship, a therapist describing a near-PTSC self-encounter (Rutter, 1989) eloquently noted that "the mere presence of sexual innuendo from a man who has power over her can determine whether she experiences her femininity as a force to be valued and respected or as a commodity to be exploited" (p.36). These gender relationships are explored in detail in a review by Quadrio (1996).

Gabbard (1997) noted that in one case of PTSC in which he evaluated both parties (patient and therapist) "the sexual relationship...as in most cases...began with the therapist providing 'non-sexual' hugs. Although some would argue that the latter three continuums collapse into motive-driven dichotomies, the first continuum represents a much less clear cut and often paradoxical sliding scale of utility and intent. Even before the point of PTSC is reached there is a lot of evidence to suggest that friendship (whether during or after therapy, remembering case example 4) and even inordinate familiarity, can be destructive to the therapeutic process, and set the foundations for future PTSC.

Using a well-publicised case (see Shostrom, 1965; Weinrach, 1990/ 1991) available in a video series on psychotherapy, was the fact that psychotherapist Carl Rogers, who became somewhat of a father substitute for his long-standing patient Gloria, and that an enduring friendship stemmed from their high level of rapport, really beneficial for her in light of the fact that she ultimately committed suicide (Kotler, 1993)?

Growth of the humanistic-egalitarian therapeutic orientation may have also facilitated the discussion of therapists' feelings in therapy, including desires for and sexual fantasies about patients (as in the first vignette), possibly disguising "poor coping with countertransference [which] may increase the chance of sexual intimacies" (Zelen, 1985, p.179).

Gabbard (1997) proposed that "many sexual boundary violations grow out of misguided efforts to love the patient back to health" (p. 323), while idealisation and adulation of the therapist – a common psychotherapeutic transference phenomenon – may delude the therapist into believing that he or she is the only practitioner who can help the patient, a circumstance also conducive to the evolution of PTSC, especially in the case of narcissistic or lonely therapists.

Characteristics of Therapists at Risk of Transgressing

Many psychologists perceive colleagues who transgress sexually with patients as "invariably psychopathic", but "in this 'us/ them' scenario, there is little for the rest of us to learn about our own vulnerability to boundary violations (Gabbard, 1997, p. 321). That author identified two discontinuities in this model of understanding PTSC, the first being that psychologists are either ethical or character-ologically flawed (i.e., psychopathic). The second discontinuity involves neglect of the influence of convergent factors such as "clinical error and ethical misconduct in the development of sexual boundary violations during therapy" (p. 322) that may be a result of "poor training or bad technique" (p. 322).

Reviewing the PTSC literature, four continuums pertaining solely to the practitioner are indeed:

1. Character flaws, PDs (see Celenza & Hilsenroth, 1997), or psychopathy (see Gabbard, 1997), although these qualities may in fact be considered to exist along a scale from mild to severe;
2. Incompetence (see Sherman, 1993, p. 70) or "impairment" (Freudenberger 1986, cited in Quadrio, 1992) where PTSC may be viewed as more serious misconduct along a continuum of general incompetence;
3. Vulnerability (or culpability?), with loneliness and traumatic personal life events including childhood sexual abuse (Jackson & Nuttall, 2001), divorce or marital difficulties and burnout (see Ackerley, Burnell, Holder & Kurdek, 1988; Gabbard, 1997) at one end of the spectrum and sheer ruthlessness at the other (as portrayed in vignette 4), definitely appears to constitute another continuum, with at least one author exploring the special vulnerability of male therapists (Brooks, 1990);
4. A closely connected and obviously critical (but sometimes difficult to calibrate) continuum is that of motive and to a lesser degree context. As alluded to, is the psychologist's behaviour being modulated by client manipulation, situational variables, loneliness, overwhelming, unchecked emotional or sexual attraction (Folman, 1991), opportunism or ruthlessness (Gabbard, 1997)?

Wegman and Lane (2001) noted that "offending therapists can typically exhibit symptoms of psychotic disorders, predatory psychopathy, lovesickness, and masochistic surrender" (p. 73; see also

Bond, 1998, for a review of therapists at risk). In an early categorization of therapists engaging in PTSC, Stone (1984; cited in Quadrio, 1992) proposed the existence of a "typology of offenders" spanning the therapist-centred continuums. Therapists transgressing were classified into six "types" Quadrio caricatured as "sad, bad, mad, immature, grandiose and schizoid" (p. 353). Using the medical model, these categories clearly encompass all major psychiatric axes, including the depressive, psychotic and personality disorders (PDs).

Tremlow and Gabbard (1989) reduced the categorization to "ruthless and exploitative" versus "lovesick", a two-factor solution that research may indicate is proportionately tilted in the latter direction (Gabbard, 1997; Gartrell et al., 1986). As Ellard (1996) stated, "there are the unspeakable scoundrels and there are the depressed vulnerable people who, having put a foot wrong, fall over" (p. 132). More recently, "in a national, randomly drawn sample of 323 mental health practitioners, three of five men who reported severe childhood sexual abuse and whose psychological symptoms met the criteria for a high degree of psychological distress reported sexual boundary violations with clients" (Jackson & Nuttall, 2001, p. 200; see also Nuttall, 1997). Another study found male nurses working in a psychiatric hospital "who were victims of childhood sexual abuse are at particularly high risk of becoming sexually involved with their patients" (Bachman et al., 2000, p. 335). Irons and Schneider (1999) take an "addition-sensitive approach to the sexually exploitive professional" (book title), taking the view that many transgressions lie within the realm of compulsive sexual behaviour.

Alternatively, Gabbard (1997) noted that many practitioners would favour the former view that "therapists who transgress sexual boundary violations are invariably psychopathic and should, therefore, be thrown out of the mental health professions with dispatch" (p. 321; see also Gabbard, 1994). Quadrio (1992) suggests that irrespective of the type of offender destruction of the (feminine) relational self of the (male) therapist is at the core of PTSC, with revenge underlying the behaviour of offenders at the ruthless pole and a lost sense of self tending to guide the conduct of "lovesick" therapists. The question of whether psychologists who transgress can "be safely returned to practice" (Plaut, 2001, p. 7) is not

the subject of this paper, but interested readers are referred to a review by Plaut (2001) and other contributions in this area (e.g., Gonsiorek, 1995; Irons & Schneider, 1999).

Although Quadrio's insight is luminous and understanding the psychology of transgressing therapists is imperative in discussions of PTSC, it should be evident that any focus on explanations of therapist motivations must always be subordinate to the "need" continuum, which, in turn, must always be weighted entirely towards the needs of the client within the context of any psychotherapeutic situation to be considered ethical. The issue of therapist vulnerability and rehabilitation remains important, but of relevance separate from the psychotherapeutic relationship and client needs.

It is also possible to envisage several patient-centred continuums. One that will not receive any credence in this paper is the degree to which one "will endorse and focus on the concept of [patients] as responsible...for [PTSC]" (Pope, 1990, p.235). The parallel here with rape, paedophilia or incest is obvious, and, despite claims that "the therapist is every bit as much in the power of the consumer, as the consumer is in the power of the therapist" (Wright, 1985, p.117), "the single biggest predictor of exploitation in therapy is a therapist who has exploited another [client] in the past" (Bates & Brodsky, 1989, p.141), as illustrated in the fourth vignette earlier in this paper. It is clear that this factor involving therapist recidivism is independent of patient characteristics, excepting offending therapists' preferences in homing in on specific vulnerabilities recognized in victims.

Therapeutic Power Differential Invalidates Patient Consent to PTSC

A second patient-centred continuum, related to the "client-blame" continuum, and given prominence by those who vitiate the power-differential inherent in the client-therapist relationship, is consent; i.e., to what degree has the client, in any instance of PTSC, agreed willingly to sexual relations, or, alternatively, to what extent can a client be expected to provide informed consent – if at all? Perhaps the primary argument supporting, or at least justifying, PTSC as ethically acceptable rests on the principle of autonomy which avers that two mentally unimpaired adults should be allowed to do whatever they wish, so long as they do not harm anyone else, assuming for a moment that the clients in question do not

include minors, or mentally or emotionally impaired adults (who presumably constitute a significant proportion of patients seeking or referred for psychological therapy).

Defenders of this position may criticise the conventional views as paternalistic (see Goldberg, 1973; Walby, 1990), whose protagonists in turn argue that the special nature of the therapeutic relationship invalidates consent and that transference in the relationship makes it analogous to the parent-child relationship, rendering PTSC symbolic incest (Sherman, 1993). If one concurs with the premise then this is a powerful argument, but many do not, particularly helpers other than psychotherapists (Sherman, 1993). Similar arguments paralleling PTSC with rape also collapse if the power differential – increasingly underemphasised by the humanitarian shift – is undermined, with the suggestion that some form of power differential is inevitable in almost all relationships.

A third patient-centred continuum may involve the veracity of victimised patients' claims of abuse or PTSC, which may range from genuine to exaggerated or false. Although this in an important area of research in itself and false but credible claims are not rare (see Williams, 2000), the relevance of this somewhat discontinuous dynamic in relation to the present paper appears to reinforce the importance of awareness and proper adherence to the prescribed ethical guidelines being espoused to additionally safeguard against one's vulnerability to any such inflated or false claims by predatory purported victims.

Significantly, in regard to the inverse phenomenon (i.e., the probability of unreported but probably valid complaints) Parsons and Wincze (1995) "found that Rhode Island therapists had indirectly acknowledged committing 120 boundary violations during a 3-year period" (p. 75), including 37 instances of sexual misconduct despite the Rhode Island psychologists' statutory body receiving just one complaint of PTSC, again demonstrating the limited relevance of patient behaviours in discussions of the ethics of PTSC from the perspective of therapist culpability.

For completeness, a final, hypothetical, patient-centred continuum is the extent of damage – or, to be open-minded, benefit – incurred due to PTSC, with a neutral effect in the centre of such a continuum. Such a continuum is another that will not be given much credence in relation to arguments condoning, justifying, rationalising or excusing PTSC. Quite simply, a vast body of research contends that, over and

above the annihilation of professional objectivity, PTSC has an adverse impact on patients and usually involves their exploitation (Bates & Brodsky, 1989; Feldman-Summers & Jones, 1984; Gartrell et al., 1986; Rutter, 1981/ 1989; Stake & Oliver, 1991; Wincze et al., 1996), which is the major rationale for the universal prohibition of PTSC by professional psychology bodies worldwide.

As reflected in the APS and APA ethical guidelines and the third vignette, which illustrated the possible effect of posttherapy sexual relations, the passage of time after termination of therapy does not necessarily diminish the impact of subsequent PTSC. Although the actuarial data alone indicates that a "substantial percentage of patients appear to be harmed by posttermination involvements" (Pope & Vetter, 1991, p.433), even modest harm to a small percentage of patients engaged in posttherapy PTSC can strongly justify prohibition of post-therapy PTSC entirely.

A most apt analogy impeccably illustrates this point: "The increasingly strict laws prohibiting drunk driving are in no way invalidated, undermined, or contradicted by research indicating that only a relatively small percentage of the instances in which one drives while intoxicated result in actual damage to people or property" (Pope & Vetter, 1991, p.433).

Impact of PTSC on Patients

In the preceding decade, sexual abuse in psychotherapy and counselling from the perspective of the patient has become the subject of many research papers and books (e.g., Garrett & Davis, 1994, in which PTSC was described by one commentator in the jacket blurb as a "fate worse than death"). Ninety percent of 559 surveyed people in one study who had experienced PTSC as clients were judged to be negatively affected (Bouhoutsos, Holroyd, Lerman, Forer, & Greenberg, 1983). Harm included mistrust of opposite-sex relationships, hospitalisation and suicide. Other studies have demonstrated guilt, shame, "an expectation of not being believed" (Galletly, 1996, p. 133), depression, increased anxiety, substance abuse, social isolation, loss of confidence, diminished trust in subsequent caregivers and exacerbation of symptoms for which the client originally sought help (Haspel, Jorgenson, Wincze, & Parsons, 1997). Confusion, resentment, anger and a sense of abandonment are other emotions often experienced (Corey

& Corey, 1989; Quadrio, 1996).

Using materials related to the assessments of forty women "who experienced sexual abuse in therapy" (p. 124), Quadrio (1996) found that "68% had a history of childhood abuse, and one half were themselves helping professionals" (p. 124). The results of her exegesis demonstrated that "the majority were seriously damaged by the abusive therapy" (p. 124), with most offending practitioners "senior, well-qualified therapists of high status", some of whom "were charismatic leaders or teachers" (p. 124).

Not surprisingly, no research exists that demonstrates PTSC is harmless, or in any way beneficial, apart from satisfying the misplaced needs of the offending practitioner, although in past decades a few authors openly refuted this position (e.g., McCartney, 1966; Shephard, 1971). Ultimately, erotic contact also fosters client dependence (Corey & Corey, 1989), which is unlikely to lead to empowerment, improved mental health, or a higher level of self-sufficiency. Finally, the objectivity of the therapist is irrevocably lost in the event of PTSC.

Boundary Crossings versus Violations

A number of articles have been written in the preceding few years on the subject of boundary crossings and violations (e.g., Kroll, 2001). According to the APS Ethical Guidelines (2002), "crossings are departures from commonly accepted practice that...may be seen as appropriate" (e.g., "attending a client's special event or borrowing a [client's] book", p. 40), while violations relate to unequivocal transgressions, including eroticised touching and offering psychological services to family members.

Abstinence: Applicability of the Confidentiality Principle

Gabbard (1997) highlighted the potential "perils of secrecy" (p. 324) in psychotherapy, remarking that "among the many ironies...is that the privacy of the confidential therapist-patient relationship is both the cornerstone of practice and a major risk factor in the development of boundary violations. What transpires...is not observed by anyone other than the two participants. The therapist then must rely on internal monitoring: a form of scrutiny that will always be imperfect and...subject to the vagaries of

countertransference, bias, denial and unconscious wishes for the patient to meet the therapist's needs" (p. 324). That author was regularly surprised by "how rarely therapists avail themselves of regular supervision or consultation", preferring a course of "rugged individualism" (p. 324) fraught with the dangers inherent in isolation, which both from a professional and personal viewpoint, "can be a fertile field for the development of boundary violations" (p. 326) and is strongly discouraged, especially in private practice (B. Healey, personal communication, 1999).

In addition, a puissant ethical argument against PTSC, utilising a parallel between abstinence from PTSC and confidentiality, precludes the "my-case-is-different/ innocuous" defence where transgressions occur and does not require any empirical evidence. General principle III (a) of the Australian Code of Professional Conduct states succinctly that "psychologists must respect the confidentiality of information obtained from persons in the course of their work as psychologists" (p.4). Indeed, confidentiality is a cornerstone not only of psychology in general, but the psychotherapeutic relationship in particular. The wider public's confidence in this principle permits clients to feel that they may divulge information to their therapist without fear of public embarrassment, prejudice or ridicule. Breaches of confidence are only acceptable in extreme circumstances as all violations threaten the public's confidence in the principle.

When clients enter into relationships with a therapist they must, to receive optimal care, expose to the therapist their inner worlds, or even their bodies, in the case of physical examinations or the so-called "body therapies", referred to at the start of this paper. If members of the public are lead to believe that their relationship with their therapist may become sexual or even ordinarily intimate, they will feel constrained in divulging their history and exhibiting their souls.

Although many clients come to idealise their therapist, most do not perceive practitioners of psychology, medicine or other health care professionals as potential friends or lovers. Every episode of PTSC threatens this principle of professional abstinence and consequently threatens the treatment of all clients. The principle of autonomy permits freedom of action as long as no one else is harmed. Therefore, each instance of PTSC potentially harms everyone.

Period of Prohibition

Case 3, presented earlier, helped illustrate Section B (principles 10-12) the APS Code of Ethics regarding PTSC. A final continuum, and one already touted as perhaps most likely to warrant genuine ethical debate, is the temporal or moment-in-time scale. Specifically, at what point is PTSC ethical or in any way justifiable during therapy – in the event of extraordinary circumstances (e.g., imminent nuclear war or Noah's ark-like circumstances) – or after (or before?) psychological intervention?

There is considerable debate about when therapy or transference can be said to end (Appelbaum & Jorgenson, 1991). This argument may be unfurled along the temporal continuum to debate about the ethics of sex with former clients. Recalling, and expanding, the parallel with confidentiality, PTSC would seem unethical irrespective of when therapy ends. As the emotions generated by therapy may be extremely potent and enduring many therapists believe that the "ban" on PTSC ought to be indefinite and that "even after the professional relationship has been terminated, the same feelings are immediately re-established if [client and therapist] get back together" (Gabbard; cited in Sherman, 1993, p.68).

Notwithstanding the fact a number of renowned psychoanalysts are believed to have transgressed sexually with their patients during and after therapy and many mental health care practitioners marry their former clients, the original power imbalance is likely to remain. Akin to the APS Code of Ethics, Section 4.07(b) of the APA's Ethics Code (quoted earlier), which puts the onus on the psychologist to vindicate any instance of PTSC after therapy "in light of all the relevant factors" springs to mind as highly ethical in safeguarding the well-being of the client and compelling the therapist to prudently heed all of the potential needs and insecurities of the client, surely the essence not only of successful therapy but also of a moral and ethical practitioner.

The prevalence of PTSC has thrust the subject into the public spotlight, but other issues such as the repressed/ recovered memory debate and films such as 'Gross Misconduct' alert us to the possibility of false accusation, raised earlier (Williams, 2000; see also Mahon & Gerrie, 1993). In PTSC, fictitious claims may occur at a rate of around 4% (Pope & Vetter, 1991), but, significantly, focus attention on the issue of how to prevent behaviours leading to the possibility of PTSC, as well as the hazards of using

unconventional, unjustified or ambiguous practice procedures that may be misinterpreted by or detrimental to patients and leave the psychologist vulnerable to scrutiny. Celenza (1998) reviewed the precursors of PTSC, focussing on subtle boundary violations in everyday practice. Other forms of unethical sexual behaviour include lecturer/ supervisor-student/ supervisee and trainer-trainee sexual contact (Bartell & Rubin, 1990; Cruikshanks, 2000; Pope, Keith-Spiegal, & Tabachnick, 1986; Pope, Levenson, & Schover, 1979), which may be viewed as a seed crystal for acceptance and perpetuation of unethical attitudes within the profession of psychology.

Boundary Violations: Signs and Possible Solutions

Several papers advocate that educative, preventative and remedial interventions are needed in the helping profession (Bridges, 1994; Gabbard, 1997; Spickard et al., 2002), in addition to shifting the attitudes of many therapists, for the sake of violated clients, as well as therapy and additional disciplinary procedures for "impaired" therapists (Quadrio, 1992/ 1996). A number of studies have aimed to enlighten the public and practitioners of warning signs or "red flags" (Folman, 1991) that delineate the subtle erosion of professional boundaries paving the way for PTSC (Gabbard, 2001, Sherman, 1993). Listed below are fifteen possible indicators:

1. Change in conversational matter and tone from the patient to the practitioner (recalling the "need" continuum), or from the clinical to the personal
2. Self disclosure which involves "burdening the patient with the therapist's own problems" (Gabbard, 2001, p. 285), leading to a "role-reversal situation in which the therapist seeks help from the patient for personal difficulties" (p. 285).
3. Inordinate psychologist-patient familiarity
4. "The confusion of supportive therapy and boundaryless therapy" (Gabbard, 1997, p. 324), in which "an attitude of anything goes" leading to an "informal friendly style of interaction" (p. 324).
5. Physical contact beyond the formal (e.g., handshake) or occasional encouragement that *feels wrong*

As aforementioned, Gabbard (2001) has drawn attention to the fact, "in most cases", sexual

relationships begin with the therapist providing non-sexual hugs" (p. 322).

6. Excursions outside the office or rides home (see Celenza, 1998). These arrangements were a characteristic boundary violation of the psychologist referred to in the Abstract of this paper whose license was revoked following a range of unethical practices.
7. Extended therapy meeting over lunch, home visits or other distortions of time or place
8. Extra-therapy socialising, friendships or associations (as highlighted by the third case vignette).
9. Accepting, trading or exchanging of gifts. Simon (2001) noted that "bartering arrangements with patients do not usually work out well" (p. 288; see also Woody, 1998).
10. Not charging or waiving of debts. Although a percentage of pro bono work is customary for consultant psychologists "fee misunderstandings or disputes often disrupt treatment, undermining the therapist-patient relationship" (Simon, 2001).
11. Patient employment, bartering, personal services rendered or other business relationships (Lamb et al., 1994). In the event patients are unable to pay for psychological services, voluntary work (in lieu of fees) that is clearly specified and time-limited may be considered but, as a rule, is not advisable.
12. Scheduling appointments when no one else is around (B. Healey, personal communication, 1999).
13. Offering one's home as a place to stay for patients (a mistake made by many youth workers).
14. Clandestine or home phone calls (except as appointment reminders, cancellations or in crises)
15. Inability to set limits (e.g., refusing unreasonable requests) in therapy (e.g., because of concerns about being too aggressive). In the present era of managed care, "many therapists are tempted to forge a therapeutic alliance with the patient by displacing all aggression outside the therapeutic dyad and onto the case manager who is seen as a withholding bad object who will not allow the patient to get what he or she needs" (Gabbard, 1997, p. 327; see also Williams & Swartz, 1998).

The previous Australian Code of Professional Conduct stated: "If a psychologist, engaged in a therapeutic role with a client, identifies personal feelings suggesting physical attraction of such magnitude as to threaten loss of control which could lead to physical intimacies, the psychologist should

terminate therapy and take steps to refer the client elsewhere immediately" (p. 14). In addition, it is also important that such a psychologist, in his or her haste to despatch such a patient, has due regard for their psychological well-being, since a patients who are referred on may feel abandoned, become confused or lose confidence with regard to their sexuality if the reasons for termination and referral are not explained delicately but honestly.

A compendium of twelve preventative, precautionary measures and suggestions recommended by the author to avoid the likelihood of PTSC are listed:

1. At first meeting, make available to all patients a brochure outlining the unethical nature of PTSC and their rights, such as the APS "Charter for Clients of Psychologists" (see Appendix D, p. 109).
2. Utilise informed (and preferably written) consent procedures wherever possible and be straight-forward and honest with one's patients, one's supervisor (see Gabbard, 1997) and oneself!
3. Develop awareness of side effects of the psychotherapeutic relationship, including regression, but also idealisation of the patient, which may mark the origin of a continuum leading to love.
4. Increase knowledge of the harm PTSC and also less overt sexual behaviour causes patients.
5. Have an awareness and sensitivity to the possibility that a patient has been previously sexually abused and that such abuse may have involved PTSC, abuse by the clergy or other caregivers/ authority figures.
6. Be vigilant to minor boundary violations on the part of both psychologist and patient, as outlined.
7. Always endeavour to avoid contact and conduct which may be construed by the patient as sexual.
8. Be alert to the issue of patients' sexual behaviour and potential harassment directed towards the psychologist, setting clear boundaries and taking appropriate action (see deMayo, 2000).
9. Do not practice psychology in isolation from fellow psychologists, other health care practitioners or support staff (B. Healey, personal communication, 2000; see also Jackson & Nuttall, 2001).
10. Undertake regular clinical supervision (B. Healey, personal communication, 1999). Gabbard (1997) stated "what I have found particularly remarkable is how rarely therapists avail themselves of regular supervision or consultation" (p. 324).

11. Safeguard personal safety (e.g., panic buttons are often used in forensic/ hospital settings) and use self-protective strategies, including the capacity and will to manage unreasonable client demands, and, if problems occur, supervision or tape-recording of sessions, and/ or undertaking of therapy in view of other staff (e.g., in a room with transparent windows or otherwise visible by others).
12. Make time for a personal life and pay due attention to self-care (Gabbard, 1997).

Awareness of Sexualised Transference and Countertransference

Perhaps as a result of embarrassment and fear of censure, there is a paucity of theory and research concerning transference and countertransference issues in therapy (Bolognini, 1994; Bonasia & Slotkin, 2001). Brief consideration of the issues of transference in relation to PTSC is especially pertinent to psychological management and interventions involving brain damaged, disinhibited, personality disordered and elderly patients (deMayo, 2000; Hillman & Stricker, 2001; Housman & Stake, 1999). Alluded to earlier, transference may be defined as "the passing on, displacing or 'transferring' of an emotion or affective state from one person onto another" (Reber, 1985, p. 785). In the context of therapy, feelings and attitudes usually applicable toward significant others (often parents) are displaced onto the psychologist. Hostile feelings towards the psychologist may be referred to as negative transference, while positive transference reflects patients' agreeable attitudes. Although the state of transference is "ubiquitous in human interaction" (Reber, 1985, p. 786), "its conspicuousness in psychoanalysis" (p. 786) is often attributed to the psychologist's objectivity and neutrality, which permits unambiguous observation. However, "the immense transference pressures therapists confront, sometimes in the context of their own vulnerabilities" (Smolar & Akhtar, 2002, p. 260).

Countertransference, considered "inevitable" and often "benign" (Reber, 1985, p. 164), is the psychologist's displacement of affect onto the patient (e.g., viewing an elderly patient as a parental or grandparental figure) and, more broadly, the psychologist's "emotional involvement in the therapeutic interaction" (p. 164; see also Gabbard, 1995). The term "*countertransference* arose in the context of misbehaviour by the early analysts...[being] originally seen as something to be controlled and

suppressed, partly for the sake of the reputation of psychoanalysis" (Bonasia & Slotkin, 2001, p. 249).

Problems relevant to PTSC emerge when the psychologist habitually loses his or her objectivity and neutrality to the point where professional boundaries are distorted by emotional exchanges that shape the role played by the psychologist. At a basic level, these roles may include those of "rescuer", in response to extreme helplessness, dependency and distress on the part of the patient, or "chameleon", in which the patient's experiences or feelings perhaps mirror the psychologists, to the point that the psychologist's feelings merge with the patient's, and clinical objectivity may be lost. In this context, psychologists playing the role of rescuer, parental figure or the like may eventually become unwittingly vulnerable to even more perfidious roles (e.g., lover), as highlighted in earlier case examples.

Hillman and Stricker (2001) noted that "the presence of sexualized or eroticized dynamics are likely to lead to feelings of confusion, fear and angst for therapists" (p. 272) who may "have received little or no formal training regarding this clinical phenomenon" (p. 272). deMayo (2000) outlined a conceptual framework and specific strategies. Whether, by reworking the Oedipal relationship, erotic transference may actually be clinically harnessed – as opposed to necessarily hindering – psychotherapy is beyond the scope of this paper, but is well reviewed by Stirzaker (2000) who uses case examples.

However, it is worth remembering that any such therapeutic effects are best generated by appropriate adherence to professional boundaries from the outset of therapy. Indeed, in a general sense, "the essence of the treatment process occurs in the deprivation of gratification and in the therapist's maintaining relative neutrality and anonymity to facilitate the emergence of the transference and eventually the transference neurosis..." (Blatt, 2001, p. 290). It has also been said by Rutter (1989, p. 38): "The potential healing power of restraint at the forbidden boundary is enormous. Women and men can glimpse the possibilities of their own strengths". In routine psychological practice it is the responsibility of the psychologist to recognise the intense feelings of attraction between patient and psychologist, or on the part of one party, which may develop during therapy, within the context of proper maintenance of professional boundaries (see Guidelines on the Proscription of Sexual Relationships with Clients, APS Ethical Guidelines, p. 45, Appendix C of this paper).

Clinical Psychology Sexual Ethics Training

Bridges (1994) remarked that the "meaning and management of attraction" is one of the most "neglected areas of psychotherapy training and practice" (p. 424), sentiments shared by others (Gorton, Samuel, & Zebrowski, 1996; Samuel and Gorton, 1998; Setô, 1995). Since then, a large scale sexual ethics training survey involving 84 directors of accredited clinical psychology doctoral programs in the United States and 451 students was reported by Housman and Stake (1999) in a comprehensive review. Those authors noted that "virtually all clinical programs in our sample provided sexual ethics training" (p. 307) but that the directors of almost as many programs had not responded, many of whom may not have been providing any specific training. Those authors proposed the addition of sexual ethics training "as a criterion for accreditation" (p. 308). However, improving the effectiveness of training was deemed important in the light of certain results and the general observation that course hours did not relate directly to scores reflecting knowledge of PTSC issues and ethics.

In their survey, 73% of male and 38% of female clinical psychology students reported having had a sexual attraction to a client (see also Ladany, O'Brien, Hill, Melincoff, Knox, & Peterson, 1997), but "68% did not know that sexual feelings for clients are normal and not unethical" (p. 308). Of concern, 7% of respondent students "did not know that sex with current clients is always prohibited" and "34% did not understand that termination or transfer does not free therapists to have sex with their clients" (p. 308), a point seemingly lost on the psychologist in the first vignette presented earlier in this paper. Notably, "students who had been attracted to a client and did not discuss the attraction with a supervisor were particularly ill informed" (p. 308) and therefore at potentially greater risk of future PTSC.

Self-Care: Knowing and Healing Thyself

In comparison to the growing recognition of sexual ethics awareness training, "psychological principles, methods, and research are rarely brought to bear on therapists themselves, with the probable exception of our attempting to diagnose one another. Although understandable and explicable on many levels, the paucity of systematic study on psychotherapists' self care is unsettling" (Norcross,

2000, p. 710). This author compiled a list of ten "clinician recommended, research informed and practitioner tested...consensual self-care strategies" (p. 710) in relation to distinguishing valuable "self change" options for mental health professionals, over and above the strategies of "educated laypersons", in soothing the mind, body and soul. These were based on research by Brady, Healy, Norcross, & Guy (1995) and are presented in point form, with examples of how the author inadvertently (and increasingly deliberately) utilised these strategies while combining full-time doctoral studies, initial employment as a psychologist, early married life and family commitments, with the goal of achieving personal and professional equilibrium, and remaining focussed and emotionally centred.

1. Recognise the hazards of psychological practice. Norcross (2000) noted "that literature points to moderate depression, mild anxiety, emotional exhaustion, and disrupted relationships as the common residue of immersing ourselves in the inner worlds of distressed and distressing people" (p. 710), with confidentiality, isolation, shame, and other factors leading to professional stress that, by merely being acknowledged, may have immense therapeutic value. Like in everyone's life, there were periods throughout the author's journey as a D. Psych student when all aspects worked like clockwork and other times when difficulties in one area threatened to spill over into others. In psychological work, the personal toll is often demanding and the threshold between managing effectively and burning out at times marginal.

2. Think strategies, as opposed to techniques or methods. Norcross suggests counterconditioning (e.g., exercise, massage, meditation) and helping relationships (e.g., clinical supervision and peer support groups) as two broad strategies (with a diversity of resources and choices) for soothing the spirit and balancing emotions, all of which were used regularly by the author. The counterconditioning impact of consistent attention to a balanced and unprocessed diet (as recommended by the author's general practitioner) should also not be underestimated.

3. Begin with self-awareness and self-liberation. Schwebel and Coster (1998) listed "self-awareness/

self-monitoring" as the top ranked contributor to optimal functioning among psychologists, which Norcross (2000) noted "requires that we attend to interpersonal feedback from significant others" (p. 711). This is aided greatly by nurturing one's personal relationships and utilising clinical supervision, as discovered and re-discovered by the author many times. At times of uncertainty during new and demanding work in a prison environment, weekly supervision contributed immensely to the author's confidence and sense of mastery over recently acquired skills and approaches to professional demands that initially seemed daunting. Monitoring and reflecting on challenging transference and counter-transference processes (privately and in supervision) was a lynchpin of remaining calm and effective in a sometimes chaotic work environment during long shifts.

4. Embrace multiple strategies traditionally associated with diverse theoretical orientations. Norcross identified the duplicity in psychologists' personal lives and public careers in relation to psychologists becoming "more pragmatic, secular, and eclectic when confronting their own distress". On reflection, there is a lot of truth in this observation, with the author typically focusing on cognitive-behavioural approaches for improving mood in patients but privately adding a number of counterconditioning strategies in relation to addressing personal anguish (e.g., hot bath, massage, exercise, sport). Norcross advocates a "broad front" (p. 711) in managing self-care, an outlook echoed by the author, both in relation to personal and professional matters.

5. Employ stimulus control and counterconditioning where possible. Norcross does not necessarily recommend becoming an expert in Feng shui, but the benefits of taking the time to maintain a functional and harmonious physical work and study environment are often underrated. Additional counter-conditioning approaches listed included problem-focussed strategies such as cognitive restructuring and assertion and reading or movies for diversion. In the author's experience, immersion in either meditation or physical exercise near water, preferably a beach or moving stream, has the additional tranquil benefit of calming and clearing the mind and refreshing the senses.

6. Emphasise the human client. Norcross and the author strongly recommend the efficaciousness of healthy and constructive helping relationships (professional, platonic, sporting, intellectual and intimate)

in attending to the power of interpersonal elements in improving self-care.

7. Seek personal therapy. There is certainly no shame in seeking personal therapy if required or even episodically, with research showing that most mental health care practitioners have and "90% plus" have rated "the outcome...quite positively" (Norcross, 2000, p. 712).

8. Avoid wishful thinking and self-blame. Norcross noted that these coping styles "paralyse adaptive approaches" (p. 712), which is true both in everyone, our patients and ourselves.

9. Diversify, diversify, diversify. Balancing (or juggling!) professional responsibilities and personal needs may be especially challenging for mental health care practitioners involved in clinical work, research and higher studies, but also embraces immense privileges and rewards worth maintaining.

10. Appreciate the rewards. Gabbard (1997) noted that "therapists must attend to their personal lives so that their sexual and emotional needs are gratified appropriately...Self-care should be inculcated in individuals who have chosen to be psychotherapists...[those] who make no time for a personal life will ultimately look for personal gratification in a professional context" (p. 326).

Although utilising the ten self-care strategies outlined by Norcross (2000) are not, in themselves, either collectively or singularly, a direct antidote to avoiding boundary crossings or violations in therapy, including staving off the risk of PTSC, they may, if used regularly, lower the intensity of professional distress experienced during challenging work or amidst personal strains and ultimately aid decision making. The strategies outlined provide a healthy outlet for relieving pressure and reducing physiological or emotional stress that research shows is often heightened prior to engagement in PTSC in the majority of practitioners who have "no previous formal history of ethical misconduct" (Gabbard, 1997. p. 322). O'Conner (2001) noted that "although psychologists have significant rates of distress and impairment, numerous personal and occupational factors may decrease the likelihood that they will seek assistance when in trouble" with "current oversight approaches to the impaired professional" tending "to emphasise [ethical] code enforcement more than prevention and education" (p. 345). Aspects of the latter considerations were consequently highlighted in the preceding two sections.

Conclusion

Gabbard (1997) noted that "there is a confluence of clinical error and ethical misconduct in the development of sexual boundary violations during psychotherapy" (p. 321). Although a proportion of therapists engaging in PTSC are undoubtedly predatory sociopaths, most of the 70-80 cases assessed or treated by Gabbard (1997) were described by that Professor of Psychoanalysis and Education as "more similar to the rest of us than different" with referral sources often commenting "that the accused therapist is the 'last person we ever would have expected this to happen to'" (p. 322). Consequently, this paper aimed to clarify the distinction between boundary crossings and violations which strike at the ethos of the profession and elucidate the nature of continuums that may provide a useful framework for mounting an argument that PTSC invariably constitutes unethical behaviour within the psycho-therapeutic relationship and is almost always unethical even if it occurs after therapy has officially ended (Shavit, 2002; see also Anderson & Kitchener, 1998). It was proposed that psychologist's arguing otherwise must honestly challenge their motives and assume the onus of proof, as recommended in Section B12 of the APS Code of Ethics (1997).

Whether psychologists who transgress are best regarded as in some way characterologically flawed, impaired, unethical, personality disordered (e.g., grandiosely narcissistic), psychopathic, sexually addicted, lovesick, acutely distressed (e.g., recently divorced or made a widower) or simply incompetent, remains open to debate (Gabbard, 1994, 1997, 2001; Haas & Hall, 1991), but the deleterious effect on patients is not in question (Bouhoutsos et al., 1983; Feldman-Summers & Jones, 1984).

Ultimately, the clinical needs of the patient must be of paramount importance to the health care practitioner in a professional sense, but legitimate personal requirements, desires, dreams, hopes, fears, and health must also not be neglected (B. Healey, personal communication, ongoing). Psychologists in need of help themselves (see Norcross, 2000; O'Conner, 2001) should refer to their Code of Ethics, seek advice or information from their local statutory or professional body, and, preferably, avail themselves to collegial support (see Barnett & Hillard, 2001; Lamb et al., 2003) and clinical supervision. If necessary, they should also engage in therapy (see Gabbard, 1995) and/ or specialised training (Bridges,

1994; Spickard et al., 2002) to address issues pertaining to PTSC that, if overlooked, poorly understood or managed, may potentially disrupt or derail their patients' treatment and well-being, their own careers and taint the profession of psychology.

References

Abel, G.G., Barrett, & Gardos, P.S. (1992). Sexual misconduct by physicians. *Journal of the Medical Association of Georgia, 81*, 237-246.

Ackerley, G.D., Burnell, J., Holder, D.C., & Kurdek, L.A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice, 19*, 624-631.

Aikin, K.A. (1960). Professional secrecy as an enforceable obligation. *Proceedings of the Medico-Legal Society of Victoria, 9*, 1.

Akamatsu, T.J. (1988). Intimate relationships with former clients: National survey of attitudes and behaviour among practitioners. *Professional Psychology, 19*, 454-458.

American Psychological Association, (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychological Association Ethics Committee. (1997). Report of the Ethics Committee, 1996. *American Psychologist, 52*, 897-905.

American Psychological Association Ethics Committee (1999). Report of the Ethics Committee, 1998. *American Psychologist, 54*, 701-710.

Anderson, S., & Kitchener, K. (1996). Nonromantic, posttherapy relationships between psychologists and former clients: An exploratory study of critical incidents. *Professional Psychology: Research and Practice, 27*, 59-66.

Anderson, S., & Kitchener, K. (1998). Nonsexual posttherapy relationships. Framework to assess ethical risks. *Professional Psychology: Research and Practice, 29*, 91-99.

Appelbaum, P.S., & Jorgenson, L. (1991). Psychotherapist-patient sexual contact after termination of treatment: An analysis and a proposal. *American Journal of Psychiatry, 148*, 1466-1473.

Australian Psychological Society. (1995). *Code of professional conduct*. Carlton South, Australia: Author.

Australian Psychological Society. (1997/ 1999). *Code of Ethics*. Carlton South, Australia: Author.

Bachman, K.M., Bossi, J., Moggi, F., Stirnemann-Lewis, F., Sommer, R., & Brenner, H. (2000). Nurse-patient sexual contact in psychiatric hospitals. *Archives of Sexual Behaviour, 29* (4), 335-347.

Bajt, T.R., & Pope, K.S. (1989). Therapist-patient sexual intimacy involving children and adolescents. *American Psychologist, 44*, 455.

Barlow, D.H. (2001). *Clinical handbook of psychological disorders*. (3rd ed.). New York: Guilford Press.

Barnett, J.E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research and Practice, 32*, 205-210.

Bartell, P.A., & Rubin, L.J. (1990). Dangerous liaisons: Sexual intimacies in supervision. *Professional Psychology: Research and Practice, 21*, 442-450.

Bates, C.M., & Brodsky, A.M. (1989). *Sex in the therapy hour: A case of professional incest*. New York: Guilford.

Blatt, S.J. (2001). Commentary: The therapeutic process and professional boundary guidelines. *The Journal of the American Academy of Psychiatry and the Law, 29* (3), 290-293.

Bolognini, S. (1994). Transference: Erotised, erotic, loving, affectionate. *International Journal of Psychoanalysis, 75*, 73-86.

Bonasia, E., & Slotkin, P. (2001). The countertransference: Erotic, erotised and perverse. *International Journal of Psychoanalysis, 82* (2), 249-262.

Bond, A.H. (1998). A review of therapists at risk: The perils of the intimacy of the therapeutic relationship. *Psychoanalytic Psychology, 15*, 439-442.

Bouhoutsos, J.C., Holroyd, J., Lerman, H., Forer, B.R., & Greenberg, M. (1983). Sexual intimacy between psychotherapists and patients. *Professional Psychology: Research and Practice, 14*, 185-196.

Brady, J.L., Healy, F., Norcross, J.C., & Guy, J.D. (1995). Stress in counselors: An integrative research review. In W. Dryden (Ed.), *Stress in counselling in action* (pp. 1-27). Newbury Park, CA: Sage.

Bridges, N.A. (1994). Meaning and management of attraction: Neglected areas of psychotherapy training and practice. *Psychotherapy, 31*, 424-433.

Brodsky, AM (1989). Sex between patient and therapist: Psychology's data and response. In: G.O. Gabbard (Ed). *Sexual Exploitation in Professional Relationships* (pp. 15-25). Washington: American Psychiatric Press.

Brooks, G.R. (1990). The inexpressive male and vulnerability to therapist-patient sexual exploitation. *Psychotherapy, 27*, 344-349.

Celenza, A. (1998). Precursors to therapist sexual misconduct: Preliminary findings. *Psychoanalytic Psychology, 15*, 378-397.

Celenza, A., & Hilsenroth, M. (1997). Personality characteristics of mental health professionals who have engaged in sexualized dual relationships: A Rorschach investigation. *Bulletin of the Menninger Clinic, 61*, 90-107.

Coleman, E., & Schaefer, S. (1986). Boundaries of sex and intimacy between client and counselor. *Journal of Counselling and Development, 64* (5), 341-344.

Corey, M.S., & Corey, G. (1989). *Becoming a helper*. Pacific Grove, CA: Brooks/ Cole Publishing Company.

Cruikshanks, D.R. (2000). An investigation of factors affecting sexual boundary violations in counseling supervision. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 61* (5-A), 1750.

deMayo, R.A. (2000). Patients' sexual behavior and sexual harassment: A survey of clinical supervisors. *Professional Psychology: Research and Practice, 31* (6), 706-709.

Ellard, J. (1996). Comment. *Australian and New Zealand Journal of Psychiatry, 30*, 131-132.

Epstein, R.S. (2002). Posttermination boundary issues. *American Journal of Psychiatry, 159* (5), 877-878.

Epstein, R.S., Okasha, A., & Kay, J. (2003). *Professional ethics and boundaries, in Psychiatry* (2nd ed.). London: John Wiley & Sons.

Faulkner, K., & Faulkner, T. (1997). Managing multiple relationships in rural communities: neutrality and boundary violations. *Clinical Psychology: Science and Practice, 4*, 225-234.

Feldman-Summers, S., & Jones, G. (1984). Psychological impacts of sexual contact between therapists or other health care practitioners and their clients. *Journal of Consulting and Clinical Psychology, 52*, 1061-1054

Folman, R.Z. (1991). Therapist-patient sex: Attraction and boundary problems. *Psychotherapy, 28*, 168-173.

Gabbard, G.O. (1994). Psychotherapists who transgress sexual boundary violations. *Bulletin of the Menninger Clinic* , *58*, 124-135.

Gabbard, G.O. (1995). Countertransference: The emerging common ground. *International Journal of Psychoanalysis, 76*, 475-485.

Gabbard, G.O. (1997). Lessons to be learned from the study of sexual boundary violations. *Australian and New Zealand Journal of Psychiatry, 31*, 321-327.

Galletly, C. (1996). Comment. *Australian and New Zealand Journal of Psychiatry, 30*, 132-133.

Garrett, T. (1998). Sexual contact between patients and psychologists. *Psychologist, 11* (5), 227-230.

Garrett, T., & Davis, J. (1994). Epidemiology in the U.K. In D. Jehu (Ed.), *Patients as victims: Sexual abuse in psychotherapy and counselling* (pp. 37-57). Chichester, England: Wiley.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1986). Psychiatrist-patient sexual contact: Results of a national survey 1: Prevalence. *American Journal of Psychiatry, 143* (9), 1126-1131.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (1987). Reporting practices of psychiatrists who knew of sexual misconduct by colleagues. *American Journal of Orthopsychiatry, 57*, 287-295.

Goldberg, S. (1973). *The inevitability of patriarchy*. New York: William Morrow.

Gonsiorek, J.C. (1995). Assessment for rehabilitation of exploitive health care professionals and clergy. In J.C. Gonsiorek (Ed.), *Breach of trust: Sexual exploitation by health care professionals and clergy* (pp. 145-162), Thousand Oaks, CA: Sage.

Gorton, G.E., Samuel, S.E., & Zebrowski, S.M. (1996). A pilot course for residents on sexual feelings and boundary maintenance in treatment. *Academic Psychiatry, 20*, 43-54.

Grech, P.L. (1992). *Therapist, client and sexual contact: The ethical quandary*? Unpublished paper presented in university academic unit.

Haas, L.J., & Hall, J.E. (1991). Impaired, unethical, or incompetent? Ethical issues for colleagues and ethics committees. *Register Report, 16* (4), 6-8.

Haspel, K.C., Jorgenson, L.M., Wincze, J.P., & Parsons, J.P. (1997). Legislative intervention regarding therapist sexual misconduct: An overview. *Professional Psychology: Research and Practice, 28*, 63-72.

Healey, B.J. (Dec. 1984). Legal correspondence in response to The Victorian Psychological Council versus the psychologist under investigation. [Documents perused by author].

Hillman, J., & Stricker, G. (2001). The management of sexualized transference and counter-transference with older adult patients: Implications for practice. *Professional Psychology: Research and Practice, 32* (3), 272-277.

Holroyd, LC., & Brodsky, AM. (1977). Psychologists' attitudes and practices regarding erotic and non-erotic physical contact with patients. *American Psychologist, 32*, 843-849.

Holroyd, J.C., & Brodsky, AM. (1980). Does touching patients lead to sexual intercourse? *Professional Psychology, 11*, 807-811.

Housman, L.M., & Stake, J.E. (1999). The current state of sexual ethics training in clinical psychology: Issues of quantity, quality, and effectiveness. *Professional Psychology: Research and Practice, 30* (3), 302-311.

Irons, R.R., & Schneider, J.P. (1999). *The wounded healer: Addiction-sensitive approach to the sexually exploitive professional*. Northvale, NJ: Aronson.

Jackson, H., & Nuttall, R. (2001). A relationship between childhood sexual abuse and professional sexual misconduct. *Professional Psychology: Research and Practice, 32* (2), 200-204.

Kroll, J. (2001). Boundary violations: A culture-bound syndrome. *The Journal of the American Academy of Psychiatry and the Law, 29* (3), 274-283.

Ladany, N., O'Brien, K.M., Hill, C.E., Melincoff, D.S., Knox, S., & Peterson, D.A. (1997). Sexual attraction toward clients, use of supervision, and prior training: A qualitative study of predoctoral psychology interns. *Journal of Counselling Psychology, 44*, 413-424.

Lamb, D., Catanzaro, S., & Moorman, A. (2003). Psychologists reflect on their sexual relationships with clients, supervisees, and students: Occurrence, impact, rationales and collegial intervention. *Professional Psychology: Research and Practice, 34* (1), 102-107.

Lamb, D.H., Strand, K.K., Woodburn, J.R., Buchko, K.J., Lewis, J.T., & Kang, J.R. (1994). Sexual and business relationships between therapists and former clients. *Psychotherapy, 31*, 270-278.

McCartney, LL. (1966). Overt transference. *Journal of Sex Research, 2*, 227-237.

Malmquist, C.P., & Notman, M.T. (2001). Psychiatrist-patient boundary issues following Treatment termination. *American Journal of Psychiatry, 158*, 1010-1018.

Morrison, J., & Morrison, T. (2001). *Psychiatrists disciplined by a state medical board. American Journal of Psychiatry, 158* (3), 474-478.

Nuttall, R. (1997). *Childhood abuse: Effects on clinicians' personal and professional lives.* Thousand Oaks, CA: Sage.

Orr, P. (1997). Psychology impaired? *Professional Psychology: Research and Practice, 28*, 293-296.

Parsons, J.O., & Wincze, J.P. (1995). A survey of client-therapist sexual involvement in Rhode Island as reported by subsequent treating therapists. *Professional Psychology: Research and Practice, 26*, 171-175.

Pattison, LE. (1973). Effects of touch on self-exploration and the therapeutic relationship. *Journal of Consulting and Clinical Psychology, 40*, 170-175.

Plaut, S.M. (2001). Sexual misconduct by health professionals: Rehabilitation of offenders. *Sexual and Relationship Therapy, 16* (1), 7-13.

Pope, K. (1990). Therapist-patient sexual involvement: A review of the research. *Clinical Psychology Review, 10*, 477-490.

Pope, K.S. (1990). Therapist-patient sex abuse: Six scientific, professional, and practical dilemmas in addressing victimisation and rehabilitation. *Professional Psychology: Research and Practice, 21*, 227-239.

Pope, K.S. (1994). *Sexual involvement with therapist: Patient assessment, subsequent therapy, forensics.* Washington, DC: American Psychological Association.

Pope, K.S., Keith-Spiegal, P., & Tabachnick, B.G. (1986). Sexual attraction to clients. The human therapist and the (sometimes) inhuman training system. *American Psychologist, 41*, 147-158.

Pope, K.S., Levenson, H., & Schover, L.R. (1979). Sexual intimacy in psychological training: Results and implications of a national survey. *American Psychologist, 34*, 682-689.

Pope, K.S., & Vetter, V.A. (1991). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy, 28*, 429-438.

Quadrio, C. (1992). Sex and gender and the impaired therapist. *Australian and New Zealand Journal of Psychiatry, 26*, 346-363.

Quadrio, C. (1996). Sexual abuse in therapy: Gender issues. *Australian and New Zealand Journal of Psychiatry, 30*, 124-133.

Reber, A.S. (1985). *Dictionary of psychology*. New York: Penguin Books.

Reports of the Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1613.

Rodolfa, E., Hall, T., Holms, V., Davena, A., Komatz, D., Antunez, M., & Hall, A. (1994). The management of sexual feelings in therapy. *Professional Psychology: Research and Practice, 25*, 168-172.

Roman, B., & Kay, J. (1997). Residency education on the prevention of physician-patient sexual misconduct. *Academic Psychiatry, 21*, 26-34.

Rutter, P. (1981). *Sex in the forbidden zone*. Toronto, Canada: Ballentine Books.

Rutter, P. (1989). Sex in the forbidden zone. *Psychology Today, October,* 34-38.

Samuel, S.E., & Gorton, G.E. (1998). National survey of psychology internship directors regarding education for prevention of psychologist-patient sexual exploitation. *Professional Psychology: Research and Practice, 29*, 86-90.

Schank, J., & Skovholt, T. (1997). Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research and Practice, 28*, 44-49.

Setô, M.C. (1995). Sex with therapy clients: Its prevalence, potential consequences, and implications for psychology training. *Canadian Psychology, 36*, 70-86.

Shavit, N. (2001). Sexual involvement between psychotherapists and their former patients: Psychoanalytic perspectives and professional implications. *Dissertation Abstracts International Section B: The Sciences and Engineering, 62* (4-B), 2078.

Shephard, M. (1971). *The love treatment: Sexual intimacy between patients and psychotherapists.* New York, Peter H Wyden.

Sherman, C. (1993). Behind closed doors: Therapist-client sex. *Psychology Today, 2*, 64-72.

Shoenfeld, L.S., Hatch, J.P., & Gonzalez, J.M. (2001). Responses of psychologists to complaints filed against them with a state licensing board. *Professional Psychology: Research and Practice, 32* (5), 491-495.

Shostrom, E.L. (1965). *Three approaches to psychotherapy* (Parts 1 & 3; Film). Orange, CA: Psychological Films.

Simon, R.I. (1999). Therapist-patient sex: From boundary violations to sexual misconduct. *Psychiatric Clinics of North America, 22*, 31-47.

Simon, R.I. (2001). Commentary: treatment boundaries – Flexible guidelines, not rigid standards. *The Journal of the American Academy of Psychiatry and the Law, 29* (3), 287-289.

Smolar, A.I., & Akhtar, S. (2002). Why no sex? *American Journal of Psychotherapy, 56* (2), 260-261.

Spickard, A., Swiggart, W.H., Manley, G., & Dodd, D. (2002). A continuing education course for physicians who cross sexual boundaries. *Sexual Addition and Compulsivity, 9* (1), 33-42.

Stake, J.E., & Oliver, J. (1991). Sexual contact and touching between therapist and client: A survey of psychologists' attitudes and behaviour. *Professional Psychology: Research and Practice, 22*, 1-11.

Stirzaker, A. (2000). 'The taboo which silences': Is erotic transference a help or hindrance in the counselling relationship? *Psychodynamic counselling, 6* (2), 197-213.

Stone, A.A. (1983). Sexual misconduct by psychiatrists: The ethical and clinical dilemma of confidentiality. *American Journal of Psychology, 40*, 195-197.

Stone, M.H. (1976). Boundary violations between therapist and patient. *Psychiatric Annals, 6*, 670-677.

Vinson, J.S. (1987). Use of complaint procedures in cases of therapist-patient sexual contact. *Professional Psychology: Research and Practice, 18*, 164.

Walby, S (1990). *Theorizing patriarchy*. Oxford: Blackwell.

Wegman, R., & Lane, R. (2001). Therapist-patient sexual contact: Some dynamic considerations regarding etiology and prevention. *Journal of Psychotherapy in Independent Practice, 2* (3), 73-90.

Weinrach, S.G. (1990). Rogers and Gloria: The controversial film and the enduring relationship. *Psychotherapy, 27*, 282-290.

Weinrach, S.G. (1991). Rogers' encounter with Gloria: What did Rogers know and when? *Psychotherapy*, 504-506.

Williams, M.H. (1997). Boundary violations: Do some contended standards of care fail to encompass commonplace procedures of humanistic, behavioural and eclectic psychotherapies? *Psychotherapy, 34*, 239-249.

Williams, M.H. (2000). Victimized by "Victims": A taxonomy of antecedents of false complaints against psychotherapists. *Professional Psychology: Research and Practice, 31* (1), 75-81.

Williams, J., & Swartz, M. (1998). Treatment boundaries in the case management relationship: A clinical case and discussion. *Community Mental Health Journal, 34*, 299-311.

Wincze, J.P., Richards, J., Parsons, J., & Bailey, S. (1996). A comparative survey of therapist sexual misconduct between an American state and an Australian state. *Professional Psychology: Research and Practice, 27* (3), 289-294.

Wood, B.J., Klein, S., Cross, H.J., Lammers, C.J., & Elliot, J.K. (1985). Impaired practitioners: Psychologists' opinions about prevalence, and proposals for intervention. *Professional Psychology: Research and Practice, 16,* 843-850.

Woody, R.H. (1998). Bartering for psychological services. *Professional Psychology: Research and Practice, 29*, 174-178.

Wright, R.H. (1985). The Wright way: Who needs enemies? *Psychotherapy in Private Practice, 3*, 111-118.

Zelen, S.L. (1985). Sexualization of therapeutic relationships: The dual vulnerability of patient and therapist. *Psychotherapy, 22*, 178-185.

Zoller, I.K., & Miller, S.J. (1973). *The erosion of medicine from within.* In E. Friedson (Ed.). The professions and their prospects. London: Sage.

Dual or Multiple Professional Relationships

At times psychologists may find themselves in a situation where different professional services are required by the same client and where the goals of those services are not necessarily compatible. An example of a dual professional relationship would be the case of a psychologist engaging in both therapeutic and court-reporting relationships with the same client. There is the potential for these roles to be confused and consequently the risk of boundary violations. The ethics of treatment and those of providing forensic reports are very different since in treatment there is the duty of beneficence, whereas in a court setting there is a duty to discover the truth.

Former Clients

Boundary issues can occur with former clients, and the psychologist should always be aware that a former client may wish to re-establish the psychologist/client relationship in the future.

Summary

In many areas there can be no absolute guidelines for ethical boundary management. It is the responsibility of psychologists to inform themselves of the risks of boundary violations and the potential for harm or exploitation of current and former clients that boundary violations entail and to respond appropriately.

Where Multiple Relationships Arise:

- The psychologist must consider whether their personal needs are taking precedence over the needs of the current or former client. Often this problem occurs when the psychologist is experiencing personal difficulties, for example, separation or loss of some kind. In family, social, academic or business relationships the expectations and obligations are different from those of the psychologist/client relationship. Frequently the psychologist gains special knowledge about a client, and the relationship contains an inherent power differential. Self-disclosure based on psychologists' needs should only occur in appropriate settings, such as supervision of the psychologist with a colleague.
- The psychologist needs to consider their personal agenda and what he/she stands to gain through the dual or multiple relationships with the current or former client. Evidence suggests that there is considerable scope for rationalisation in such situations and it is highly recommended that the psychologist consult with a professional colleague if in any doubt.
- With a former client, psychologists should carefully consider to what extent they and the former client can be equals in the new relationship. Is the client still dependent on the psychologist? Would the former client want to re-establish a professional relationship in the future? Important considerations would include the nature and duration of the psychologist/client relationship. Ethically, the new role must not undo the good of the old role. Psychologists may need to consider a moratorium of sufficient length of time before establishing a social relationship with a former client.
- Finally, in this difficult area the responsibility for maintaining boundaries is the psychologist's, not the client's. Psychologists must exercise sound professional judgement in all cases in order to maximise their client's autonomy while minimising risk of harm to the client.

References

Anderson, S. K., & Kitchener, K. S. (1996). Nonromantic, posttherapy relationships between psychologists and former clients: An exploratory study of critical incidents. *Professional Psychology: Research and Practice*, 27, 59-66.

Gabbard, G. O. (1996). Lessons to be learned from the study of sexual boundary violations. *American Journal of Psychotherapy*, 50, 311-322.

Gottlieb, M. C. (1993). Avoiding exploitive dual relationships: A decision-making model. *Psychotherapy*, 30, 41-48.

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry*, 155, 409-414.

Hermansson, G. (1997). Boundaries and boundary management in counselling: The never-ending story. *British Journal of Guidance and Counselling*, 25, 133-146.

Holub, E. A., & Lee, S. S. (1990). Therapists' use of nonerotic physical contact: Ethical concerns. *Professional Psychology: Research and Practice*, 21, 115-117.

O'Connor Slimp, P. A., & Burian, B. K. (1994). Multiple role relationships during internship: Consequences and recommendations. *Professional Psychology: Research and Practice*, 25, 39-45.

Owen, I. R. (1997). Boundaries in the practice of humanistic counselling. *British Journal of Guidance and Counselling*, 25, 163-174.

Schank, J. A., & Skovolt, T. M. (1997). Dual relationship dilemmas of rural and small community psychologists. *Professional Psychology: Research and Practice*, 28, 44-49.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice*, 26, 499-506.

Simon, R. I. (1991). Psychological injury caused by boundary violations precursors to therapist-patient sex. *Psychiatric Annals*, 21, 614-619.

Williams, M. H. (1997). Boundary violations: Do some contended standards of care fail to encompass commonplace procedures of humanistic, behavioural and eclectic psychotherapies? *Psychotherapy*, 34, 238-249.

Williams, J., & Swartz, M. (1998). Treatment boundaries in the case management relationship: A clinical case and discussion. *Community Mental Health Journal*, 34, 299-311.

Woody, R. H. (1998). Bartering for psychological services. *Professional Psychology: Research and Practice*, 29, 174-178.

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GUIDELINES ON THE PROSCRIPTION OF SEXUAL RELATIONSHIPS WITH CLIENTS

The *Code of Ethics* (1997/1999) of the Australian Psychological Society includes Sections that specify restrictions on the types of non-professional relationships that psychologists may have with current and former clients. In drawing up these Guidelines, it was noted that psychiatrists in Australia are prohibited from having sexual relations with any clients, regardless of time elapsed since termination of the professional relationship. These Guidelines, developed for psychologists, proscribe sexual relations with current and former clients but take into account the diverse nature of professional relationships that psychologists may have with clients, and the broad definition of client provided in the *Code of Ethics*.

Two Sections are pertinent:

Section B7

Psychologists must avoid dual relationships that could impair their professional judgement or increase the risk of exploitation. Examples of such dual relationships include but are not limited to, provision of psychological services to employees, students, supervisees, close friends or relatives.

Section B8:

Psychologists must not exploit their professional relationships with clients sexually or otherwise.

In the case of sexual relationships, the restriction on psychologists engaging in sexual relationships with clients (B8, and see below B9 to B12) is part of the broader restriction on psychologists engaging in dual relationships with clients (B7). There are also relevant specific issues related to psychologist-client physical contact (see *Guidelines relating to Procedures/Assessments that Involve Psychologist-Client Physical Contact*) and broader issues related to boundaries in professional relationships (see *Guidelines on Managing Professional Boundaries and Multiple Relationships*).

Sexual relationships are not just relationships involving sexual intercourse but are construed more broadly.

The restrictions on sexual relationships with current and former clients (as defined below) are set out in the *Code*:

Section B9:

Sexual relationships between psychologists and current clients must not occur. When a therapeutic procedure entails some level of physical intimacy with a client, informed written consent must be obtained from the client or the client's legal guardian prior to the introduction of that procedure.

Section B10:

No psychologist may engage in a sexual relationship with a former client when less than two years have expired since the ending or termination of the professional relationship.

Section B11:

In circumstances where more than two years have elapsed since the ending or termination of the professional relationship between psychologist and former client, in determining whether a sexual relationship between psychologist and former client is unethical, the following matters will be taken into consideration:

a) the length of the professional relationship;

b) the nature of the professional relationship;

c) the client's mental state at the time he or she commenced the sexual relationship with the psychologist;

d) the circumstances in which the professional relationship ended or was terminated;

e) the duration of time that has expired since the ending of the professional relationship.

Additionally, any other salient matters may be taken into consideration when evaluating the conduct of a psychologist who has engaged in a sexual relationship with a former client.

Section B12:

Where it has been established that a sexual relationship existed between a psychologist and a former client after the expiry of 24 months from the ending or termination of professional relationship, the onus shall be on the psychologist to establish that the client was not vulnerable to exploitation as a consequence of the prior professional relationship.

A psychologist who is found to have engaged in a sexual relationship with a client or former client may be liable for a range of sanctions including expulsion from the Society. Psychologists should also note that Psychologists Registration Boards in Australia have de-registered psychologists for engaging in sexual relations with clients, and malpractice litigation has successfully occurred against mental health professionals who have engaged in similar behaviour.

Rationale for the prohibition:

The prohibition on psychologists engaging in sexual relations with current or former clients is based on five factors:

- clients may be vulnerable to exploitation in the context of the therapeutic, teaching, consulting and supervisory relationship. Hence, particular safeguards - such as the prohibition on sexual relationships - are required to protect clients.
- clients who engage in sexual relationships with therapists are frequently adversely affected by the experience.
- the personal involvement of psychologists with clients impairs the provision of professional services to the client.
- sexual relationships with clients are not a legitimate part of therapy and can never constitute an appropriate therapeutic intervention or any other service. Hence, there can never be a legitimate professional reason for sexual involvement with a client.
- relations with former clients may be exploitative given the previous power differential inherent in the professional relationship of psychologist and client.

Clients sometimes develop intense feelings of affection for their psychologist and vice versa and these feelings may or may not be welcomed by the other party. This phenomenon is described within the psychoanalytic framework by the concepts of transference and counter transference. There are many psychologists who would acknowledge the existence of the phenomenon without accepting this explanation of its underpinnings. However, it is the responsibility of the psychologist as the professional to recognise the boundaries. Recognising the possible existence of intense emotions between clients and psychologists is essential if proper management of the relationship is to be maintained.

Common questions answered:

1. Who is the client?

The *Code of Ethics* defines 'client' as the recipient of psychological services. The term may subsume patients, students, research participants, supervisees, other direct recipients, other professionals, referral agencies or organisations. Psychologists should be mindful that the person they see in their consulting room or office may not be the only party with whom they have a relationship and to whom they have responsibilities.

2. Does the prohibition apply to all clients?

Some have argued that the prohibition on psychologists engaging in sexual relationships with clients really only has merit and application for clients who have been in long-term therapy or counselling, where intimate issues have been canvassed and a strong relationship developed between the client and

psychologist. However, it is the view of the Australian Psychological Society that psychologists must not engage in sexual relationships with *any* of their clients, irrespective of the duration and intensity of the professional relationship.

3. What is a professional relationship?

While the *Code of Ethics* provides a definition of 'client', a professional relationship exists when there is a contract to provide a psychological service. In the case of an individual person, the contract is with that person; in the case of an organisation, then the individual may or may not be the direct client. That is, the nature of the professional relationship with an individual within an organisation may be neither contractual nor direct. Thus, any subsequent sexual relationship may or may not be proscribed. However, the onus still rests with the psychologist to demonstrate that the nature of the professional relationship that exists or existed is not compromised.

4. Former clients

Psychologists are absolutely prohibited from engaging in sexual relationships with current clients. In relation to former clients, psychologists are prohibited from engaging in sexual relationships for a period of two years after the professional relationship ends or is terminated. Note that any psychologist who engages in a sexual relationship with a former client after the expiry of this time may be judged to have behaved unethically if such action exploited the former client. Sections B11 and B12 of the *Code*, reproduced above, elaborate on this issue.

5. Does ending the professional relationship escape the prohibition?

Not necessarily. As previously noted, the prohibition on psychologists engaging in sexual relations with clients applies to former clients for at least two years after the professional relationship has ended or been terminated. After this period of time, the onus would be on the psychologist to demonstrate that his/her conduct was not exploitative of a former client.

6. Sexual relationships are dual or multiple relationships

The prohibition on psychologists engaging in sexual relationships with clients is part of a broader prohibition on psychologists' exploitation of their professional relationships with clients and of a restriction on psychologists engaging in dual or multiple relationships with clients where professional judgement could be impaired.

July 1998

ETHICAL GUIDELINES RELATING TO PROCEDURES/ASSESSMENTS THAT INVOLVE PSYCHOLOGIST-CLIENT PHYSICAL CONTACT

Clients may be vulnerable to exploitation in professional relationships. Clients' abilities to make judgements about their welfare may be threatened by: the power differential between them and their psychologist; ignorance of accepted therapeutic practices; trust in the knowledge, skill and integrity of the psychologist. Hence, psychologists must ensure that they discharge adequately their duty to protect the client and preserve the integrity of the client-psychologist relationship, particularly when employing procedures involving psychologist-client physical contact. This ethical guideline does not cover informal physical contact such as shaking hands on greeting or a comforting touch on hand or shoulder.

Guiding Principles

1. Psychologists must be especially sensitive to social and cultural conventions and practices in the clients' own communities, when contemplating procedures involving psychologist-client physical contact. For example, in some cultures, physical contact in any form may be totally unacceptable to clients. Psychologists should check with the client or guardian what specific physical contact might be acceptable.

   General Principles (APS Code of Ethics, 1997/1999)

   III Propriety

   (b) Psychologists must be sensitive to cultural, contextual, gender and role differences and the impact of those on their professional practice on clients ...

2. Psychologists must ensure that they provide sufficient information to clients to enable them to provide full and informed written consent to treatment.

   Section A: Psychological Assessment Procedures (APS Code of Ethics, 1997/1999)

   2. Psychologists must supply clients with explanations of the nature and purpose of the procedures used and results of the assessment, in language the recipient can understand and with appropriate accompanying contextual information ...

   Section B: Relationships With Clients (APS Code of Ethics, 1997/1999)

   5. When working with young persons or other clients who are unable to give voluntary, informed consent, psychologists must protect these clients' best interests and will regard their responsibilities as being directed to the parents, next of kin, or guardians. The psychologist shall endeavour to obtain consent of young people and these other clients.

   Section E: Research (APS Code of Ethics, 1997/1999)

   4. Psychologists must preserve and protect the respect and dignity of all [research] participants and endeavour to ensure that participants' consent to be involved in the research is voluntary. Wherever possible, participants must be appropriately informed of the nature and purpose of the investigation. Psychologists must inform participants of the nature of the research and that they are free to participate or decline to participate or to withdraw from the research. Such informed consent must be appropriately documented.

   12. The psychologist must take all reasonable steps to ensure participants are not exposed to risk of injury incidental to the procedures used, for example, from faulty stimulus presentation or recording equipment.

3. Where interventions or assessments are employed that require physical contact between psychologist and client (e.g., biofeedback), it is always necessary that a third party be in the immediate vicinity. A client's wishes to have a third party present should be respected. The location and identity of the third party (partner, family member, employee of the psychologist etc) must be agreed upon before the commencement of the therapeutic activity.

4. Procedures that require the client to be undressed, partially or fully, are exceptional and go beyond the boundaries of established practice. In the unusual circumstances where this may be appropriate, the

5. When research, assessment or treatment procedures are employed that measure genital response, the attachment of instrumentation must be performed by the client, in private. If this is not possible and/or not appropriate, the requirements of (i) written informed consent, and (ii) the presence of a third party are to be complied with stringently by the psychologist.

6. It is unethical for a psychologist to engage in any form of activity with the client which could be construed as sexual and/or which reduces professional objectivity. If a psychologist, engaged in a therapeutic role with a client, identifies personal feelings suggesting physical attraction which could lead to sexual intimacies, the psychologist should consider therapy or supervision for him or herself, or terminate therapy and take steps to refer the client elsewhere immediately.

Section B: Relationships With Clients (APS Code of Ethics, 1997/1999)

8. Psychologists must not exploit their professional relationships with clients sexually or otherwise.

9. Sexual relationships between psychologists and current clients must not occur. When a therapeutic procedure entails some level of physical intimacy with a client, informed written consent must be obtained from the client or the client's legal guardian prior to the introduction of that procedure.

September 1998

The Australian Psychological Society Ltd

ABN 23 000 543 788

CHARTER FOR CLIENTS OF PSYCHOLOGISTS

Before people can work as psychologists they must be registered with the Psychologists' Registration Board in their State or Territory. Boards are administered through Acts by the State and Territory Ministers of Health. Your psychologist should be displaying his or her current registration certificate. Your psychologist may also be a member of the Australian Psychological Society (APS), which is the largest professional association of psychologists in Australia, and the author of the profession's Code of Ethics.

As a client of a psychologist, you have a right to expect that:

- You will be treated with respect
- You will receive a clear explanation of the service you will receive
- Your consent for any service will be sought by the psychologist prior to the service commencing and as it progresses
- You will receive an explanation about the nature and limits of confidentiality surrounding the service
- You will receive competent and professional service
- You will receive a clear statement about fees
- You will be clear about the outcome that you and the psychologist are working toward
- You will receive an estimate of the number of sessions required to achieve the outcome
- You will receive a service free from sexual harassment
- You will be shown respect for your cultural background and language tradition

NOTE:
If you have any concerns about the conduct of your psychologist, call either the Psychologists' Registration Board in your State or Territory, or the Australian Psychological Society on 1800 333 497 or (03) 8662 3300.

February 2002

Research Project 3

Psychopathic Traits in a Young Person with Conduct Disorder

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Minor Placement Report, submitted in March, 2003, in partial fulfilment

of the requirements for the degree of:

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AUSTRALIA

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Abstract

A case study of a 13 year old boy with previous DSM-IV diagnoses of Attention-Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD), referred for therapy as part of a Probation Order, is presented. The young person's offences included several counts of theft and burglary. A Conduct Disorder (CD) diagnosis was established at assessment. Personality testing indicated highly elevated scores on four Millon Adolescent Clinical Inventory (MACI) base scales; Delinquent Predisposition, Unruly, Social Insensitivity and Impulsive Propensity. Psychometric evaluation with the Wechsler Intelligence Scale for Children, Third Edition (WISC-III), Australian Adaptation, placed the young person at the 84th percentile (high average range) of general intelligence. Performance IQ and Processing Speed Index scores were at the 95th and 97th percentiles. Cognitive testing was perceived by the young person as an opportunity to display his intellectual ability. Neuro-psychological indications of attention, concentration or working memory difficulties or psychomotor retardation – common in ADHD profiles – were absent. His observed verbal (versus performance) scale inferiority has been documented in forensic populations. In addition to his intellect, the young person's mother reported that her son excelled in most sports. Shortly before referral, he had been expelled from school (for the third time) and had a history of failing to form positive relationships with adults, preferring the company of individuals from his own or younger age groups whom he felt able to influence or impress. He resided at home with his mother and two younger siblings, with only occasional paternal contact. His father had moved out a decade earlier and evaded attempts to be contacted by the author and Juvenile Justice Office. Initial interventions were centred on establishing rapport and consistent contact, engaging around preferred activities such as sport, developing a busy, predictable schedule that involved the young person in meaningful activity, and offering positive reinforcement and pro-social behaviour modelling. Ongoing therapy involved validation of his life experiences, uncovering the depth of previously concealed antisocial behaviours and related cognitions, combined with minimization of the risk of secondary gains arising from his belief that any illegal or immoral behaviours (and justifications) were acceptable. In this regard, a fine line was maintained in which the prominent underlying egotistic and narcissist trends in personality were – rather than being ignored or suppressed – harnessed towards competitive scholastic and sporting achievement, instead of entirely hedonistic, anarchic or nihilistic behaviours and attempts to manipulate others. Pre-planning for school reenrolment was also undertaken, with a view to establishing strong internal and external support networks and liaison between all parties. To this end, a management plan was developed to reduce splitting by the young person, to increase uniformity and clarity regarding each person's function and to maximise the ultimate goal of eventual normal social integration.

Presenting Problem: Referral from Juvenile Justice Department

A 12 year, 11 month old first-time (detected) offender, George Croft[1] was the first person referred to the author in his role as consultant psychologist, with the state-wide Adolescent Forensic Health Service (AFHS), to the local Juvenile Justice (JJ) Department (Dept.). The first 50 days of employment in this position and report herein also satisfied the requirements of the final clinical psychology doctorate placement. A description of the function, priorities and organisational structure of the AFHS, part of the Centre for Adolescent Health, is provided in Appendix E (pp. 162-164).

George had received a Probation Order at the Children's Court, with a requirement to undertake counselling as directed by his Probation Officer. His offences included numerous shop thefts and two burglaries. The formal referral of George to the author by the JJ Dept. noted a diagnosis of ADHD. Several broad areas of concern and suggested intervention were nominated, including "Anger Management", "Violence" and "Psychological Issues". These concerns arose in relation to George's offences, as well as material in psychiatric and educational reports. Reference to "uncontrollable behaviour" was made in one teacher's report from his previous school, from which he was expelled following an extensive record of indiscretions (as well as suspected arson) which had lead to numerous reprimands, after-class detentions and suspensions, his final act consisting of obscene threats against a female teacher.

Offending Behaviour

Prior to any contact with George and his family, the author was briefed about his offences and other background factors pertaining to his criminal activities by his referring JJ worker, who had prepared a pre-sentence report. Detailed reference was also made to his Children's Court Order, Police Summary of Offence documentation, correspondence from the Child Protection Dept. and relevant material in psychiatric and educational reports.

Perusal of his referring Probation officer's pre-sentence psychosocial report revealed that George's

[1] Pseudonyms have been used and other details have been altered to protect the identity of the young person

mother, Mrs. Croft (also a pseudonym), had said that her son had been "stealing before he could talk". It was noted that Mrs. Croft was always challenging him about items he had brought home which were not his. Threats by George's desperate mother to contact the police were made to her son as a last resort and had been increasingly carried out prior to George being charged with several of his offences. Although Mrs. Croft had not been involved in the provision of any evidence used against her son, it was also evident from the pre-sentence report that George resented what he referred to as his mother's "interference" in his criminal activities.

George was aged 11-12 years during the 13 month period of his proven criminal offending. His offences consisted of six counts of shoplifting, involving the theft of a jacket, CDs, video games, a cricket bat, and sneakers, all committed on his own. George had walked out of a department store wearing the sneakers he stole, after having them fitted by a saleswoman and jogging out of the store as she placed his old sneakers in a carry bag. He was apprehended by security staff after being chased and cornered in the shopping centre car park and subsequently attempted to escape when police were called. George denied selling stolen CDs to students at school, and although several statements were made by other students, additional charges were dropped. Two counts of burglary related to the theft of a bicycle and tools from inside a locked garage and the theft of numerous items from an unoccupied house that was to be auctioned several streets from where George lived.

Young Person's Background: Psychiatric/ Educational Reports

Previous psychiatric and human service reports about George and his family alluded to a DSM-IV diagnosis of ADHD (Combined Type) that had been made when George was 3½ years old by a prominent child psychiatrist, who was periodically involved with George throughout the next 8 years. Telephone contact was made with the psychiatrist, who verified George's unusually early – and subsequently verified – ADHD diagnosis in the context of oppositional, conduct disordered and extremely manipulative behaviours, in addition to a precocious intellect.

Confirmation of ADHD and coexisting ODD had been made when George was 8 years old by the

same psychiatrist. It was notable that George's hyperactivity had not ameliorated on various, sustained regimes of either stimulant or anti-psychotic medication between the ages of 3½ to 4, 6 to 7, 8 and 10 years of age. At high doses, transient sedation and, at times increased agitation, had occurred, with no diminution of his misbehaviour. The psychiatrist's view was that although the hyperactive elements of the ADHD diagnosis remained pertinent to more recent conceptualisations of his functioning, George had demonstrated over the years that he had significantly more control over his behaviour than initially believed. In the psychiatrist's view, expressed via personal communication, George had not only the qualities of an antisocial personality (except the requisite age of 18 years), but was also the most extreme form of fledgling psychopathic personality he had encountered in a young person in two decades of psychiatric practice.

From the start of George's school life, which has featured a total of three formal expulsions, his behaviour has been variously described in summary reports by principals as "outrageous", "extreme", "attention seeking", "bullying" and "disruptive". Specific behaviours included stealing (including money from teachers' handbags), "constant lying", vandalism, suspected fire lighting and the intimidation, physical and occasionally sexualised harassment of female students and teachers.

Classroom reports from several schools reported George was of above average scholastic ability but rarely completed set work and frequently orchestrated avoidance techniques, from losing pens and pencils to feigning illness. Given replacement pencils, he had been known to chew them up and swallow parts, apparently as a sign of bravado and defiance and to activate a need for medical attention in order to sabotage his class involvement. Increasing concerns were his manipulation and inciting of impressionable students to engage in a wide range of antisocial behaviours, his open defiance, threats against teachers and sexualised behaviours, including simulating masturbation or intercourse and making sexually explicit comments or threats (e.g., "I am going to rape you" and "you're a poo pusher").

Another psychiatric assessment undertaken when George was 8 years old established a diagnosis of ODD, but also acknowledged the suspicion by others of exposure to or involvement in abusive sexual experiences. Although there has been no evidence of George being a victim of sexual abuse,

conversations with his mother indicated that she had been raped during a home invasion six years earlier which George had not directly witnessed but knew about via second hand information.

Recent psychiatric appraisal by an independent therapist without previous involvement reaffirmed the existence of numerous ADHD symptoms, but postulated that his antisocial behaviour was better understood as masking underlying depressive features stemming from marked psychosocial disruption and the existence of longstanding "deprivation", with concomitant emotional difficulties. This opinion contrasted with conventional ideas of "psychopathy and depression [as] mutually exclusive constructs" (Lovelace & Gannon, 1999, p. 169). Describing him as "disturbed" but "likeable", that psychiatrist noted the theft of a $2 coin from under his desk (returned by his mother at the next session). Report recommendations, suggested in reference to George's next school placement, included the utilization of a full-time teacher's aid and psychological intervention, which was arranged. However, teachers' reports indicated that George had been abusive towards the teacher's aid and refused to talk to the school guidance officer allocated to him. He was expelled after two terms of his final year of primary school. George's mother stated to the author that although she had agreed with the psychiatric report's recommendations and appreciated the psychiatrist's support regarding her son's school placement, she believed George had "sucked him in" to believing that her son was "sad" as opposed to "bad". Mrs. Croft had also doubted whether the proposed interventions had been sufficiently "heavy duty".

In subsequent pre-testing for literacy skills in his first year of high school, George placed in the top 25% of Year 7 students. Enhanced arrangements were made incorporating the psychiatrist's previous recommendations and the institution's own protocols. The school George enrolled at was considered one of the best resourced in the state. Special arrangements were made to provide an environment which was stimulating, nurturing, consistent and incorporating firm, appropriate boundaries.

In the six months that the school's teaching staff and principal persevered prior to expelling George, daily records of his conduct were maintained. Evaluations of his behaviour were summarised as "acceptable to unbelievably distressing". A comment made by George, as reported by a new student teacher he had "targeted" (according to the principal's report), was "will all the teachers go to the

funeral if a teacher gets shot?" His treatment of other students included extortion regarding lunch money and the trafficking of cannabis. Parents had also made inquiries to the school regarding why George "gets away with murder", despite the school's graded and "sensible" use of detentions, internal suspensions, praise, "the odd bribe", appropriate encouragement and full suspensions. In conclusion, the principal had noted that during George's final suspension significant numbers of students had approached teachers from across the year level to express how much they dreaded the possibility of George's return. Numerous reports were also made to the school detailing George's extracurricular activities, including train surfing and throwing stones at cars. Interestingly, truancy and punctuality were not noted issues at this or previous schools, with George having an excellent record of attendance.

Attempts at linking George with internal and external counsellors, therapists and teacher's aids failed, as he had either refused to engage or proceeded to harass, attempt to humiliate or manipulate each professional he was referred to, until they rejected him and withdrew from ongoing involvement. George's mother indicated that George delighted in lowering the morale of helping professionals, and that the termination of involvement always "put him in a good mood". In the school summary report's closing paragraph, George was described as "shamelessly manipulative", being the "most disturbed student we have ever worked with" and "believing strongly that he requires a team of expert people to work with and for him".

Adolescent Psychopathy

The increasingly refined concept of psychopathy is based primarily on psychometric research using subgroups of adult forensic populations (Hare, Forth, & Haft, 1989; Hare, 1993), but its relevance to crime across the lifespan is becoming more widely accepted (Hare, Forth, & Strachan, 1992). Two growing areas of research are the trajectory of childhood ADHD and CD in relation to adult substance abuse, personality disorders (PDs) and criminality (Baker, Knight, & Simpson, 1995; Eyestone & Howell, 1994; Farrington, Loeber, & Van Kammen, 1990; Zoccolillo, Pickles, Quinton, & Rutter, 1992) and the early identification of psychopathy in children and adolescents (Forth, Hart, & Hare,

1990; Frick, O'Brien, Wootton, & McBumett, 1994; Lynam, 1996, 1997, 1998).

Although aggressive and antisocial behaviours are traditionally the primary reason up to half of all child and adolescent clinic referrals (Robins, 1981), much less than half of antisocial youth become antisocial adults (Farrington, 1983). Furthermore, over 50% of adolescent crime perpetrated in society is committed by a prolific minority of the offending cohort, said to be around 6% (Wolfgang, Figlio, & Sellin, 1972), with similar proportions reported among adult offenders (Lynam, 1996, 1997). This persistent criminal subset typically encompasses the psychopaths, who comprise around one fifth of prison populations, but infiltrate all sections of society (Hare, 1993).

Even more than the scale of offending, the hallmark of criminal psychopathy its sheer variety (Hare, 1993), with the distinguishing feature of psychopathy per se the core personality factors additional to the behavioural manifestations of CD and APD. These defining traits include pathological lying, lack of empathy, manipulation, grandiosity marked by a grossly inflated and insightless sense of entitlement, superficiality, shallow affect, callousness and boredom proneness (Hare, 1993; Lynam, 1996). Many indications or clear cut evidence of these personality traits were evident in George's file reports, with floridly manipulative behaviours emerging very early in life.

Social, familial, temperamental, behavioural and neuropsychological factors associated with criminal activity include early family disruption, low levels of affection and cohesiveness, lack of discipline, neglect and abuse, interaction with a pro-criminal peer group, ADHD symptoms (impulsivity and hyperactivity), egocentrism, reduced self-regulation skills, low conditioning proneness leading to weak socialisation and risk-taking conduct, and below average or relatively low verbal intelligence (Atkins & Stoff, 1993; Bleiberg, 2001; Devita, Forth, & Hare, 1990; Dolan, 1994; Farrington, Hart, Forth, & Hare, 1990; Hinshaw, 1994; Loeber & Van Kammen, 1990; Moffitt & Lynam, 1994; Zoccolillo, Pickles, Quinton & Rutter, 1992), with neuropsychological differentiation of psychopathic and nonpsychopathic criminal offenders even proposed (Hart, Forth, & Hare, 1990). In George's assessment, all of these factors were carefully evaluated.

The importance of contributions from multiple informants in assessing ADHD and disruptive child

behaviour has been outlined (see Loeber, Green, Lahey, & Stouthamer-Loeber, 1991). In George's case, the evidence from archival educational sources for psychiatric diagnoses underpinning his unruly behaviour was compelling. When interviewed, his mother provided further confirmation of clear signs of persistent, underlying personality features that augured for the existence of fledgling psychopathy.

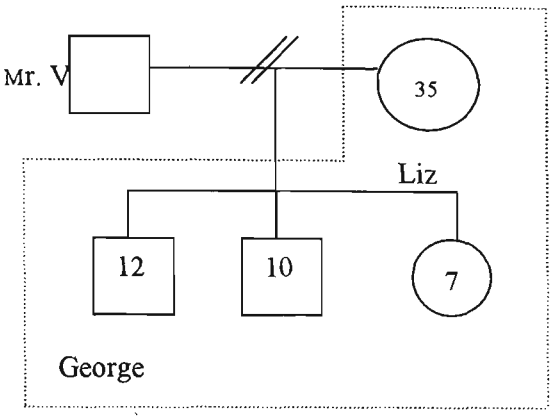
A key issue in psychopathy research is the utility of treatment. Although not yet indicated in psychopathic adults (Hare, 1993), it is understandably considered unsavoury to imagine not attempting psychological therapies in the case of adolescents and children assessed as having psychopathic personality traits. Limited research in relation to psychopathy and PDs in younger people suggests that intensive early treatment is worthwhile and advisable (Bleiberg, 2001; Loeber & Dishion, 1983; Reid, 1981), with suitable interventions targeting the family, social, interpersonal and scholastic milieu, as well as individual functioning (Bleiberg, 2001). That author noted that "youngsters with personality disorders may come across as strikingly arrogant, defiant, and manipulative, yet their demeanour typically masks devastating experiences of vulnerability and pain" (jacket blurb) and "they excel at defeating the efforts to help them" (p.1). A feature of George's background was his capacity to derail any interventions or strategies devised by helping professionals and academic personnel to ameliorate his misbehaviour or invoke collaboration towards pro-social goals. Therefore, merely establishing a substantial and meaningful alliance was identified as a primary objective of therapy.

Psychosocial History: Interview with Mother

At referral to the author, George was awaiting placement in a new school, having been expelled during his first year of secondary school several months earlier. He lived with his 35 year old mother and two younger siblings a in a well kept, rented 3-bedroom house provided by the Dept. of Housing in a middle-class suburb that had been the place of their residence for several years. The immediate family genogram is displayed overleaf. As part of the initial assessment, the author interviewed George and his mother, Mrs. Liz Croft (whose children had assumed her maiden name), with her ex-husband, George's natural father Sam Valiotis (pseudonym), eluding all efforts to contact him.

Figure 1

George's Family Genogram (pseudonyms used)



While George was in the company of his JJ worker, Liz was interviewed by the author at home. She presented as a petite, intelligent, woman, beleaguered by a combination of George's relentless unruliness, defiance and lying and her own physical limitations and pain in relation to a chronic, degenerative back problem. Later conversations with Liz revealed that she had suffered an initial back injury as a result of her ex-husband, Sam Valiotis (pseudonym), now aged 36 years, pushing her to the ground eleven years ago. The injury had eventually required surgery, which had apparently been disadvantageous, requiring constant pain-killing medication and periodically leaving her immobilised.

Liz reported that Sam had often been violent during their marriage, describing him as a "Jekyll and Hyde" who claimed to never remember "belting me" and, to this day, "swears he never did". However, Liz said that, more than the physical mistreatment, she dreaded his "psychologic and emotional abuse". Liz used to "wonder what mood he'll be in" when he returned home from work, and said "he'd only tell you what he wanted you to know". She had "left him altogether" a few times, packing up and taking George away interstate when he was 3 years old but they "always got back together", as a result of a combination of "threats", "recriminations" and Sam's charm and crying, which "wore her down".

An only child whose own parents died early in her marriage, Liz said that Sam used to torment her, saying "You have no family". George's maternal grandmother died of cancer when George was aged 5½ years, with Liz reporting that the two had been very close. Apparently George had never "played up

to her" and had been "like butter in her hands", thanking her when she had cooked a meal and even taking his plates to the sink, something he had rarely done since. Liz' father had passed away six months later. Liz said that George had not been as close to her father, who had sometimes conflicted with Mr. Valiotis in his attempts to mete out discipline. She recalled an occasion when George was 5 years old and was trying to pick a rose for his grandmother in her own garden, against her father's advice. To teach George a lesson he had deliberately ripped the rose from George's hand, cutting his fingers.

Mr. Valiotis' own father had died two decades earlier when Sam was 8 years old. The circumstances had involved Sam jumping out to surprise his father, precipitating a massive heart attack. Liz further revealed that Sam told George after an argument with her on George's eighth birthday, "I didn't have a father, so why should you". Following further investigation, it emerged that Sam had often told George from the age of about 5 years that he was "hopeless", "no good" and "you'll never be anything". Liz said she had once asked Sam, "Do you think you are punishing George for your father's death?" but did not receive an answer. Liz said that Sam's mother, who passed away early in their marriage, had never spoken English and had been "treated like dirt" by her son. She recalled an occasion when Sam had hit her on the head with a lump of bread and deliberately poured cordial over her. Liz said that Sam had not been physically violent towards her until after they were married. Their courtship had been quite brief, and they had married in their early twenties.

Mr. Valiotis, a civil engineer, lived on his own half an hour away, separated from Liz more than a decade earlier but remaining in irregular contact. Liz said that his career was "everything" to him and he had once told her "you wreck my career and you'll end up in a river". Liz summed up her ex-husband as a "dictator" and a "tyrant" in reference to the period of their marriage, but also acknowledged that he had "mellowed out" a little in the last few years. Using the words "manipulative", "immature", "selfish" and "scheming" to describe Mr. Valiotis in reference to similarities between Sam and George, Mrs. Croft said that her ex-husband reminded her of an "adult version of George". This appraisal of Mr. Valiotis is highly relevant to George's personality trajectory in terms of known relationships between parents' and children's psychopathology relating to adolescent CD and hyperactivity (Lahey, Piacentini,

McBurnett, Stone, Hartdagen, & Hynd, 1987). According to Liz, Mr. Valiotis tended to arrange contact with their children with little, if any notice, and just as often failed to visit on time or at all, without contacting them to reschedule. Liz also said that George alternated between idolising, resenting and sometimes expressing hatred towards his father, with whom he had had little contact in the past two years. Secrecy (on Mr. Valiotis' part) had apparently been a feature of their marriage. Liz had never been informed of job changes since his departure, with cessation, reductions or delays in resumption of maintenance payments the usual indication to her that he had changed positions. Liz said that Sam resented having to pay maintenance at all, at one stage attempting to throw doubt over paternity, but her threat to order a DNA test had ended his objections.

One of the first comments Liz made to the author was "George is very different from my other kids". Her pregnancy with George, while unexpected, had proceeded well and the birth was normal. George was an active baby and toddler, achieving motor developmental milestones somewhat ahead of expectations, but was also a "difficult" infant, always fidgeting and rejecting of affection. In conjunction with frequent "misbehaviour" (with Liz citing throwing food – in itself not uncommon – as an example), Liz reiterated that George was invariably advanced in his development, crawling, walking and learning far more quickly than his siblings. Due to high activity levels as a toddler, specialist assistance was sought and he was diagnosed as suffering from ADHD when aged 3½ years. George was prescribed Mellaril[2] (Thioridazine) drops at this time, Ritalin at 6 years of age, and later dexamphetamine. Under the direction of her son's treating psychiatrist, Mrs. Croft stopped administering medications when George was about seven, as these were "not benefiting him enough to warrant it". Liz said that she followed through with all recommendations made by the psychiatrists who treated her son, often against the wishes of Mr. Valiotis, who had told her "You're going to scar my son, taking him to those nuts".

Upon cessation of medication on each occasion, there was no apparent change – either deterioration or improvement – in George's behaviour. In comparison to George, Liz depicted her younger son and

[2] Mellaril is an antipsychotic medication of the phenothiazine class. In George's case, it was used to lower arousal (activity) level and indirectly gradually improve socialisation and thinking (see Tierney et al., 2002, p. 1083)

daughter as "normal", well behaved and affectionate, which is how they presented during later home visits. George's nine year old sister had a courteous manner and engaging smile, with the author taken aback during the first home visit by her offer of a coffee, which Liz hardly needed to assist her with. Though mildly delayed developmentally and requiring extra academic assistance, Liz said that her younger son was able to be "moulded like putty – if you show him the right way of doing something he'll try his best". He presented as very reserved and Liz's description sounded a little controlling.

Liz said that she loved her eldest son George "dearly", but, pointedly, used the word "evil" when asked by the author to summarize him in a word. Liz said that since George had been expelled from his last school she had been relentlessly subjected to his difficult behaviours at home, including dominating his siblings, playing constant "mind games" with her and increasingly refusing to take anything she said seriously. When asked by the author who looked after their seven year old kelpie cross, Liz said that he had originally been bought for the family but George had found him in a pet shop and exercised some responsibility for him, assisting in his feeding and washing. Liz said that George displayed considerable affection towards him (as later observed by the author) and she knew of no instance when George had ever been vindictive towards animals, which was reassuring.

Liz' degenerative back condition periodically rendered her wheelchair-bound, occasionally requiring hospitalisation. Although her son's criminal offences were committed during a 13 month period (as determined by items recovered from previously reported thefts), Liz said that the crimes leading to his current Probation Order were mainly committed in a two week spree whilst he was voluntarily placed in government housing during her last hospital admission. Mr. Valiotis had apparently declined to look after the children, with George's siblings placed in the care of friends of Mrs. Croft who had refused to consider looking after George. Although presenting as hopeful at the introduction of another psychologist to assist with her son, Liz informed the author that George did not open up easily, if at all, with people outside the family and not to expect too much. According to his mother, George's main interests – apart from "manipulating people" – included cricket, golf and the home play station (i.e., videogames). From his mother's descriptions, positive significance was noted in relation to George's

evident intellectual and athletic prowess, the latter including state age level placings in both sprint and long distance running events in earlier years.

The author's first experience of George was one of being completely ignored when introduced, much as both his mother and the referring JJ worker had predicted. A meaningful exchange arose when the author asked George if he knew much about a recent cricket result. After initially appearing taken aback, he was quick to rifle off a series of statistics. An offer of a hit of cricket drew an enthusiastic response, with the first series of meetings based simply on developing a degree of rapport and a mutual understanding that the sessions between the author and George would be weekly, as part of the conditions of his Probation Order, as recommended by his Probation officer.

In normal circumstances, young offenders are required to make their own way to centrally based appointments with their JJ worker and therapist. However, due to George's age and his mother's inability to bring him to appointments, the author arranged to meet with him at his house. This arrangement was also aimed at reducing his likelihood of mixing with delinquent youth on the public transport system. From this point the author took George to other settings (e.g., cricket nets, cafés), with a view to encouraging open communication. When George started at a new school a month later, appointments were, for convenience, often scheduled at school after hours.

Assessment/ Treatment

Prior Diagnoses: ADHD and Oppositional Defiant Disorder

Prior to being referred to the author by the JJ Dept., George had received formal diagnoses with two psychiatric disorders, namely ADHD (Combined Type) and ODD, each according to DSM-IV criteria. A careful review of considerable available archival material was an important part of George's assessment, in relation to the secondary consultative role of the author with the JJ Dept. (facilitating immediate, informed involvement in management issues relating to the young person) and also enabling a targeted face-to-face assessment, without unnecessary re-evaluation of verified information. The clinical diagnostic criteria (A, parts 1 and 2) for ADHD are displayed overleaf in Table 1.

Table 1

Diagnostic criteria for DSM-IV 314 Attention-Deficit/ Hyperactivity Disorder, with criteria met by George marked with an asterisk (*), and especially characteristic criteria noted by two asterisks (**)

Six or more of the following symptoms of Inattention (a. to i.) or Hyperactivity/ Impulsivity (j. to q.)

(1) Inattention:

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

* (b) often has difficulty sustaining attention in tasks or play activities

(c) often does not seem to listen when spoken to directly

(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions) [*Can often be attributed to oppositional behaviour in George's case, so criteria not met*]

* (e) often has difficulty organizing tasks and activities

* (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

* (g) often loses things necessary for tasks or activities (e.g. toys , school assignments, pencils, books, or tools) [*It is acknowledged that this is often deliberate in George's case*]

** (h) is often easily distracted by extraneous stimuli

(i) is often forgetful in daily activities

(2) Hyperactivity:

(i) often fidgets with hands or feet or squirms in seat

** (j) often leaves seat in classroom or in other situations in which remaining seated is expected

* (k) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

* (l) often has difficulty laying or engaging in leisure activities quietly

** (m) is often "on the go" or often acts as if "driven by a motor"

[*Mrs. Croft described her son's movements as "robotic", with the connotation of a sinister undercurrent palpable in her description*]

(n) often talks excessively

Impulsivity:

(o) often blurts out answers before questions have been completed

* (p) often has difficulty awaiting turn

* (q) often interrupts or intrudes on others (e.g., butts into conservations or games)

Although diagnostic criteria for ADHD were met, reluctance on the part of George's psychiatrist about the utility of this diagnosis was communicated to the author. It was the psychiatrist's view that therapy with stimulant medication had never had any impact on George's mood, cognition or behaviour despite his compliance and new concerns had emerged that he had voiced an intention to sell any medication prescribed to other children and had no intention of using it himself. It was the psychiatrist's view that George's behaviours were substantially a product of core personality attributes, as much – if not increasingly more than – uncontrollable impulses.

Other requisite criteria for ADHD, including the presence of some symptoms before the age of 7 years and impairment in two or more settings (e.g., school and home) were clearly met, although several criteria may have been better explained by personality processes, as alluded.

The other previous psychiatric diagnosis of ODD was made when George was 8 years old. This disorder is described in DSM-IV as "a recurrent pattern of negativistic, defiant, disobedient, and hostile behaviour toward authority figures that persists for at least 6 months" (p. 91). The clinical criteria (A) for 313.81 ODD are listed in Table 2, with conditions met by George again marked with one asterisk (*), and especially characteristic criteria noted by two asterisks. These were determined in reference to the psychiatric report establishing the diagnosis.

Table 2

Diagnostic criteria for DSM-IV 313.81 Oppositional Defiant Disorder

Four or more of the following are present:	
(1) often loses temper	* (2) often argues with adults
** (3) often actively defies or refuses to comply with adults' requests or rules	** (4) often deliberately annoys people
** (5) often blames others for mistakes/ misbehaviour	* (6) is often touchy/ easily annoyed by others
(7) is often angry or resentful	(8) is often spiteful or vindictive

The ODD seemed highly pertinent to George's recent functioning, with DSM-IV also noting that, "in a significant proportion of cases, ODD is a developmental antecedent to Conduct Disorder" (p. 92).

Mental State Examination

Oval-faced, brown haired and rangy at around 5'6", George was tall for his age and entering a growth spurt when first seen at home in the lounge room. Minor scarring across the right cheek, consisting of shallow indents and grooves, was caused when aged five in an attack by the (destroyed) family Rottweiler. Well-groomed and neat in appearance, George presented as quiet, somewhat detached and emotionally closed. His stream of thought was normal, with no evidence of tangentiality, flight of ideas, loosening of associations, thought blocking, incoherence or perseveration. Remaining fairly still while on the couch (watching television), his general level of psychomotor activity was not typical of someone diagnosed with severe ADHD. He did not fidget, display (or appear to suppress) signs of restlessness or interrupt the author, although at no stage gave his full attention either. Instructed by his mother to turn off the television and pay attention, he grudgingly obliged and faced the author.

George's demeanor was marked by minimum eye contact and parsimony of language, punctuated by bursts of talking when a topic of interest emerged, such as sport (e.g., cricket), music (D12, Eminem), controversies, crime, violence, war or human suffering of any kind. For example, he found humour in an advertisement about sponsoring a starving child and also became animated when his offences were referred to. These were not discussed, but merely noted to in relation to clarifying consent to psychological intervention, ethical issues regarding confidentiality and the sharing of information, including a legal requirement of the author to report serious threats to self or others, or specific criminal activities, to statutory authorities (e.g., JJ Dept. or police). George laughed at the idea of self-harm with suicidal ideation, but, upon further probing, mentioned spraying himself in the eyes with (stolen) aftershave on one occasion, and head-butting the desk to cause a nose bleed on another, simply to get out of class.

An early impression was that George may use the counselling/ therapy process as a vehicle for secondary gains in relation to stories about his offending and attempts to split or manipulate liaison between professionals involved in his care. References to his JJ worker as "an old bag", the police as "stupid" (and an air of resentment towards his mother) appeared to be part of an effort to demonstrate his disdain for authority and draw an opinion or tacit collaboration from the author. His speech was a

little croaky due to normal deepening relating to his early adolescent developmental stage, but was clear, well-enunciated, measured and neither loud nor soft. At times he hesitated before answering questions, as though in a police interview or court room, despite the author's attempt to generate an open, relaxed atmosphere. When making a seemingly important point George allowed himself fleeting eye contact with the author, as though to emphasize his message. There was a palpable sense that when George was not talking or even apparently listening that he was thinking intensely, mulling over the author's motives for asking certain questions, framing (and withholding) his own thought processes and hesitating unless he had something significant to say. The atmosphere was of a barrister's chambers, as opposed to a first interview with a 12 year old expelled from school in his mother's lounge room.

Quality of affect was euthymic, the range somewhat blunted and restricted, although reactive. George's mood was apparently even and normal in the weeks leading up to initial examination, although he acknowledged considerable boredom due to being away from school with "nothing to do". Regarding eating and sleeping patterns, George reported a healthy, if not voracious, appetite, and consumption of regular meals and snacks, although he complained that his mother restricted his food intake. His sleeping pattern appeared sound, but he acknowledged staying up late playing video games ("Playstation"), sometimes leading his mother to rouse him the next day. There were no current disclosures or symptoms relating to the present, recent or distant past indicative of depression, mania (as distinct from ADHD-related agitation), anxiety, obsessions, rituals, paraphilias, pyromania (in contrast with collateral material), derealisation, dissociation, paranoia, delusions, hallucinations, thought disorder, or other psychotic processes. Asked to rate his mood state in relation to his overall happiness or otherwise (from 1-10 with 1 representing his worst mood ever and 10 his happiest), he gave himself a 7, with improvement hinging on "starting school" again. George denied current illicit drug use and showed no interest in using or acquiring drugs or medications of any kind (including cigarettes), but admitted trying cannabis in Year 4 (aged 9 years) and not enjoying it. Later conversations with Mrs. Croft about his early cannabis use lead to an acknowledgement that both she and her husband had occasionally smoked marijuana early in their marriage and that George had remembered this, telling her

"you did it, so don't tell me not to". Fortunately, his use was only experimental, with no desire expressed to continue using the substance, although he acknowledged on-selling the drug at his last school to make some money. George indicated that he was not adverse to the idea of obtaining alcohol, saying that an older girl had given him Jim Bean after a church function recently, insinuating that he had enjoyed the effect it had on him. The girl in question was a 16 year old from George's last school who had befriended him and who George's mother relied on to take him to a church group he no longer attended. Liz doubted that the girl had given George alcohol.

Regarding his medical history, George said that he was healthy and proudly noted that he was getting taller. He reported that his father was tall and a bone test had shown that he would end up 6'2". When asked what this meant to him, George said that he looked forward to becoming a "giant" so that everyone would be "scared" of him. He also said tall people get more "respect". George mentioned that he enjoyed fighting, asking whether the JJ Dept. could fund his enrolment in martial art classes, which the author told him was unlikely. George said that it was unfair that his younger brother and sister were allowed to do karate, but his mother did not let him. A later conversation with George's mother confirmed her aversion to George taking up any martial arts, as he had previously been taught taekwondo and had practiced techniques on his brother, knocking out a tooth several years ago. Liz confirmed that George was very healthy, being unable to recall a time he had ever been sick, except when he had once pretended to be unwell in order to be excused from visiting family friends.

A meeting with George, his JJ worker and the author was scheduled to clarify arrangements for psychological intervention. Given the lack of structure in George's life and uncertainty regarding his next school placement, these issues were prioritised and a second meeting arranged for two days time. A "net session" of cricket involving the author and George alternating between batting and bowling to each other, was mutually agreed to, with a view to discussing his immediate recreational and academic intentions, hopes and goals. Liz provided subsequent feedback about the initial meeting via a phone conversation, saying that she was surprised at how much her son had "opened up" for a first meeting, and mentioning that George was – for the first time – positive about the idea of seeing a psychologist.

However, she also expressed reservations about the notion of "rewarding" his bad behaviour by making visits too much "fun". The author discussed the plan to negotiate a balance between rewarding pro-social actions and dissuading antisocial behaviours as appropriate, but that developing sound rapport and a consistent, working relationship with George was especially important from the outset, given his uninterrupted history of sabotaging relationships with helping professionals and authority figures.

Goals of Psychological Intervention

The author liaised with his clinical supervisor, George's JJ worker, the regional JJ Manager, George's mother, the arresting police officers and local Sergeant in relation to George's offences, a previous psychiatrist who assessed George on three occasions, the Dept. of Education, the local cricket club, and other relevant agencies prior to and following the mental state examination and full perusal of archival materials at hand, prior to scheduling open-ended involvement, with a minimum of six sessions, to be summarised in this placement report. Psychological intervention was to consist of once weekly 60-120 minute sessions, with additional homework tasks, with specific aims geared to:

1. Assess George's general intelligence (using the WISC-III), personality (MACI) and cognitions in relation to his everyday functioning (How I Think Questionnaire) during sessions 1-8.
2. Refer George for psychiatric assessment by the child psychiatrist who has previously assessed George from age 3½ years and set up ongoing phone contact (monthly or as required).
3. Facilitate George's re-enrolment in a new school, appropriate to his needs, in cooperation with his JJ worker and schedule pre-enrolment meetings with the principal and year co-ordinator to development a management plan and contact designed to contain difficult behaviours and encourage pro-social actions.
4. Encourage George's involvement in structured day time activities/ sport. Further inquiries to be made with local cricket, football and athletics clubs, community gymnasium and guitar lessons availability; this process to be assisted by the involvement of a sessional JJ worker (a voluntary member of staff attached to the JJ Dept. with experience in working with young people).

5. Arrange mentoring via any of several reputable community agencies, including the Big Brother program, and make contact with the Australian Football League Club George supports to inquire about contact with senior players and match day involvement as a reward for George's commitment to ongoing treatment goals and to reignite his interest and participation in sport.

Initial Sessions and Cricket/ School Enrolment

The author met with George for a cricket net session, as scheduled, and good rapport was further developed over the course of two hours. George appeared more relaxed than when initially interviewed at home. Alternate turns were taken bowling and batting, using a leather cricket ball, pads and bat (supplied by George) and pitch and nets attached to the local cricket club, followed by catching practice on the oval. It was evident that George had exceptional hand-eye coordination, quick reflexes and generated considerable pace in his bowling for his age. George was not reluctant to promote his cricketing abilities, singing his own praises at every opportunity and bragging about how he had intimidated an opposing batsman with consecutive "bouncers" (bowling deliveries aimed at the head and upper body) in pre-season training, after being invited to join the local squad the previous season. Given a cultural taboo against boastfulness that is impressed on Australian children from a young age, George's proclamations were considered in the context a psychopathy-linked pattern called "aberrant self-promotion" characteristic of "a narcissistic personality configuration in combination with antisocial behaviour" (Gustafson & Ritzer, 1995, p. 147). George indicated that waning interest due to a weak local team and a niggling knee problem attributed to rapid growth had scuttled his cricketing involvement last year, but he would like to play in the new season starting in two weeks. Discussions with George's mother lead to arrangements via the JJ Dept. to fund his involvement in the local cricket club.

It was the author's experience that young offenders with communication difficulties or a reluctance to engage oftentimes open up in the context of non-office environments or whilst engaged in physical activities of any kind (e.g., billiards or other games, sport, eating, listening to music or even driving). This proved to be the case with George.

Throughout breaks in cricket practice and during the next week (partly involving meeting the principal and staff at a prospective school), George spoke to the author at length about a number of his antisocial behaviours, his rationalisations and justifications, and aspects of his relationship with his father. He revealed having made numerous crank phone calls to police for fun during the preceding 12-18 months and, six months earlier, having exploded a soda bomb with a friend in the local park adjacent to the cricket club. It also transpired, not unexpectedly, that George had only been charged with a fraction of the shop thefts for which he had received the Probation Order. George's main source of pocket money was selling golf balls he collected from a near-by gold club. The retrieval of balls partly involved wading into an adjacent swamp, but netted him up to $50 for a day's foraging, especially after busy weekends or tournaments. He attempted to justify his shoplifting by saying he had been banned from the golf club, as a result of suspected theft from the clubhouse (which he denied) and had no other source of money to obtain the material goods "everyone else" his age had.

George said that he saw his father, Mr. Valiotis, about once a fortnight, with the two going out to play table tennis or catching up for a meal. However, ongoing communication with George's mother suggested George had overstated the frequency of contact. George related three incidents which conveyed information about his father's character that corroborated the apparent existence of Cluster B personality traits inferred from Mrs. Croft's descriptions. The most recent contact had involved an outing to the Casino, in which Mr. Valiotis had attempted to get his son into a nightclub, an occurrence not denied by Mr. Valiotis when Liz queried him about it afterwards. George said that "we were almost in. This huge Greek bouncer had let us through, but a second guy stopped us and asked for ID". George said that his father had told the bouncer that his son was an army cadet and had left his ID in the car, parked "miles away", but another doorman had arrived and warned the two to leave. George said that his father was organising fake ID and with a bit more height he should be able to "get in" soon. To the author, George may be able to pass for, at best, 15 or 16 years, but his father's attempt to pass him off for 18 seemed fanciful, as well as irresponsible. George said that his father had bought him a couple of alcoholic drinks in an adjacent bar before bringing him home.

George also described another episode in which his father, with George in the car, had ordered food in the drive through facility of a restaurant, then changed his mind and feigned having made another order when they had arrived at the cashier bay. George said that his father had humiliated the cashier attendant, an adolescent female, and asked to see the manager, prior to being given an upgraded meal deal and apology by the restaurant, which George said was "legendary".

A final episode involving Mr. Valiotis surfaced only when the author indicated that he wished to discuss issues in relation to George's Probation Order, future schooling and counselling initiatives with his father, to which George cynically responded "Good luck – You'll never find him!" When asked why, George said his father believed the Human Services Dept. had lied about him in court reports (relating to custody and child protection matters) and that he would never have anything to do with "them". Since George's Probation Order, Mr. Valiotis had apparently changed his home and mobile phone numbers and no one knew where he worked. When probed further, George related a poignant incident of several years ago when, as a ten year old, he had tracked down his father's work location in a car factory just outside of Melbourne. Without informing his mother, George had skipped school that day and taken a country train to the factory, entered the building and found his father's office. George said that his dad had "cracked it", shouting at him in front of office staff, and giving him $5 to catch a train home. He had also threatened never to see George if he ever "pulled this stunt" again. George said that his dad had "disappeared" for a few months afterwards, taking his phone "off the hook".

When asked how the incident had made him feel, George said that he had wanted "to kill" his father, but was now very wary about trying to get in contact with him, preferring to wait for his phone calls. When asked whether he still felt angry towards his father, George said "sometimes", but was not inclined to elaborate. Reference was also made to his father's high income, with George describing him as "loaded". Later discussions with his mother indicated that Sam Valiotis had begun studying while they were married, and that had completed his engineering degree after separating. She believed that he held a senior management position with a car company which involved frequent interstate travel.

New Diagnosis: Conduct Disorder (CD)

Shortly after George's referral, the author arranged a consultation with the psychiatrist with whom George had had ongoing previous contact and good rapport. An assessment was conducted, with the author present in an observation role. George was receptive at interview, answering all questions. The key outcomes of the psychiatric review were confirmation of ADHD (a revision to Predominantly Hyperactive/ Impulsive Type) and a new diagnosis of co-morbid DSM-IV CD (Moderate severity), the criteria for which are displayed below in Table 3, with those met by George indicated.

Table 3

Diagnostic criteria A (1-15) for DSM-IV 312.8 Conduct Disorder, with criteria met by George marked with an asterisk (*), and especially characteristic criteria noted by two asterisks (**)

A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months.

Aggression to people and animals:

* (1) often bullies, threatens or intimidates others
* (2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm (e.g., a bat, brick, knife, etc.)
* (4) has been physically cruel to people
(5) has been physically cruel to animals
* (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of property

? (8) has deliberately engaged in fire setting with the intention of causing serious damage (alleged)
* (9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

* (10) has broken into someone else's house, building or a car
** (11) often lies to obtain goods or favors or to avoid obligations (i.e., con others)
** (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting...forgery)

Serious violation of rules

(13) often stays out at night despite parental prohibitions, beginning before age 13 years
* (14) has run away from home overnight at least twice while living in parental or surrogate home
(15) is often truant fro school, beginning before age 13 years

Like ADHD, with which it is often comorbid, CD is not an uncommon diagnosis in young males, with a prevalence of 6-16% according to the DSM-IV. Almost synonymous with involvement in a variety of criminal activities, George conservatively qualified for the specifier of Moderate intensity,

given that he met at least nine criteria, especially in regard to deceitfulness and aggression. In hindsight, the Severe specifier would not have been inappropriate, given that "many conduct problems in excess of those required to make the diagnosis" (DSM-IV, p. 87) were present and for a variety of reasons, including limited time and lack of full disclosure, only a subset of George's antisocial behaviours were catalogued.

Session 5: Intellectual Assessment Using WISC-III

All subtests of the Wechsler Intelligence Scale for Children, Third Edition (WISC-III), Australian Adaptation, except the optional "Mazes", were administered by the author in the presence of a probationary psychologist on university placement who made pertinent observations and assisted in reporting the assessment. The WISC-III is a standardised psychometric test for children and adolescents between the ages of 6 to 16 years. It provides a number of distinct measures of intellectual functioning calculated to reflect the child's level of ability relative to other children or adolescents of the same age. The full-scale intelligence quotient (FSIQ) score reflects the young person's general level of ability as demonstrated over a broad range of tasks involving a diverse range of skills and abilities. The WISC-III includes a measure of Verbal IQ reflecting ability in tasks which specifically address the child's verbal understanding, recall and reasoning abilities. A Performance component measures ability in tasks which require skills such as non-verbal reasoning, analysing visual information into its components, integrating parts into wholes and organising material into logical sequences.

The intellectual assessment was completed in a single afternoon session, with George engaging well with the author and generally relaxed and compliant with all procedures. He presented as appearing to be motivated to do well on the test and was eager to complete the assessment quickly. Although offered a brief break in testing for a snack on a number of occasions, George indicated that he preferred to continue with the testing "to get it over with". Between subtests George frequently reached into his pocket for sweets which he had brought with him, but he did not offer to share them with others present. The psychologist viewing the assessment noted that on several occasions George rather

ostentatiously raised the front of his school shirt to fidget with a yellow acrylic weave belt and chrome buckle which he was wearing loosely around his waist. This behaviour was especially evident in the later trials of some subtests (e.g., Block Design; Vocabulary), when George appeared to be somewhat frustrated and was struggling to produce correct responses to the items.

George's FSIQ was calculated as falling within the High Average range, where only 16% of 13 year olds would perform at a higher level. There was a significant difference between his Verbal IQ (in the Average range, better than 63% of his peers) and his Performance IQ (in the Superior range and above the level of 95% of same-aged peers). A summary of his results are displayed in Table 4.

Table 4

George's Wechsler Intelligence Scale for Children – Third Edition (WISC-III) Results

	IQ/ Index	%ile	95% Confidence Interval
Verbal	105	63	99-111
Performance	125	95	115-131
Full Scale	115	84	109-120
Verbal Comprehension (VC)	104	61	97-111
Perceptual Organisation (PO)	117	87	107-124
Freedom from Distractibility (FD)	106	66	96-114
Processing Speed (PS)	129	97	115-134

The discrepancy between George's Verbal and Performance scores was statistically significant, occurring in fewer than 15% of children at his age. Research into neuropsychological functioning with conduct disordered children, people with Cluster B or psychopathic personality traits and offenders in general (Dolan, 1994; Hart, Forth, & Hare, 1990; Lapierre, Braun, & Hodgins, 1995; Moffitt & Lynam, 1994; Smith, Arnett, & Newman, 1992) suggests that the Verbal IQ is often either below average or relatively low compared to the Performance scale, akin to George's profile. A final observation was that George's Verbal Scale score, while superior to 63% of same-aged peers, was – at least on face value – slightly inferior to his top 25% rating for literacy skills at his previous school. This comparison may reflect either slippage or a plateau in his verbal development as a result of interrupted schooling, whilst acknowledging the impossibility of direct comparisons between quite diverse assessments.

There were also differences in performance across the four indexes (Is) of intelligence, namely Verbal Comprehension (VC: Average range), Perceptual Organisation (PO: High Average), Freedom from Distractibility (FD: Average) and Processing Speed (PS: Superior). George's POI score showed that he is functioning within the High Average range, better than around 87% of children of his age. In children who have been diagnosed with ADHD it is more common for the FD and PS indexes to be relatively low compared to the other two indexes. In George's case, FD was indeed one of the two relatively low indexes, while the other (PS) was easily his highest. In fact, only 3% of 13 year olds record quicker processing speeds than George. It should also be noted that, although FD (and VC) were relatively low, both were in the average range (at the 66th and 61st percentiles respectively). It was concluded that George's cognitive profile was not especially suggestive of ADHD. However, the spread of George's scores across each of the six subtests which comprised his Performance Scale (see WISC-III face sheet; Appendix F) was significantly greater than the breadth of scores commonly found in children of his age. This indicated that George's non-verbal abilities probably did not operate as a single, unitary construct but that some area (or areas) of strength or weakness, relative to his overall ability, may have existed within the cluster of skills which combined in his Performance component.

To identify relative strengths or weaknesses in George's Performance Scale, his score for each individual subtest in the Performance Component was compared against the mean score derived from all six Performance subtests. This analysis revealed that George's score on the Block Design subtest is significantly lower than his score for any of the other Performance subtests. Therefore, the Block Design subtest represents a domain of relative weakness in George's non-verbal abilities. No other relative strengths or weakness were detected in the Performance Scale. Notably, his problem-solving performance on the Block Design subtest appeared to be hindered by a perseverative tendency to rotate the blocks in an anti-clockwise motion and his failure to rotate the blocks in a forward motion. This may reflect a tendency for George to conceptualise the puzzle in a two-dimensional frame of thinking, neglecting the three-dimensional approach which is required for good performance in this subtest. A rigidity, or lack of flexibility in conceptualisation (rather than a fluid, systematic and insightful

approach) also appeared to be evident in George's approach to problem solving. When his strategy of rotating the blocks clockwise failed to produce solutions (e.g., on trials 9 and 11) he became visibly frustrated, but did not attempt to employ any other problem-solving strategies. This is quite inconsistent with his performance on all other Performance Scale subtests and suggested that George may rigidly apply previously learned methods when confronted with an unusual or particularly difficult task.

Whilst there was evidence of the likelihood of a slight practice effect given that George had previously been assessed with the WISC-3 (three years ago) and WISC-R Verbal Scale a year earlier, it should also be noted that for various reasons George's schooling had been fragmented during this period with at least six months lost and minimal periods of sustained application whilst enrolled and attending school. The net effect on George's true intellectual capacity was unknown with certainty but any slight practice effect would certainly be offset by this factor to a greater or lesser degree.

Personality Assessment: Millon Adolescent Clinical Inventory (MACI)

The MACI (Millon, 1993) is a self-report inventory requiring "true" or "false" responses to 160 statements designed to assess personality characteristics and clinical syndromes in adolescents aged 13 to 19 years (see Appendix G, p. 166). It provides scores on 27 clinical scales, comprising "personality patterns" (12 diagnostic scales), "expressed concerns" (8 scales) and "clinical syndromes" (7 scales). George was assessed in Session 6, shortly after his thirteenth birthday, the minimum age requirement of the MACI. He answered 158 of 160 questions, being unable to provide a response to items 25 and 115. All validity scales were within acceptable ranges, with X (Disclosure) = 310 (valid scores ranging from 201 to 589) and VV (Reliability) = 0, indicating the most valid profile. George's Y (Desirability) and Z (Debasement) scores suggested he neither exaggerated, nor underplayed, the extent of any difficulties or virtues. After the purpose of the assessment was explained as helping the author to better understand his thoughts, feelings and behaviours, George himself said that he "had nothing to lose" and expressed his interest in answering the statements according to "exactly how I feel". George's work rate was reasonably brisk, but there were no signs that his test taking approach was in any way unconsidered, rushed or

otherwise compromised. Random perusal of numerous individual items seemed to aptly reflect the author's impression and general understanding of George's range of typical behaviours and beliefs.

All raw scores were converted to base rate (BR) scores (ranging from 1-115) using the relevant BR transformation tables in Appendix C-1 of the MACI Manual. No further adjustments to BR scores were necessary, as George's Scale X score was between the low/ high cut-points (275/ 400), he was not in an intense or acute emotional state when completing the inventory and his BR score for Scale Y was not 4 or more points greater than his BR score for Scale Z. Furthermore, George's highest Personality Pattern BR scores were not on Scale 4, 5 or 7, so the Denial/ Complaint adjustment was not required. In the MACI, BR scores > 75 indicate the entity measured is clinically present and scores > 85 represent clinical prominence. George's scores are displayed in Table 5.

Table 5

MACI Base Rate (BR) Scale Scores; Descending Order of Clinically Elevated Scores (Highest to Lowest), with Brief Description and a Selection of Low Scores (staggered) for Comparison

Code/ Scale	Description	Score
CC: Delinquent Predisposition	Non-compliance with societal regulations	109
6A: Unruly	Equivalent of **CD** or adult **Antisocial PD**	99
F: Social Insensitivity	Generalised indifference to the feelings/ reactions	
	of others; Lacking in empathy (psychopathic trait)	96
DD: Impulsive Propensity	Self-explanatory: Key feature of ADHD	94
6B: Forceful	Sadistic, strong willed, tough minded, dominant	
	over or abusive of others; May enjoy pain	79
4: Dramatizing	Exhibitionistic = **Cluster B PD**; Engage in manipulative,	
	seductive, gregarious and attention-getting manœuvres	74
BB: Substance-Abuse Proneness	(Self-explanatory)	72
5: Egotistic	Similar to **Narcissistic PD**; Self-centred,	
	arrogant, exploitive; Inflated sense of entitlement	69
8A: Oppositional	Equivalent of **ODD** or Negativistic PD	66
7: Conforming	Equivalent to DSM-IV **Obsessive-Compulsive PD**	36
3: Submissive	**Dependent PD;** Inverse correlation with psychopathy	34
2A: Inhibited	Expect life to be distressing; Active-detached	25
1: Introversive	Equiv. to DSM-IV **Schizoid PD**; Passive-detached	22
8B: Self Demeaning	Masochistic, obsequious, self-sacrificing	20
2B: Doleful	Glumness, pessimism, motoric retardation	1

Clinical Formulation

Five scales were clinically present (score > 75), as seen in Table 5. These included two out of twelve Personality Patterns, Unruly (109; clinically prominent) and Forceful (79). Dramatizing (74), Egotistic (69) and Oppositional (66) were below a clinical level, with Borderline Tendency in a normal range. Delinquent Predisposition (109) and Impulsive Propensity (94), each clinically prominent, were the two out of seven elevated Clinical Syndromes, with Substance-Abuse Proneness (72) marginally below a clinical level. Only one scale on Expressed Concerns was raised (i.e., Social Insensitivity; at 96 clinically prominent), with Childhood Abuse and Sexual Discomfort below normative levels, decreasing concerns about possible mistreatment tentatively raised in a prior psychiatric report.

The MACI results provided confirmation that CD was the most relevant, current clinical diagnosis, and accurately reflected George's recent behaviour, apparent outlook and the others' views regarding his personality (i.e., his mother, teachers, psychiatrists, other children's parents, JJ Dept., and police).

As noted, all validity indicators were met and individually scrutinized responses "checked out" in terms of the author's impression of George's psychological functioning. Relating these results to the MMPI or Eysenck's theory of personality, his most distinct personality trait would presumably be manifested by elevation in the Psychopathic Deviate or Psychoticism dimensions (see Millon, 1993). In relation to DSM-IV Personality Disorder nosology, Cluster B traits, especially antisocial tendencies, were pronounced, as opposed to the constellation of attributes characteristic of Clusters A or C.

The extent of elevation on Delinquent Predisposition, Unruly, Social Insensitivity and Impulsive Propensity (combined with his calculating, as opposed to out-of-control, demeanour), was the first line of psychometric evidence pointing beyond a diagnosis of CD and more closely aligned with fledgling adolescent psychopathy, as forecast in an earlier psychiatric report. The fact that George had – to date – presented to the author as quite likeable, engaging and outgoing (all traits commonly seen in adult psychopathy; Hare, 1993) seemed to add weight to the unnerving, accumulating evidence of underlying psychopathic tendencies, but, conversely, also provided hope that George could participate and integrate successfully (and pro-socially) in school, at home and in the wider community.

Formal Assessment of Psychopathy

In view of George's elevation on several MACI scales found by Murrie & Cornell (2000) to correlate most strongly with psychopathy in adolescents aged 12 to 17 (as measured by a modified version of the PCL-R[3]; see Forth, Hart, & Hare, 1990; Hare, 1993), George's score on Murrie and Cornell's experimental 20-item Psychopathy Content scale (PCS) was calculated. Those authors found that this carefully selected group of MACI items correlated strongly with the modified PCL-R scale (r = .60) and had high internal consistency (α = .87) in a group of 90 adolescents in an inpatient psychiatric unit. In their sample, PCS scores ranged from 0 to19 (M = 9.54, SD = 5.25). George's score of 16 placed him more than one SD above the inpatient mean and in their high-psychopathy group. Notably, three items in this scale that George did not endorse specifically related to frequent or excessive cannabis use. Significantly, though, George had used cannabis much earlier in life, had been trafficking the drug at his last school and was young in relation to the inpatient comparison group, a proportion of whom would presumably have been admitted for psychotic processes related to cannabis use, given their high mean scores on the MACI substance abuse proneness scale.

The other item not endorsed in the psychopathic direction in the PCS scale (false to item 42 "I see myself as falling far short of what I'd like to be") possibly highlighted George's narcissism, which many authors contend is related to psychopathy anyway (Gustafson & Ritzer, 1995). On further questioning he was initially unable to specify what he would like to be, then nominated an ambulance paramedic, the same response he had given to a similar question at a school pre-enrolment interview several weeks earlier. His response had been interpreted by the school principal as a desire to help others, with no dispute or clarification from George at the time. However, he told the writer on this occasion that the real reason was so he could drive really fast and go through red lights with his siren blaring. Given George's high score on this experimental psychopathy measure (16/ 20, plus accompanying reasons the remaining four items were not endorsed), in addition to his aforementioned

[3] PCL-R stands for: Psychopathy Check List – Revised (Hare, 1991)

elevation on MACI scales correlated with the modified PCL-R, a formal assessment using the latter measure was undertaken, based on further semi-structured interviewing and static background information from archival sources, as recommended by Hare (1991).

The scoring criteria used in the 20-item PCL-R consists of ratings for each psychopathy-related item from 0 (nil symptoms) to 1 (maybe or in some respects) to 2 (prominent symptoms) which are summed to yield a score out of 40, with 30+ designated the threshold for psychopathy. In the modified PCL-R utilised, developmentally inappropriate items (9 and 17) were omitted, violent crimes on 18 (juvenile delinquency) received a 2 and non-violent crimes a 1, while on item 20 (criminal versatility), ≥ four offences were rated a 2, three offences a 1, and ≤ two a 0 (see Murrie & Cornell, 2000). George's scores are shown in Table 6.

Table 6

Psychopathy Check List – Revised Factors and Items, with George's Scores (from 0-2) in Brackets; Omitted Items Developmentally Inappropriate for Adolescence Accompanied by Strikethrough

Factor 1 (*Interpersonal Style*)	Factor 2 (*Unstable lifestyle/ Behaviour*)
1. Glibness/ Superficial Charm (1)	3. Need for Stimulation/ Proneness to Boredom (2)
2. Grandiose Sense of Self Worth (1)	~~9. Parasitic Lifestyle~~
4. Pathological Lying (2)	10. Poor Behavioural Controls (1)
5. Conning/ Manipulative (2)	12. Early Behavioural Problems (2)
6. Lack of Remorse or Guilt (2)	13. Lack of Realistic, Long-term Goals (2)
7. Shallow Affect (1)	14. Impulsivity (2)
8. Callous/ Lack of Empathy (1)	15. Irresponsibility (2)
	11. Promiscuous Sexual Behaviour (0)
16. Failure to Accept Responsibility for Own Actions (1)	
	~~17. Many short-term Marital Relationships~~
	18. Juvenile Delinquency (1)
	19. Revocation of Conditional Release (0)
	20. Criminal Versatility (2)

George's raw score of 25, when adjusted for the omitted items, gave him the equivalent of a total score of 28, marginally below the threshold for psychopathy. However, using the reasonable notion of a

continuum from normalcy to extreme psychopathy (Murrie & Cornell, 2000) his raw score would have placed him in those authors' high-psychopathy group (modified PCL-R score $\geq$ 22). Since George's age (13 years, 1 month) placed him at the young end of their age range and assessments based on the PCL-R, George's score must indeed reasonably place in either the psychopathic or fledgling psychopathic range. In hindsight, the decision to offer safe-sex education/ counselling seemed justified, given his burgeoning interest in the opposite sex, impulsivity and limited responsibility in other areas of his life. Preventing or dissuading George from re-offending and limiting his further involvement in the criminal justice system – corresponding to PCL-R items 18-20 – were also perceived as important goals by the author and George's JJ worker in his decelerating his potential trajectory into full blown psychopathic functioning. These were especially critical goals given George's age and his positioning on the psychopathic diagnostic cusp, corresponding to diminishing therapeutic effectiveness (Rice, Harris, & Cormier, 1992), if not the point of no return.

Legacy/ Implications of Bezotzovschina: Rebuilding Positive Male Role Models

Dire predictions of developing psychopathy on the basis of personality functioning, prior behaviour and convergent professional opinion was considered with familial and psychosocial factors, including Mrs. Croft's protective, nurturing role as George's mother, against the evidently destructive impact of a largely absent father, with a seemingly deleterious ongoing influence. Although no specific word exists in English, there is a Russian term translated as "bezotzovschina" (M. Galak, personal communication, 2002) denoting *fatherlessness* that seemed applicable to George. The crucial role of the father as a model of how to (or not to) behave for boys is universally accepted. However, for most of George's life, this male exemplar was not physically present. Nonetheless, Mr. Valiotis' son appeared to share an innate predisposition towards Machiavellian and antisocial functioning characteristic of psychopathic individuals that was compounded by the added burden of his idealisation towards a man whose belligerent, antagonistic treatment of others George had clearly romanticized. This opinion was based on input from both George and Mrs. Croft, in addition to the author's impressions. Mr. Valiotis,

through omission of discipline and apparent tacit approval of his son's behaviour, or by example, had inculcated in George a basic philosophy that you grab whatever you want, do whatever feels good at the time, manipulate and disregard the feelings of others. In George's own words, "if someone tells me what to do, I'll go the other way".

On the basis of George's mother's recollections it appeared that George had never been a naturally affectionate baby, but she had clearly attempted to transmit warmth, love and emotional closeness in her relationships with all her children, including George. In fact, she made a point of telling her children she loved them everyday and hugged them regularly, although George had apparently almost always squirmed, recoiled, slipped away or otherwise evaded any overtures of physical affection. Unlike Liz, George's father apparently sent out the reverse message, most vividly emphasized by his explosion when his son turned up at his place of work. According to Bleiberg (2001) a child's "path to ruthlessness" (p. 106) in the pathogenesis of subsequent antisocial PD emanates when "their pleas [for attachment] are regularly ignored, and their efforts to secure closeness are ridiculed, precipitate abandonment or abuse, and often generate destructive, unreflective mental states in their caregivers" (p. 106). Such children, Bleiberg further noted, shift "their attention from internal states of vulnerability toward manipulation and control of the environment" (p. 106).

A key element of George's therapy, identified as critical to any likelihood of future success, was exposing George to positive male role models. The author ideally envisaged building a team of constructive male influences (and strong female role models) around George. At George's prospective school, it emerged – fortuitously – that one of the experienced form coordination teachers also shared the portfolio for physical education, with subsequent liaison indicating that, in many ways, he would be a suitable form teacher and potential mentor for George. The author also focussed on the availability of meaningful male role models elsewhere.

Following a meeting with JJ management initiated by the author, resources were prioritised, enabling the allocation of a sessional worker to George to facilitate and reinforce behavioural aspects of this therapy (e.g., recreational activities and pro-social modelling). The person selected was a robust,

but good humoured, easy going man of 55 years, who also happened to be an ex-school principal with a keen awareness of boundaries, a reputation for being able to handle very difficult adolescents and an ardent interest in cricket, football and golf – all prerequisite qualities!

A final arrangement made by the author was fast tracking the matching of a "Big Brother" with George via a local, well-established agency of the same name, specifically set up to provide disadvantaged or delinquent boys with older male role models. This arrangement was regarded as important with a view to the future, which, in 11 months times, would no longer involve the author, JJ Dept. sessional worker and other resources connected with George's Probation Order (provided he did not re-offend).

The intended purpose of these arrangements was not to supplant the decisive paternal role (with ongoing, albeit futile, efforts being made to contact George's father). Instead, the introduction into George's life of the author, an appropriate JJ sessional worker, a Big Brother and a suitable male form coordination teacher, was part of a concerted, deliberate effort to saturate George with consistent role models of healthy male behaviour, showing him that men influential in many aspects of his life can be fun, supportive of him, but, importantly, reliable, firm but fair, and tough if appropriate. It was important that each of the men selected had a strong personality, given George's uncanny ability to manipulate and override others.

School Enrolment – Formal Management Plan Implementation

Prior to George becoming enrolled in a new school, meetings were held between the principal, school staff, George's form (coordination) teacher, the in-house student counsellor and the author, who drafted a preliminary management plan at the school's request, based on maximising George's opportunities for academic and sporting success, tailoring a fair, graded and transparent disciplinary process based on the school's own protocols and minimising splitting between teaching and mental health professionals involved with George. Bi-weekly phone contact and fortnightly meetings were arranged. A behaviour contract was signed by George and the principal detailing disciplinary procedures and rewards available according to school policy and specific, verifiable arrangements with each of

George's teachers were implemented, including behaviour ratings pertaining to each class.

The author incorporated additional rewards, contingent with the school's expectations and his mother's reports of George's home behaviour. The primary incentive was a visit to meet senior players and coaching staff in the local Australian Football League (AFL) club George supported if he succeeded in making a trouble free start at his new school and behaved well at home. A further incentive was match day attendance, including the pre-match warm-up and coach's address to players, should he maintain his good behaviour, completion of all required homework and compliance with the spirit of his Probation Order. These planned outings were arranged via a contact of the author who was affiliated with the club George supported.

George negotiated the first week of school without incident, although reference to his educational record on the Dept. of JJ file indicated he had the capacity to bide his time when starting at a new school. His socialisation in relation to the opposite sex clearly got off to a promising start, judging by the fact that he was flanked by two girls from the same year when the author attended his school to meet him for his weekly appointment. In a discussion about opposite-sex relationships, George denied any prior sexual contact but said he had kissed a few girls and was "impressed" by several of the girls in his year level and intended to take a girl he had just met out to the movies. In view of his personality functioning, which reflected a high level of risk-taking behaviours, sensation-seeking and impulse propensity, consideration was given to enrolling George in a group program for young adolescent offenders (12-16 year olds) promoting sexually transmitted disease (STD) awareness and developing safe sex practices. However, given the overall plan in George's case to steer him away from further criminal justice system involvement and dissuade him from making links with an offending peer group, the content of the course was perused by the author and offered in one-on-one educative counselling. George was unaware of the prevalence and variety of STDs he may expose himself to without contraceptive use and his reaction to descriptions and pictures of the effects of some STDs was one of few times the author observed him to be genuinely perturbed. His aversive reaction was taken as an indication the counselling had had timely impact.

Underlying Cognitions and Distortions: How I Think (HIT) Questionnaire

Rather than simply categorising George's personality, a finer-grained analysis of the nature of possible cognitive distortions underlying his antisocial behaviours was sought as a prelude to the application of CBT to the psychological intervention. Towards this end, George completed the HIT Questionnaire (Barriga & Gibbs, 1996; Barriga, Gibbs, Bud Potter, & Liau, 2001) in Session 7 (see Appendix H, pp. 168-170). This self-report inventory, completed in 5 to 15 minutes, consists of 54 statements that describe "how you think about things in life" (instruction on Item Booklet). Respondents are asked "Is it fair to say that this statement describes my thinking during the last 6 months?" in relation to a 6-point Likert scale (from agree strongly to disagree strongly). For example, item 7 asks "If I see something I like, I take it" (to which George answered "agree"). Item 11 asks "If someone leaves a car unlocked, they are asking for it to be stolen" (George responded "disagree strongly").

Based on Gibbs & Potter's four-category typology of self-serving cognitive distortions (Gibbs, Potter & Goldstein, 1995), namely Self-Centered (primary distortion), Blaming Others, Minimizing/ Mislabeling and Assuming the Worst (all secondary distortions), the HIT Questionnaire also contains four "behavioral referent subscales". These are Opposition-Defiance (based on disrespect for rules, laws or authorities), Physical Aggression, Lying and Stealing. These four categories of antisocial behaviour are derived from the DSM-IV CD and ODD syndromes.

Finally, the eight subscales comprise three summary scales. These are an Overt Scale (OV), based on the Opposition-Defiance and Physical Aggression subscales and a Covert Scale (CV), constituted by the Lying and Stealing subscales. Two validity scales control for impression management and suspect or otherwise unacceptable response sets, with an Anomalous Responding (AR) scale incorporated "to screen for disingenuous, incompetent, or otherwise suspect responding. For example, disagreement with the items 'Sometimes I get bored' can be interpreted as implausible" (p. 7) and Positive Fillers (PFs) comprising pro-social statements camouflaging and counterbalancing the negative content of the clinical items. George's results are displayed overleaf in Table 7. His AR scale score was well within the acceptable range, suggesting that he responding validly.

Table 7

George's HIT Questionnaire Profiles: Summary Scores, Cognitive Distortions and Behavior Referents

%iles	Summary Scores			Cognitive Distortions				Behavioral Referents			
100	HIT	OV	COV	SC	BO	MM	AW	OD	PA	L	S
95											
90				**92**							
85				CLINICAL							
80											
75											**74**
				BORDERLINE CLINICAL							
70			68			70		68			
65	66	64								64	
60									62		
55											
50					48						
35							33				

As seen in Table 7, only one subscale score (SC: Self-Centered) was in the clinical range and one other was in the borderline-clinical range (Stealing). Minimizing/ Mislabeling was in the upper non-clinical range with Opposition-Defiance, at the 68th %ile, remarkably similarly placed to George's 8A scale (Oppositional) on the MACI (66th %ile). Although not measuring identical constructs, his HIT Questionnaire SC score was relatively high compared to his sub-clinical score on the MACI Egotistic scale (69). Finally, George's Overt and Covert HIT summary scores were not clinically elevated.

In a sense, George's HIT Questionnaire results were not quite as useful as may have been envisaged, in that there was limited material to incorporate into cognitive-behavioural interventions targeting obvious, defined cognitive distortions underlying his deviant behaviours, such as the propensity for stealing. Interestingly, there were psychometric suggestions that his lying and oppositional defiance, although previously impacting greatly on teachers and others, were not as prolific as might be assumed in reference to school reports. Instead, the HIT results seemed to support the psychopathy assessment findings and author's observations that George's behaviours were quite calculated (whether for maximum self-gain or impact) and underpinned by personality factors, rather than distorted thinking per se.

Sessions 9-10

The eighth session with George consisted of attendance at an Australian Football League (AFL) team training session and a post-training visit to the players' rooms. This outing had been arranged by the author with the blessing of the JJ. Dept., his mother, and also the staff at George's new school, given that he had behaved well in the first fortnight, with only a handful of minor indiscretions recorded against him. These involved interrupting others in class on several occasions and running in the hallway. However, there were promising early signs that George had accepted direction from his form coordination teacher and had shown his sporting ability in school football training, impressing coaching staff with his fierce (but legitimate) tackling, shepherding (blocking opponents and protecting team mates) and long kicking. The coach in charge – also George's form teacher – and appointed football captain had in fact earmarked George for a key position (centre-half forward) usually reserved for the strongest and most talented player on the team. It was indicated to the author by his form teacher (and George!) that his team mates had embraced George's rugged style of play, conferring increased status among his school peers. An early challenge identified in George's counselling with the author was refraining from boasting about his immediate impact, knuckling down to performing in the classroom (as well as on the field) and showing everyone due respect, including boys not on the team.

On the day the author picked George up to take him to AFL training he appeared to wish to convey a blasé manner and mind-set about the outing, where upon the author said he was happy to cancel it if George was no longer keen. Not surprisingly, George immediately expressed renewed interest. A focus on George's demeanour and his apparent intention to project an image of himself as "cool" and not wanting or needing anyone's involvement in his affairs drew a smirk, followed by frank acknowledge-ment that image was important to him. He went on to declare that he was "charismatic", but was unable to explain who had made this suggestion or where he had come across this term. When asked what charismatic meant, George said that he was able to convince people to do whatever he wanted. When asked how important his was to him he went on to say that people who were successful had charisma. He informed the author that it was the teacher's role to manipulate kids to do what the teacher wanted

and that teachers without charisma were not respected. On further probing George said the author's role was to "con him" into behaving and that people in business never get ahead without "taking people's money". Although George's points were not without merit, the author attempted to provide examples of people who were successful – using George's criteria (i.e., being wealthy) – as a result of developing innovative ideas and working hard (e.g., Bill Gates), as opposed to deceiving people. Local examples of high profile, charismatic people whose deception had led to criminal sanctions were also provided.

George had brought Eminem and D12 CDs which the author permitted him to play on the way to AFL training. The material contained explicit and violent themes, which, although unsavoury and concerning in some ways, was very popular with many boys of George's age group and permitted an opportunity to gain further insight s into his psychologic needs. Allowing George a healthy degree of freedom to express his opinions, outlook and even taste in music to an adult audience was considered important outlet for him throughout therapy and permitted the discussion of related cognitions and emotions related to his range of behaviours.

Once at the football ground, George appeared excited but surprisingly hesitant and apprehensive about the prospect of meeting players. After watching training George was invited into the rooms by the head trainer, known to the author, and introduced to several senior players and the coach, each of whom took time out to talk to him. George presented as being in awe of the players, with his shyness a great contrast to his usual bravado and self-assuredness. Arrangements were made to be present at the following week's AFL night game involving this team, with George invited to the pre-match address.

Following further favourable school and home behaviour reports, George attended the match, in the company of the author and his newly appointed sessional JJ worker, the aforementioned ex-principal selected as part of a team of male mentors. George enjoyed the night and was again endearingly introverted when taken into the rooms for the pre-match address. During the game itself he was very well-behaved, except for an incident prior to which he had been eating hot chips and talking about his voracious appetite. After his meal he proceeded to begin eating his paper cup, which the author and JJ worker discouraged, leading to him spitting the pieces out, some of which hit a spectator in the next

row. This led to a heated moment in which the spectator confronted George, who apologised and picked up the pieces, after prompting from the author. Although the incident did not entirely mar the evening, it was a reminder that George's exuberance and, at times, arrogance, was always bubbling below the surface, as part of his personality constellation and disposition. An ongoing challenge was challenging or redirecting the excessively narcissistic and hyperactive elements. A major purpose of the AFL outing and school football involvement was to channel his boundless energy, intensity and aggression towards a physical outlet with the added benefit of a disciplined, team environment. There were signs that George's self-worth and confidence was improving in this regard and strategies were also being made by the school to ignite an interest in reading, science and art. At the author's suggestion, arrangements were also made for George to be entered into a state-wide mathematics competition.

The following weekend George was assigned a Big Brother via the organisation described earlier, after an exhaustive search for someone suitable who may end up being matched with George for the longer term. This man had an involvement in music, which was beneficial given an interest George had in playing drums and the guitar. Although acknowledging general improvements in mood and behaviour, George's mother continued to express reservations about the "excessive" attention and resources being devoted to her son. This was partly based on comments George apparently made to her and his siblings such as "you see, crime pays" and "I'm the puppeteer, pulling the strings". Issues related to George's narcissism, egotistic outlook and the ever present threat of secondary gains linked to his offending continued to be raised both openly and indirectly in George's therapy. All professionals and adults involved in his Probation Order, therapy, education and recreational needs liaised regularly as part of the individual management plan devised by the author.

Discussion: Initial Treatment Outcomes

Using several barometers of progress, there was evidence of improvement in George's psychosocial functioning during the fifty day period spanning his ten assessment/ therapy sessions. From a correctional perspective, there was no evidence of further police contact, new or pending charges, or

disclosures of criminal activity since his referral. In therapy, George admitted to ongoing impulses to offend when in shopping centres and practical arrangements were made with his cooperation to limit aimless time spent in environments conducive to fostering offending ideation. Prompt reenrolment in school and modifications in the external environment and social milieu (e.g., a busy program recreational program) were key elements of the intervention geared towards preventing recidivism.

In addition to cessation of criminal activity, the intervention aimed to clarify George's psychiatric diagnosis, assess his intellectual ability and elucidate his personality functioning and characteristics in relation to expressed concerns and clinical syndromes. These goals were all achieved. A formal diagnosis of CD and reconfirmation of ADHD reflected recent offending behaviours and conduct at school and at home. George was in the above-average range of general intelligence, with his perceptual organisation and processing speed in the top few percent his age group. Personality testing reflected prominent psychopathic traits, including a delinquent predisposition, impulsive propensity and social insensitivity. The psychopathic trend was verified following specific assessment using a modified version of the PCL-R.

The implementation of an individual management plan and introduction of male mentors and role models into George's life were undertaken. The author developed a strong working relationship with the young person, who for the first time accepted the involvement of a mental health professional and was engaged in regular, ongoing therapy. Minimal problems were encountered during George's initial weeks of enrolment in a new school, with a positive impression resulting from his participation in the school football team.

Relation of Case to Adolescent Psychopathy Literature

George met clinical criteria reflecting budding adolescent psychopathy. This assessment was based on the early emergence of a combination of ADHD and Conduct Disorder, PCL-R criteria, behaviours documented in archival material and detailed observations made during therapy. Background factors were identified that placed George at increased risk of accelerating towards adult antisocial and psychopathic functioning. These included a largely absent father with narcissistic and antisocial traits,

parental martial conflict and violence leading to divorce, early criminal justice system and protective care involvement (due to his mother's physical incapacity), numerous school expulsions and moderately low socioeconomic status. However, significant interventions were orchestrated by the author to counteract the ongoing effect of George's risk factors. Mentoring and male role model development was implemented to engender positive adult relationships and provide George with examples of healthy male behaviour. The management plan arranged at school enrolment facilitated coordination of resources and reduced splitting by the young person. George's considerable intellectual ability and sporting prowess are potentially protective factors in relation to his psychosocial integration and development and a primary goal of the intervention was to motivate George to develop these strengths, if only for his own benefit initially. To this end, narcissistic aspects of his functioning were not discouraged in relation to pro-social behaviour, being harnessed if appropriate but challenged where counterproductive.

Future Considerations and Long-Term Planning

The young person presented in this case study was quite likeable and, when so predisposed, highly personable, with an uncanny ability to get others "on side". These characteristics were actually congruent with psychopathic tendencies, apparently arising from both an innate predisposition and early psychosocial factors, including family discord and emotional deprivation. By using a collaborative approach, the author fostered an enduring therapeutic relationship conducive to engaging George in meaningful dialogue about his inner world, leading to new insights regarding his thoughts and behaviours. Accessing associated emotions was more elusive, with George inherently reluctant to acknowledge and loath to disclose or discuss his feelings. Arresting George's trajectory towards adult psychopathy involved containing and preventing his offending behaviours, structuring his day to day life, maximising his natural abilities, fostering the therapeutic relationship and developing positive male role models. Longer term planning involved a continuation of these interventions and increasing focus on helping George to understand the links between his cognitions, feelings, behaviours and developing identity, which need not inevitably be shaped or bound by the psychopathic aspects of his personality.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Atkins, M. S., & Stoff, D. M. (1993). Instrumental and hostile aggression in childhood disruptive behavior disorders. *Journal of Abnormal Child Psychology, 21,* 165-178.

Baker, D., Knight, K., & Simpson, D.D. (1995). Identifying probationers with ADHD-related behaviors in a drug abuse treatment setting. *Criminal Justice and Behavior, 22* (1), 33-43.

Barriga, A.Q, & Gibbs, J.C. (1996). Measuring cognitive distortions in antisocial youth: Development and preliminary evaluation of the How I Think Questionnaire. *Aggressive Behavior, 22,* 333-343.

Barriga, A.Q., Gibbs, J.C., Bud Potter, G., & Liau, A.K. (2001). *How I Think (HIT) Questionnaire Manual.* Champaign, IL: Research Press

Baumeister, R.F., Smart, L., & Boden, J.M. (1996). Relation of threatened egotism to violence and aggression: The dark side of high self-esteem. *Psychological Review, 103,* 5-33.

Bleiberg, E. (2001). *Treating personality disorders in children and adolescents. A relational approach.* New York: The Guilford Press.

Chandler, M., & Moran, T. (1990). Psychopathy and moral development: A comparative study of delinquent and nondelinquent youth. *Development and Psychopathology, 2* (3), 227-246.

Conacher, G.N., & Quansey, V.L. (1992). Predictably dangerous psychopaths. *The Lancet,* 340, 794.

Devita, E., Forth, A.E., & Hare, R.D. (1990, June). *Psychopathy, early family background, and criminal behavior.* Paper presented at Canadian Psychological . Association meeting, Ottawa, Ontario.

Dolan, M.C., & Coid, J. (1993). *Psychopathic and antisocial personality disorders: Treatment and research issues.* London: Gaskell.

Dolan, M. C. (1994). Psychopathy – A neurobiological perspective. *British Journal of Psychiatry, 165* (2), 151-159.

Eyestone, L.L., & Howell, R.J. (1994). An epidemiological study of attention-deficit hyperactivity disorder and major depression in a male prison population. *Bulletin of the American Academy of Psychiatry and Law, 22* (2), 181-193.

Farrington, D.R. (1983). Offending from 10-25 years of age. In K.T. Van Dusen & S.A. Mednick (Eds.), *Prospective studies of crime and deliquency* (pp. 17-37). Boston: Kluwer-Nijoff.

Farrington, D. P., Loeber; R., & Van Kammen, W B. (1990). Long-term criminal outcomes of hyperactivity-impulsivity-attention deficit and conduct problems in childhood. In L. N. Robins & M. R. Rutter (Eds.), *Straight and devious pathways from childhood* to *adulthood* (pp. 62-81) New York: Cambridge University Press.

Forth, A.E., Hart, S.D., & Hare, R.D. (1990). Assessment of psychopathy in male young offenders. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2*, 342-344.

Frick, P., O'Brien, B., Wootton, J., & McBumett, K. (1994). Psychopathy and conduct problems in children. *Journal of Abnormal Psychology, 103*, 700-707.

Gacono, C.B., & Hutton, H.E. (1994). Suggestions for clinical and forensic use of the Hare Psychopathy Checklist-Revised (PCL-R). *International Journal of Law and Psychiatry, 17*, 303-317.

Gibbs, J.G., Potter, G.B., & Goldstein, A.P. (1995). *The EQUIP program: Teaching youth to think and act responsibly through a peer-helping approach*. Champaign, IL: Research Press.

Gustafson, S.B., & Ritzer, D.R. (1995). The dark side of normal: A psychopathy-linked pattern called aberrant self-promotion. *European Journal of Personality, 9* (3), 147-183.

Halperin, J. M., O'Brien, J. D., Newcom, J. H., Healey, J. M., Pascuaslvaca, D. M., Wolf, L. E., & Young, J. G. (1990). Validation of hyperactive, aggressive, and mixed disorders: A research note. *Journal of Child Psychology and Psychiatry, 31*, 455-459.

Hare, R.D. (1991). *The Hare Psychopathy Checklist-Revised.* Toronto, Ontario: Multi-Health Systems.

Hare, R.D. (1993). *Without conscience. The disturbing world of the psychopaths amongst us.* New York: Pocket books.

Hare, R.D., Forth, A.E., & Strachan, K. (1992). Psychopathy and crime across the lifespan. In R.DeV. Peters, R.J. McMahon, & V.L. Quinsey (Eds.), *Aggression and violence throughout the life span (pp. 285-300).* Newbury Park, CA: Sage.

Hare, R.D., Forth, A.E., & Haft, S.D. (1989). The psychopath as prototype for pathological lying and deception. In J.C. Yuille (Ed.), *Credibility assessment (pp.* 24-49). Dordrecht, The Netherlands: Kluwer.

Hart, S.D.. Forth, A.E., & Hare, R.D. (1990). Performance of criminal psychopaths on selected neuropsychological tests. *Journal of Abnormal Psychology, 99,* 374-379.

Harpur, T.J., & Hare, R.D. (1994). The assessment of psychopathy as a function of age. *Journal of Abnormal Psychology, 103,* 604-609.

Hart. S.D., Kropp, P.R., & Hare, R.D. (1988). Performance of psychopaths following conditional release from prison. *Journal of Consulting and Clinical Psychology, 56,* 227-232.

Hinshaw, S. P. (1987). On the distinction between attentional deficits/ hyperactivity and conduct problems/ aggression in child psychopathology. *Psychological Bulletin, 101,* 443-463.

Hinshaw, S. P. (1994). Conduct disorder in childhood: Conceptualization, diagnosis, comorbidity, and risk status for antisocial functioning in adulthood. In D. Fowles, P. Sutker, & S. Goodman (Eds.), *Progress in experimental personality, and psychopathology research: Vol. 18. Psychopathy and antisocial personality: A developmental perspective* (pp. 3-44). New York: Springer.

Lapierre, D., Braun, C, M., & Hodgins, S. (1995). Ventral frontal deficits in psychopathy: Neuropsychological test findings. *Neuropsychologia, 32* (2), 139- 151

Lahey, B. B., Piacentini, J. C., McBurnett, K., Stone, P., Hartdagen, S. & Hynd, G. (1987). Psychopathology in the parents of children with conduct disorder and hyperactivity. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 163-170.

Lezak, M. D. (1995). *Neuropsychological assessment* (3rd ed.). New York: Oxford University Press.

Lilienfeld, S. O., & Waldman, I. D. (1990). The relation between childhood attention-deficit hyperactivity disorder and adult antisocial behavior re-examined: The problem of heterogeneity. *Clinical Psychology Review, 10,* 699-725.

Lilienfeld, S.O., & Andrews, B.P. (1996). Development and preliminary validation of a self-report measure of psychopathic personality traits in non-criminal populations. *Journal of Personality Assessment, 66,* 488-524.

Loeber, R., Brinthaupt. V. P., & Green, S. (1990). Attention deficits, impulsivity, and hyperactivity with or without conduct problems: Relationships to delinquency and unique contextual factors. In R. J. McMahon & R. D. Peters (Eds.), *Behavior disorders of adolescence: Research, intervention and policy in clinical and school settings (pp.* 39-61). New York: Plenum Press.

Loeber, R., & Dishion, T. (1983). Early predictors of male delinquency: A review. *Psychological Bulletin, 94,* 68-99.

Loeber, R., Green. S. M., & Lahey, B. B., & Stouthamer-Loeber, M. (1991). Differences and similarities between children, mothers, and teachers as informants on disruptive child behavior. *Journal of Abnormal Child Psychology, 19,* 75-96.

Loeber, R., Stouthamer-Loeber. M., Van Kammen, W., & Farrington, D. (1989) . Development of a new measure for self-reported antisocial behavior in young children: Prevalence and eliability. In M. W. Klein (Ed.), *Cross-national research in self-reported crime and delinquency.* Dordrecht, The Netherlands: Kluwer.

Lovelace, L., & Gannon, L. (1999). Psychopathy and depression: Mutually exclusive constructs? *Journal of Behavior Therapy & Experimental Psychiatry, 30* (3), 169-176.

Lynam, D.R. (1996). The early identification of chronic offenders: Who is the fledgling psychopath? *Psychological Bulletin, 120*, 209-234.

Lynam, D.R. (1997). Pursuing the psychopath: Capturing the fledgling psychopath in a nomological net. *Journal of Abnormal Psychology, 106*, 425-438.

McHoskey, J.W. (2001). Machiavellianism and personality dysfunction. *Personality and Individual Differences, 31* (5), 791-798.

McHoskey, J.W., Worzel, W., & Szyarto, C. (1998). Machiavellianism and psychopathy. *Journal of Personality and Social Psychology, 74* (1), 192-210.

Millon, T. (1993). *Millon Adolescent Clinical Inventory (MACI) Manual.* Minneapolis, MN: National Computer Systems.

Moffitt, T E. (1990). Juvenile delinquency and attention deficit disorder: Boys' developmental trajectories from age 3 to age 15. *Child Development, 61,* 893-910.

Moffitt, T E. (1993). Adolescence-limited and life-course persistent antisocial behavior: A developmental taxonomy. *Psychological Review, 100*, 674-701.

Moffitt. T E., & Lynam, D. R. (1994). The neuropsychology of conduct disorder and delinquency: Implications for understanding antisocial behavior. In D. Fowles, P. Sutker. & S. Goodman (Eds.), *Progress in experimental personality and psychopathology research: Vol. 18. Psychopathy and antisocial personality: A developmental perspective* (pp. 233-262). New York: Springer.

Murrie, D.C., & Cornell, D.G. (2000). The Millon Adolescent Clinical Inventory and psychopathy. *Journal of Personality Assessment, 75* (1), 110-125.

Newman, J. P., & Wallace, J. F (1993). Divergent pathways to deficient self-regulation: Implications for disinhibitory psychopathology in children. *Clinical Psychology Review, 13,* 699-720.

Newman, LP., Pattersonj.GM., & Kossoh, D.S. (1987). Response perseveration in psychopaths. *Journal of Abnormal Psychology, 96, 145-148.*

O'Brien, B. S., & Frick, P. J. (1996). Reward dominance: Associations with anxiety, conduct problems, and psychopathy in children. *Journal of Abnormal Psychology, 24,* 223-240.

Patrick, C.L. Bradley, M.M., & Lang, P.J. (1993). Emotion in the criminal psychopath: Startle reflex modulatuion. *Journal of Abnormal Psychology, 102,* 82-92.

Reid, W.H. (1981). *The treatment of antisocial syndromes.* Toronto: Van Nostrand Reinhold.

Rice, M., Harris, G., & Cormier, C. (1992). An evaluation of maximum-security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior, 16,* 399-412.

Robins, L.N. (1978). Aetiological implications in studies of childhood histories relating to antisocial personality. In R.D. Hare & D. Schalling (Eds.), *Psychopathic behavior: Approaches to research (pp. 255-271).* Chichester, England: Wiley.

Robins, L.N. (1981). Epidemiological approaches to natural history research: Antisocial disorders in children. *Journal of the American Academy of Child Psychiatry, 20,* 566-580.

Serin, R. C. (1991). Psychopathy and violence in criminals. *Journal of Interpersonal Violence,* 6, 423-431.

Serin, R.C. (1993). Diagnosis of psychopathy with and without an interview. *Journal of Clinical Psychology, 49,* 367-372.

Smith, S. S., Arnett, P A., & Newman, J. P (1992). Neuropsychological differentiation of psychopathic and nonpsychopathic criminal offenders. *Personality and Individual Differences, 13,* 1233-1243.

Steingard, R., Biederman, J., Doyle, A., & Sprich-Buckminster (1992). Psychiatric comorbidity in attention deficit disorder: Impact on the interpretation of Child Behavior Checklist results. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 449-454.

Trevethan, S.D., & Walker, L.J. (1989). Hypothetical versus real-life moral reasoning among psychopathic and delinquent youth. *Development and Psychopathology, 1* (2), 91-103.

Walker, J. L., Lahey, B. B., Hynd, G. W., & Frame, C. L. (1987). Comparison of specific patterns of antisocial behavior in children with conduct disorder with or without coexisting hyperactivity. *Journal of Consulting and Clinical Psychology, 55*, 910-913.

Wechsler, D. (1992). *Manual for the Wechsler Intelligence Scale for Children – Third Edition. Australian Version.* Australia: Harcourt Brace & Company.

Wolfgang, M.E., Figlio, R.M., & Sellin, J.T. (1972). *Delinquency in a birth cohort*. Chicago: University of Chicago Press.

Wong, S. (1988). Is Hare's Psychopathy Checklist reliable without the interview? *Psychological Reports, 62,* 931-934.

Zoccolillo, M., Pickles, A., Quinton, D., & Rutter, M. (1992). The outcome of childhood conduct disorder: Implications for defining adult personality disorder and conduct disorder. *Psychological Medicine, 22*, 971-986.

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Adolescent Forensic Health Service

The **Adolescent Forensic Health Service** is a department of the Centre for Adolescent Health, which is part of the Women's and Children's Health Care Network.

The Centre is affiliated with the University of Melbourne.

The **Adolescent Forensic Health Service** is funded by the Department of Human Services, Juvenile Justice Section.

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Centre for
ADOLESCENT
HEALTH

Adolescent Forensic Health Service

The Adolescent Forensic Health Service aims to develop and provide innovative programs and quality health care services to high risk young people in the Juvenile Justice system.

Services and Programs

Custodial Health Teams

The Adolescent Forensic Health Service provides comprehensive health services to young people in custody including primary health care, psychosocial assessment and alcohol and drug counselling at both Parkville Youth Residential Centre (PYRC) and Melbourne Juvenile Justice Centre (MJJC).

Primary health programs offered include universal screening for STI's and BBV's, drug withdrawal and health promotion. Other services provided include 1) programs designed on the principles of harm reduction and safety in relation to anger management, violence intervention and reduction in offending, 2) secondary consultation and 3) health information for clients and Juvenile Justice staff.

Community Team

The Community Team provides specialist forensic health services to the metropolitan Juvenile Justice Units, thereby targeting young people on community-based Juvenile Justice orders. Staff provide secondary consultation on a wide range of health related issues and facilitate external referrals to community agencies. The Community Team provides:

- psychosocial assessments
- individual therapy (limited capacity)
- group treatment interventions
- offence specific group programs.

Peer Education Program (PEP)

The Peer Education Program (PEP) is designed to influence and change behaviour norms of young people. The program aims to raise young people's understanding of drugs and drug use issues in society by developing knowledge about alcohol, drugs and infectious diseases.

The program invites young people to attend training workshops via the agency they may be involved with.

The PEP is a statewide service that uses a harm reduction focus that is in-line with the national drug strategy. The program targets young people in:

- Juvenile Justice Centres
- Juvenile Justice Units
- Community based organisations.

The PEP is also able to assist community organisations to develop peer oriented approaches for working with young people by providing training and information workshops.

Adolescent Forensic Health Service

The Male Adolescent Program for Positive Sexuality (MAPPS)

The Male Adolescent Program for Positive Sexuality (MAPPS) is a statewide assessment and treatment service for adolescents who have committed sexual offences.

MAPPS is responsible for the assessment and treatment planning of all adolescent sex offenders in the Victorian Juvenile Justice System.

MAPPS staff provide secondary and tertiary consultancy on a wide range of issues associated with adolescent sexual aggression.

MAPPS provides numerous training programs on treatment, risk management, organisational awareness, policy development and others.

The MAPPS program actively supports and contributes to research into adolescent sexual aggression.

Mission Statement

To work with young people to help them make choices to stop their offending, and to maximize healthy behaviours in order for them to integrate safely within the community.

The Adolescent Forensic Health service

The Adolescent Forensic Health Service aims to develop and provide innovative programs and quality health care services to high risk young people in the juvenile justice system

Community Team

Historically, young people within the Juvenile Justice system have had difficulty accessing mainstream health services. Adolescents, particularly young men, are reluctant in their health seeking behaviour and often do not attend agencies even when a service is available. Young people on community-based orders have found it difficult to access, or be maintained within, local community health services, including mental health. Models of service delivery in these mainstream services are often not designed with the particular needs of this group in mind and are therefore challenged, as they do not meet the needs of such young people. The risk for this client group is that an already marginalised population becomes further disadvantaged.

Aims of the Community Team

The Adolescent Forensic Health Service Community Team, aims to improve the access to health services for these young people by:

- providing an outreach service to the metropolitan Juvenile Justice Units
- engaging young people through their contact with the Juvenile Justice Workers
- being flexible about where the young person is seen, for example, home visits and community visits
- persisting in attempts to engage the young person, beyond that which other services would normally have the capacity
- providing a comprehensive initial assessment to ascertain the presenting problems and priorities for the young person's forensic health needs, so that the most salient issues are addressed.

Service Delivery

The Community Team works from a base at the Adolescent Forensic Health Service in Parkville. Each of the four metropolitan Juvenile Justice Units is serviced at their Unit by a smaller multidisciplinary representation from within the Community Team. Despite the limitations in resources, this model maximises the skill base available to the young people seen at each of the Units.

The young people have Juvenile Justice Orders from Probation through to Parole and are being supervised by the Juvenile Justice Units while they complete their community-based order. The Community Team works with male and female young people aged 10 – 21years.

While the Team does not have the capacity for a crisis response given the funding arrangements, assistance is provided either directly or by telephone to Juvenile Justice staff in order to access services that are resourced appropriately for that function.

Forensic Health Care Needs

Mental health needs of Juvenile Justice clients in the community have proved to be significant and the majority of referrals for assessment to the Community Team have involved presenting problems of an emotional or psychiatric nature. Access to secondary consultation with the Adolescent Forensic Health Service Consultant Psychiatrist is now incorporated into the program.

The Community Team planned for a staged implementation:

1. Community linkages
2. Secondary consultation
3. Direct client work – assessment and individual therapy

4. Direct client work – group programs
5. Health promotion

All five stages have commenced. Many significant service linkages have been made with child and adolescent mental health services, adult mental health services, community agencies and drug services. Of particular interest are the joint initiatives that are established currently. Such linkages are seen as important steps in assisting young people to gain entry to services. This would be achieved by: increasing other agencies' awareness of the needs of this client group; demystifying other professionals' beliefs about this population; creating opportunities for young people on community based orders to meet health professionals, and by sharing skills, which occurs between professionals during such joint ventures. It also provides the opportunity to tailor programs to meet the specific needs of this group.

Secondary consultation is a priority activity for the Team. The Juvenile Justice Workers have greatest access to young people on community-based orders and in many cases have been able to establish a relationship with the young person. The Community Team has sought to support these staff in a way that acknowledges their skills and resources.

In circumstances where a young person's health needs are unclear, or where they have specific forensic health needs and there is no community agency available or accessible to the young person, the Community Team can provide assessment and intervention as appropriate. This is usually undertaken in the form of a comprehensive psychosocial assessment with a detailed report. Recommendations can include the ongoing involvement of the Team where no other community agency is able to meet the identified needs. In order to assist in catering for some of the needs of young people on community-based orders, group programs are also being offered.

Networking

The Community Team continues to create opportunities for building new community links with community agencies and strengthening existing relationships in order to improve the range and accessibility of services available to young people with forensic health issues. In addition, health promotional activities will be undertaken to assist young people on community-based orders, so that those who are healthy can stay healthy, those who are at risk can minimise their health risk behaviours and those who are unwell can maximise their quality of life.

If you would like further information about the Community Team, please contact the Adolescent Forensic Health Service: **Phone:** (03) 9389 4424

Fax: (03) 9389 4444
Email: afhs@cryptic.rch.unimelb.edu.au
Web site:
www.rch.unimelb.edu.au/adolescent/AFHS.html

We are located at 900 Park Street, Parkville 3052.

The Adolescent Forensic Health Service is a department of the Centre for Adolescent health, which is part of the Women's and Children's Health Care

The Centre is affiliated with the University of Melbourne.

The Adolescent Forensic Health Service is funded by the Department of Human Services, Juvenile Justice Section.

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ool _____ Grade _____

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WISC-III™

Wechsler Intelligence Scale for Children–Third Edition

AUSTRALIAN VERSION

Subtests	Raw Scores	Scaled Scores					
ture Completion	26		15		15		
formation	21	11		11			
ding	82		17				17
nilarities	25	13		13			
ture Arrangement	44		12		12		
ithmetic	21	11					
ck Design	40		8		8		
cabulary	35	9		9			
ject Assembly	11		16		16		
mprehension	26	10		10			
ymbol Search)	—		(14)				14
igit Span)	16	(11)				11	
lazes)			( )				
Sum of Scaled Scores		54	68	43	51	22	31
		Verbal	Perfor.	VC	PO	FD	PS
		Full Scale Score 22		OPTIONAL			

P.K.

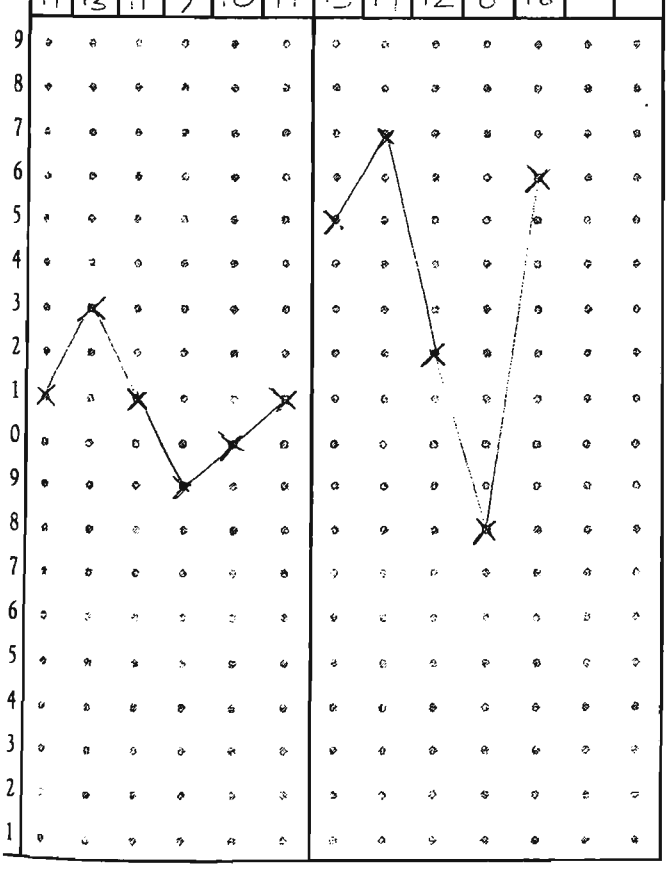
	Year	Month	Day
Date Tested			
Date of Birth			
Age			

	Score	IQ/ Index	%ile	95% Confidence Interval
Verbal	54	105	63	99 - 111
Performance	68	125	95	115 - 131
Full Scale	122	115	84	109 - 120
VC	43	104	61	97 - 111
PO	51	117	87	107 - 124
FD	22	106	66	96 - 114
PS	31	109	97	115 - 126

P.K.

Subtest Scores

Verbal						Performance						
Inf	Sim	Ari	Voc	Com	DS	PC	Cd	PA	BD	OA	SS	Mz
11	13	11	9	10	11	15	17	12	8	16		

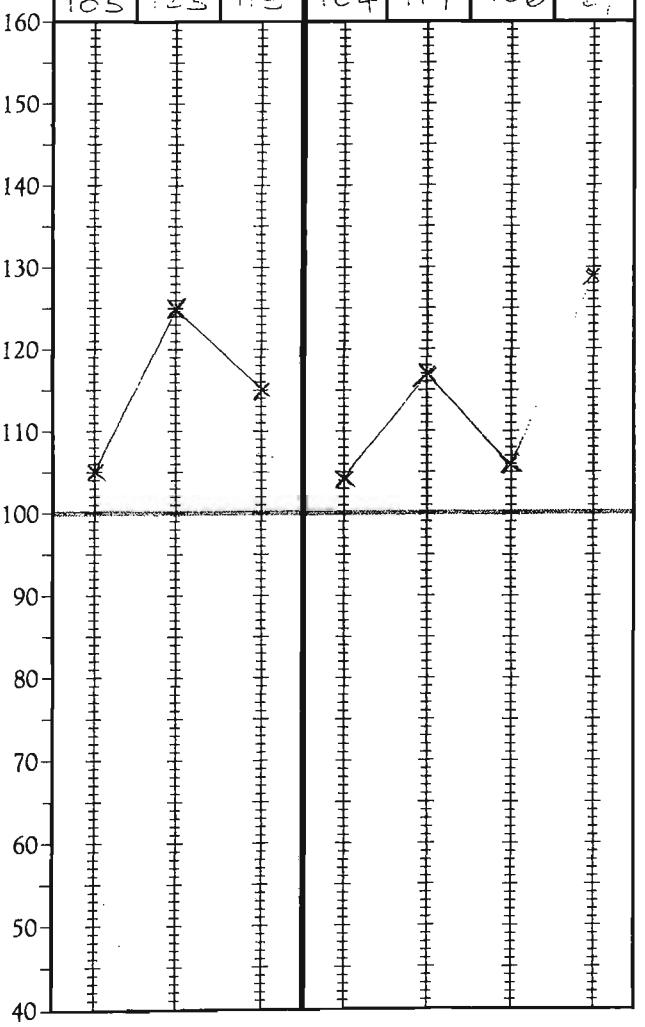


IQ Scores

VIQ	PIQ	FSIQ
105	125	115

Index Scores (Optional)

VCI	POI	FDI	PSI
104	117	106	109



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HARCOURT BRACE & COMPANY, Australia

MACI™
Millon Adolescent Clinical Inventory™

by Theodore Millon, PhD, with Carrie Millon, PhD, and Roger Davis

MICROTEST Q™ Assessment System

NAME (Optional) _____

_____

IDENTIFICATION NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
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5	5	5	5	5	5	5	5	5
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7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

BIRTH DATE

MONTH		DAY		YEAR	
0	0	0	0	0	0
1	1	1	1	1	1
	2	2	2	2	2
	3	3	3	3	3
	4		4	4	4
	5		5	5	5
	6		6	6	6
	7		7	7	7
	8		8	8	8
	9		9	9	9

Which two of the following trouble you the most?

1ST	PROBLEMS	2ND
1	Body/Looks	1
2	Career Goals	2
3	Court Problems	3
4	Drugs/Alcohol	4
5	Family Life	5
6	Fearful/Worrying	6
7	Lack of Confidence	7
8	Lack of Friends	8
9	Lonely/Depressed	9
10	Moody/Irritable	10
11	Restless/Bored	11
12	Schoolwork	12
13	Sexual Feelings	13
14	Sick/Tired	14
15	Other	15

TEST DATE

MONTH		DAY		YEAR	
0	0	0	0	0	0
1	1	1	1	1	1
	2	2	2	2	2
	3	3	3	3	3
	4		4	4	4
	5		5	5	5
	6		6	6	6
	7		7	7	7
	8		8	8	8
	9		9	9	9

GENDER

1 Male
2 Female

CURRENT SCHOOL GRADE

Junior or Senior High School	7	8	9	10	11	12
College	1	2	3	4		
Not Attending	0					

DIRECTIONS:

1. Print your identification number in the spaces. Then find the circle below each space that has the same number and blacken it. In a similar way, complete the Birth Date and Test Date boxes.
2. Blacken the circle for either male or female. Blacken the circle that shows your current school grade. In the same way, blacken the two circles that best describe your problems. Your counselor will complete the information in the shaded section.
3. Use a soft black lead pencil only, and fill in the circles with a heavy, dark mark.
4. If you want to change an answer, erase it carefully and then fill in your new choice.
5. Do not make any marks outside the circles.

COUNSELOR DIRECTIONS:
This section may be used to record information used in your research.

Q		R				S	T	U	V	W	X	Y	Z
0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2	2
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6	6	6	6	6	6	6	6	6	6	6	6	6	6
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8	8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9	9

National Computer Systems P. O. Box 1416 Minneapolis MN 55440 Phone 1-800-627-7271

Product Number 51429

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48080

TEST DIRECTIONS:

The following pages contain a list of statements that young people use to describe themselves. They are printed here to help you in describing your feelings and attitudes. Try to be as honest and serious as you can in marking the statements since the results will be used to help your counselor learn about you and help you plan your future.

Do not be concerned if a few statements seem unusual; they are included to help teenagers with many types of problems. If you agree with a statement or decide that it describes you, fill in the T to mark it True (● F). If you disagree with a statement or decide that it does not describe you, fill in the F to mark it False (T ●). Try to mark every statement, even if you are not sure of your choice. If you have tried your best and still cannot decide, mark the F for False.

There is no time limit for completing the inventory, but it is best to work as rapidly as is comfortable for you.

This form will be scored by computer and the results will be kept confidential.

I would much rather follow someone than be the leader.

I'm pretty sure I know who I am and what I want in life.

I don't need to have close friendships like other kids do.

I often resent doing things others expect of me.

I do my very best not to hurt people's feelings.

I can depend on my parents to be understanding of me.

Some people think of me as a bit conceited.

I would never use drugs, no matter what.

I always try to do what is proper.

I like the way I look.

Although I go on eating binges, I hate the weight I gain.

Nothing much that happens seems to make me either happy or sad.

I seem to have a problem getting along with other teenagers.

I feel pretty shy telling people about how I was abused as a child.

I've never done anything for which I could have been arrested.

I think everyone would be better off if I were dead.

Sometimes, when I'm away from home, I begin to feel tense and panicky.

I usually act quickly, without thinking.

I guess I'm a complainer who expects the worst to happen.

It is not unusual to feel lonely and unwanted.

Punishment never stopped me from doing whatever I wanted.

Drinking seems to have been a problem for several members of my family.

I like to follow instructions and do what others expect of me.

I seem to fit in right away with any group of new kids I meet.

So little of what I have done has been appreciated by others.

I hate the fact that I don't have the looks or brains I wish I had.

I like it at home.

I sometimes scare other kids to get them to do what I want.

Although people tell me I'm thin, I still feel overweight.

30 T F When I have a few drinks I feel more sure of myself.

31 T F Most people are better looking than I am.

32 T F I often fear I'm going to panic or faint when I'm in a crowd.

33 T F I sometimes force myself to vomit after eating a lot.

34 T F I often feel as if I'm floating around, sort of lost in life.

35 T F Most other teenagers don't seem to like me.

36 T F When I have a choice, I prefer to do things alone.

37 T F Becoming involved in other people's problems is a waste of time.

38 T F I often feel that others do not want to be friendly to me.

39 T F I don't care much what other kids think of me.

40 T F I used to get so stoned that I did not know what I was doing.

41 T F I don't mind telling people something they won't like hearing.

42 T F I see myself as falling far short of what I'd like to be.

43 T F Things in my life just go from bad to worse.

44 T F As soon as I get the impulse to do something, I act on it.

45 T F I've never been called a juvenile delinquent.

46 T F I'm often my own worst enemy.

47 T F Very few things or activities seem to give me pleasure.

48 T F I always think of dieting, even when people say I'm underweight.

49 T F I find it hard to feel sorry for people who are always worried about things.

50 T F It is good to have a routine for doing most things.

51 T F I don't think I have as much interest in sex as others my age.

52 T F I don't see anything wrong with using others to get what I want.

53 T F I would rather be almost anyplace but home.

54 T F I sometimes get so upset that I want to hurt myself seriously.

55 T F I don't think I was sexually molested when I was a young child.

56 T F I am a dramatic and showy sort of person.

57 T F I can hold my beer or liquor better than most of my friends.

58 T F Parents and teachers are too hard on kids who don't follow rules.

59 T F I like to flirt a lot.

60 T F To see someone suffering doesn't bother me.

61 T F I don't seem to have much feeling for others.

62 T F I enjoy thinking about sex.

63 T F I worry a great deal about being left alone.

64 T F I often feel sad and unloved.

65 T F I'm supposed to be thin, but I feel my thighs and backside are much too big.

66 T F I often deserve it when others put me down.

67 T F People put pressure on me to do more than is fair.

68 T F I think I have a good body.

69 T F I feel left out of things socially.

70 T F I make friends easily.

71 T F I'm a somewhat scared and anxious person.

72 T F I hate to think about some of the ways I was abused as a child.

73 T F I'm no different from lots of kids who steal things now and then.

74 T F I prefer to act first and think about it later.

75 T F I've gone through periods when I smoked pot several times a week.

76 T F Too many rules get in the way of my doing what I want.

77 T F When things get boring, I like to stir up some excitement.

78 T F I will sometimes do something cruel to make someone unhappy.

79 T F I spend a lot of time worrying about my future.

80 T F I often feel I'm not worthy of the nice things in my life.

81 T F I sort of feel sad when I see someone who's lonely.

82 T F I eat little in front of others; then I stuff myself in private.

83 T F My family is always yelling and fighting.

84 T F I sometimes feel very unhappy with who I am.

85 T F I don't seem to enjoy being with people.

86 T F I have talents that other kids wish they had.

87 T F I'm very uncomfortable with people unless I'm sure they really like me.

88 T F Killing myself may be the easiest way of solving my problems.

89 T F I sometimes get confused or upset when people are nice to me.

90 T F Drinking really seems to help me when I'm feeling down.

91 T F I rarely look forward to anything with much pleasure.

92 T F I'm very good at making up excuses to get out of trouble.

93 T F It is very important that children learn to obey their elders.

94 T F Sex is enjoyable.

95 T F No one really cares if I live or die.

96 T F We should respect our elders and not think we know better.

97 T F I sometimes get pleasure by hurting someone physically.

98 T F I often feel lousy after something good has happened to me.

99 T F I don't think people see me as an attractive person.

100 T F Socially, I'm a loner and I don't mind it.

101 T F Almost anything I try comes easy to me.

102 T F There are times when I feel that I'm a much younger person than I actually am.

103 T F I like being the center of attention.

104 T F If I want to do something, I just do it without thinking of what might happen.

105 T F I'm terribly afraid that no matter how thin I get, I will start to gain weight if I eat.

106 T F I won't get close to people because I'm afraid they may make fun of me.

107 T F More and more often I have thought of ending my life.

108 T F I sometimes put myself down just to make someone else feel better.

109 T F I get very frightened when I think of being all alone in the world.

110 T F Good things just don't last.

111 T F I've had a few run-ins with the law.

112 T F I'd like to trade bodies with someone else.

113 T F There are many times when I wish I were much younger again.

114 T F I have not seen a car in the last ten years.

115 T F Other people my age seem more sure than I am of who they are and what they want.

116 T F Thinking about sex confuses me much of the time.

117 T F I do what I want without worrying about its effect on others.

118 T F Lots of things that look good today will turn out bad later.

119 T F Others my age never seem to call me to get together with them.

120 T F There have been times when I could not get through the day without some pot.

121 T F I make my life worse than it has to be.

122 T F I prefer being told what to do rather than having to decide for myself.

123 T F I have tried to commit suicide in the past.

124 T F I go on eating binges a couple of times a week.

125 T F Lately, little things seem to depress me.

126 T F I flew across the Atlantic 30 times last year.

127 T F There are times I wish I were someone else.

128 T F I don't mind pushing people around to show my power.

129 T F I'm ashamed of some terrible things adults did to me when I was young.

130 T F I try to make everything I do as perfect as possible.

131 T F I am pleased with the way my body has developed.

132 T F I often get frightened when I think of the things I have to do.

133 T F Lately, I feel jumpy and nervous almost all the time.

134 T F I used to try hard drugs to see what effect they'd have.

135 T F I can charm people into giving me almost anything I want.

136 T F Many other kids get breaks I don't get.

137 T F People did things to me sexually when I was too young to understand.

138 T F I often keep eating to the point that I feel sick.

139 T F I will make fun of someone in a group just to put them down.

140 T F I don't like being the person I've become.

141 T F I seem to make a mess of the good things that come my way.

142 T F Although I want to have friends, I have almost none.

143 T F I am glad that feelings about sex have become a part of my life now.

144 T F I'm willing to starve myself to be even thinner than I am.

145 T F I'm very mature for my age and know what I want to do in life.

146 T F In many ways I feel very superior to most people.

147 T F My future seems hopeless.

148 T F My parents have had a hard time keeping me in line.

149 T F When I don't get my way, I quickly lose my temper.

150 T F I often have fun doing certain unlawful things.

151 T F I guess I depend too much on others to be helpful to me.

152 T F When we're having a good time, my friends and I can get pretty drunk.

153 T F I feel lonely and empty most of the time.

154 T F I feel pretty aimless and don't know where I'm going.

155 T F Telling lies is a pretty normal thing to do.

156 T F I've given thought to how and when I might commit suicide.

157 T F I enjoy starting fights.

158 T F There are times when nobody at home seems to care about me.

159 T F It is good to have a regular way of doing things so as to avoid mistakes.

160 T F I probably deserve many of the problems I have.

PLEASE DO NOT WRITE IN THIS AREA

48080

How I Think (HIT) Questionnaire

Name _____ Date _____

Age _____ Circle one: MALE / FEMALE Administered by _____

Please don't turn this page until it's time to begin.

Each statement in this questionnaire may describe how you think about things in life. Read each statement carefully, then ask yourself, "Is it fair to say that this statement describes my thinking during the last 6 months?" Your answers will be kept private.

Mark your answers on the sheet. Don't say them out loud.

Any questions?

OK, turn the page and begin.

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www.researchpress.com

1. People should try to work on their problems.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

2. I can't help losing my temper a lot.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

3. Sometimes you have to lie to get what you want.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

4. Sometimes I get bored.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

5. People need to be roughed up once in a while.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

6. If I made a mistake, it's because I got mixed up with the wrong crowd.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

7. If I see something I like, I take it.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

8. You can't trust people because they will always lie to you.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

9. I am generous with my friends.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

10. When I get mad, I don't care who gets hurt.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

11. If someone leaves a car unlocked, they are asking to have it stolen.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

12. You have to get even with people who don't show you respect.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

13. Sometimes I gossip about other people.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

14. Everybody lies, it's no big deal.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

15. It's no use trying to stay out of fights.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

16. Everyone has the right to be happy.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

17. If you know you can get away with it, only a fool wouldn't steal.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

18. No matter how hard I try, I can't help getting in trouble.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

19. Only a coward would ever walk away from a fight.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

20. I have sometimes said something bad about a friend.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

21. It's OK to tell a lie if someone is dumb enough to fall for it.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

22. If I really want something, it doesn't matter how I get it.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

23. If you don't push people around, you will always get picked on.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

24. Friends should be honest with each other.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

25. If a store or home owner gets robbed, it's really their fault for not having better security.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

26. People force you to lie if they ask too many questions.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

27. I have tried to get even with someone.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

28. You should get what you need, even if it means someone has to get hurt.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

29. People are always trying to hassle me.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

30. Stores make enough money that it's OK to just take things you need.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

31. In the past, I have lied to get myself out of trouble.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

32. You should hurt people first, before they hurt you.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

33. A lie doesn't really matter if you don't know that person.

AGREE STRONGLY	AGREE	AGREE SLIGHTLY	DISAGREE SLIGHTLY	DISAGREE	DISAGREE STRONGLY

34. It's important to think of other people's feelings.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

35. You might as well steal. If *you* don't take it, somebody *else* will.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

36. People are always trying to start fights with me.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

37. Rules are mostly meant for *other* people.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

38. I have covered up things that I have done.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

39. If someone is careless enough to lose a wallet, they deserve to have it stolen.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

40. Everybody breaks the law, it's no big deal.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

41. When friends need you, you should be there for them.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

42. Getting what you need is the only important thing.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

43. You might as well steal. People would steal from you if they had the chance.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

44. If people don't cooperate with me, it's not my fault if someone gets hurt.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

45. I have done bad things that I haven't told people about.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

46. When I lose my temper, it's because people try to make me mad.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

47. Taking a car doesn't really hurt anyone if nothing happens to the car and the owner gets it back.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

48. Everybody needs help once in a while.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

49. I might as well lie—when I tell the truth, people don't believe me anyway.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

50. Sometimes you have to hurt someone if you have a problem with them.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

51. I have taken things without asking.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

52. If I lied to someone, that's my business.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

53. Everybody steals—you might as well get your share.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

54. If I really want to do something, I don't care if it's legal or not.

AGREE STRONGLY | AGREE | AGREE SLIGHTLY | DISAGREE SLIGHTLY | DISAGREE | DISAGREE STRONGLY

Project 4: Exegesis:

Personality Disorders in Clinical Practice: Axis I Comorbidity, Management/ Treatment, Psychologist Boundary Issues and Self-Care

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Abstract

The unifying themes of the exegesis, namely the management of personality disorders (PDs) in clinical practice and psychologist self-care, evolved during my placement experiences over the preceding three years. The issue of PDs and sexual misconduct by therapists each represent somewhat unsavoury topics, while self-awareness and the psychologist's own legitimate psychological needs in relation to therapeutic work are frequently neglected. As a result, these are often areas pertaining to clinical practice given relatively little emphasis in postgraduate academic programs and during supervision of clinical work. This paper discusses these and several related themes, including the comorbidity of PDs with Axis I pathology, patients' motivation to change or embrace psychological therapy and boundary issues arising in their treatment, utilising observations made during the assessment/ treatment interventions previously reported in the research project case studies, and informed by the study of practitioner/ patient sexual transgressions. It has been the author's experience that the existence of PDs in adults presenting with mood or anxiety spectrum disorders, or in younger patients with behavioural disorders, need not necessarily discount the utility of psychological and psychosocial interventions. It may be further agued that patients with PDs, by virtue of their ubiquitous presence in clinical settings, the refractory nature of their psychological malfunctioning, and the deleterious impact of antisocial PD on society, should be a greater focus of research regarding effective treatment protocols. Also, given the high toll often exacted upon practitioners working with these difficult to engage people and the range of specific hazards encountered, a special section on psychologist self-awareness and self-care has been included in this exegesis of the placements undertaken during the completion of the author's doctoral studies.

Historical Conceptualisation of Personality Disorders, Legal Status and Current Psychiatric Nomenclature

The German psychiatrist Koch coined the term "psychopathic" in 1891, in reference to troubled or troublesome people who would today be regarded as having a PD, especially those deemed antisocial, who did not fit the criteria of "insanity" or "idiocy" (Kendell, 2002). According to Lewis (1974), Koch noted that "even in the bad cases the irregularities do not amount to mental disorder" (p. 133).

Although the term "psychopathic" is now reserved for a subset of antisocial PD (APD) involving core cognitive and affective attributes (see Hare, 1993), contemporary views of PDs have not changed greatly. Kendell (2002) noted that in the United Kingdom, a PD diagnosis is often "used to justify a decision not to admit someone to a psychiatric ward, or even to accept them for treatment – a practice that understandably puzzles and irritates the staff of accident and emergency departments, general practitioners and probation officers, who find themselves left to cope as best they can with extremely difficult, frustrating people without any psychiatric assistance" (p. 110). The author, who works as a psychologist in a consultation-liaison psychiatry team in a hospital casualty department, can report that the Australian experience is almost identical, except that casualty staff are often relieved if a person with known APD and no other psychiatric illnesses are refused entry on this basis and managed by security and/ or police intervention if uncontrollably aggressive.

The Mental Health Act (1986) is used in Victoria, Australia, in relation to the care, management (e.g., restraint, sedation and seclusion), treatment (e.g., electroconvulsive therapy), admission, detention and transfer of patients considered mentally ill, and the administration of mental health services. According to this legal, working document, "a person is not to be considered mentally ill by reason only of any" of a number of criteria. These include engagement in immoral, illegal, or drug/ alcohol taking conduct, or "that the person has an anti-social personality" (p. s.9). No references to any other common PDs, such as Borderline PD, are made. Decisions involving whether to admit and treat patients with BPD and other PDs are usually assessed on a case-by-case basis, in reference to their immediate risk of self-harming behaviour, the availability of community supports and frequency of surveillance required.

Notwithstanding legislative matters, Arntz (1999) concluded that, from a clinical perspective, "there

is enough evidence for the usefulness of PDs as diagnostic categories" (p. S97). In DSM-IV (APA, 1994), the listing of PDs "on a separate axis ensures that consideration will be given to the possible presence of Personality Disorders and Mental Retardation that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders. The coding of [PDs] on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I" (p. 26).

The main differences between PDs and Axis I illnesses such as depressive disorders and psychoses, is their "enduring, potentially lifelong nature and by the assumption they represent extremes of normal variation rather than a morbid process..." (Kendell, 2002, p. 111). Nevertheless, major psychotic illnesses, such as schizophrenia, tend to persist throughout life once established, with first onset often in adolescence. Furthermore, links between theories of PD and normal personality development and structure (e.g., Eysenck's extraversion/ introversion/ psychoticism dimensions; see Eysenck, 1961) are tenuous at best. Recently, Coccaro and Kavoussi (1997) significantly reduced irritability and aggression in several types of PD with fluoxetine (Prozac), an SSRI antidepressant also used with considerable success in the treatment of Body Dysmorphic Disorder (see Phillips et al., 1996; Research project 1). Coccaro and Kavoussi's findings represent further evidence that PDs are potentially manageable, if not wholly treatable, with a combination of pharmacological therapy and modified CBT, much like depression and, to a lesser degree, the major psychotic disorders.

Attitude of Health Care Practitioners to Personality Disorders

Mere awareness of a diagnosis of a PD is sufficient to dampen many health care practitioners' enthusiasm for working with these patients. Indifference, scepticism, lack of concern or derision towards patients with PDs is reflected in a deprecatory mindset and outlook that was evident to the author during each of the clinical psychology placements among many nursing, psychiatric and psychology professionals. As noted in Research Project 1, it was the author's impression that several patients at the community psychiatry health clinic were referred to the author *because* there were concomitant PDs perceived as unpalatable by existing staff. Steve, who had multiple diagnoses and whose BDD was treated by the author, had been described in previous nursing notes as "avoidant" and

"obsessive", but the ritualistic aspects of his BDD had never been elaborated until the author's involvement. There was a suspicion shared by the author and clinic manager (a senior clinical psychologist) that the avoidant and obsessive aspects of Steve's *personality* had dissuaded previous case managers from intervening beyond the level of managing his risk of self-harm, his level of threat to others when acutely psychotic and agitated, and his compliance with medication. Steve's most prominent personality traits fell into a category of PDs labelled Cluster C and sometimes colloquially referred to by practitioners as spanning a group of three PDs bracketed as "sad". These include Avoidant, Dependent and Obsessive-Compulsive PD. Cluster A, under the corresponding umbrella "mad", includes Paranoid, Schizoid and Schitzotypal PD. Although Steve had Axis I diagnoses of Bipolar and Schizoaffective Disorder, experiencing a broad range of pronounced psychotic symptoms during exacerbations of these illnesses, his premorbid personality and traits during therapy were not characteristic of Cluster A PDs. Although Paranoid, Schizoid and Schitzotypal PD are not infrequently viewed as less florid manifestations of schizophrenia-like illnesses corresponding to psychotic disorders in Axis I, the inter-axial connection is not always meaningful in clinical practice.

Joel, the second case described in Research Project 1, had personality traits reflective of Paranoid PD (evident in MMPI-2 testing), as well as a psychopathic trend, pertinent to the Cluster B PDs, often categorised as "bad". George, who featured in Research Project 3, was too young to be diagnosed with any PDs, but Conduct Disorder is regarded as the childhood/ adolescent version of APD. The Cluster B PDs are Antisocial (mainly affecting males), Narcissistic, Borderline and Histrionic PD (the latter two more often involving females). In George's case, background information and testimony from the young person and his mother suggested that Mr. Valiotis (George's father) exhibited personality traits indicative of Narcissistic and Antisocial PD. The three clusters of PD are shown below in Table 1.

Table 1 *DSM-IV Personality Disorder Clusters (American Psychiatric Association, 1994)*

Cluster A ("mad")	Cluster B ("bad")	Cluster C ("sad")
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive-Compulsive
	Narcissistic	

In adult community psychiatry, specialist programs for borderline PD, based on Linehan's dialectical-behaviour therapy (Linehan, 1993), are becoming widespread. These were developed from modifications of CBT for chronically suicidal individuals (see Linehan, Armstrong, Suarez, et al., 1991). However, ingrained views remain of the supposedly untreatable nature of all PDs, especially those in DSM-IV's Cluster B (Narcissistic, Antisocial, Borderline and Histrionic PD).

Lewis and Appleby (1988) used ratings of case vignettes by 240 experienced psychiatrists to demonstrate that behaviours such as suicide attempts attributed to patients diagnosed with PDs were usually regarded as being under voluntary control (as opposed to the result of mental illness) and therefore manipulative. The patients were typically viewed as "irritating, attention-seeking, difficult to manage and unlikely to comply with advice or treatment" (Kendel, 2002, p. 110).

In another study, Gallop, Lancee and Garfinkel (1989) compared attitudes to schizophrenia and borderline PD (BPD). They found that a patient's diagnostic label significantly affected the expressed empathy of psychiatric nursing personnel in a series of hypothetical patient statements. Staff "were more likely to demonstrate affective involvement in response to the schizophrenic patients' statements and...to offer belittling or contradicting responses to the statements of patients with borderline personality disorder" (p. 815), corroborating "increasing concerns that the diagnosis of borderline personality disorder has become a pejorative label for difficult patients..." (p. 815). Those authors further suggested that "staff may provide stereotypic responses and less empathic care" (p. 815) to BPD patients, compared to those with solely Axis-I diagnoses.

Negative, and often derogatory, views of BPD linger in the mental health field, while the ill will reserved for APD remains unshakable, with these patients typically consigned to the psychiatric scrapheap, typecast as impossible to help. Not infrequently, however, "what is commonly seen by clinicians as Axis II pathology is actually undertreated, subsyndromal mood disorder" (Barlow, 2001, p. 525; see Akistal, 1996).

There is also significant overlap between Axis I and II disorders, with Bipolar Disorder a good case in point. If evaluated during a period of remission, between one-fifth and just over one quarter of BD patients meet diagnostic criteria for an Axis II disorder (Carpenter, Clarkin, Glick, & Wilner, 1995;

George, Miklowitz, & Richards, 1996). Furthermore, differences between BD and Borderline Personality Disorder (BPD) are often slender (see Barlow, 2001). The "common underpinnings of affective dysregulation" (Barlow, 2001, p. 525) underlie many disorders comorbid with BPD, such as Borderline, Histrionic and Dependent PD. It is not unusual for patients with BD who are experiencing an exacerbation of symptoms as a result of substance abuse, or displaying anti-social behaviours, to be re-diagnosed with a PD. Regier et al. (1990) previously showed in large scale epidemiological research that 61% of patients with BD also met lifetime DSM-III criteria for any substance abuse or dependence.

Coexistence of Personality Disorders with Axis-I Disorders: Utility of CBT

In the preceding decade, the nosology of psychiatric illness has been dominated by the concept of "comorbidity" – the concurrent experience of more than one definitive psychiatric disorder. Dual diagnosis, a special case often reserved for coexistent major mental illness and substance abuse, frequently presented during the two clinical placements based in forensic environments. The author's experience, though, was that most patients were simultaneously diagnosable with many psychiatric disorders. Steve, the first case study presented in Research Project 1, was a typical example. Indeed, in non-specialist clinical practice, "two or three [DSM] axis I diagnoses and the same number of axis 2 diagnoses are the rule rather than the exception" (van Praag, 1996).

Just as "boundaries between bipolar and unipolar illness are sometime difficult to draw", so too "the distinction between bipolar disorder and Axis-II disorders are especially difficult" (Barlow, 2001, p. 525). BD was one of Steve's two most recent primary diagnoses (with Schizoaffective Disorder), as outlined in the first placement project report. However, it become apparent that cognitive-behaviour therapy (CBT) targeting his Body Dysmorphic Disorder (BDD) was likely to be most effective in reducing his distress levels and improving his quality of life. Steve also exhibited circumscribed Axis-II pathology, which seemed to make progress excruciatingly difficult at times, but was circumvented by persevering with a collaborative approach, using self-monitoring, that aimed to place Steve in the role of co-therapist and eventual sole arbiter of his BDD management.

With the recent exception of BPD, PDs are not customarily regarded as amenable to treatment. From a clinical perspective, the high rate of self harm among patients with BPD and the frequency of

backgrounds of sexual abuse thrust this PD into the spotlight as an illness that demanded and perhaps was *deserving* of treatment. However, other PDs simply do not present such a compelling case for intervention. As noted, the sole presence of APD, without evidence of other signs of mental illness, disqualifies patients from formal treatment in the majority of countries. Most APD cases that come to the attention of statutory authorities are "managed" by the criminal justice system, rather than mental health services (Kendell, 2002). Even this single form of PD represents a significant number of people, given that 80% of prison inmates – comprising more than one million people in the United States – are diagnosable with APD (see Lynam, 1997). In view of most clinicians' understandable aversion to attempting to treat APD, for which no recognised psychological treatments exist, George presented as a young person desperately requiring an immediate, profound and sustained intervention prior to his age and further criminal justice involvement conferring an unwelcome status somewhere in the too hard basket. Although only aged thirteen at referral, the passing of four or so years would place George in an age category in which child and adolescent mental health services would be quite reluctant to become involved or invest significant resources.

Nevertheless, adult PDs are often comorbid with Axis I disorders, and therefore a routine, relevant feature of the presentation of many patients in clinical practice, as demonstrated in the first placement case reports. In the treatment of younger age groups (children/ adolescents) in clinical-forensic environments (e.g., youth detention centres, substance abuse treatment facilities and community psychiatric clinics), psychologists are often specifically employed or asked to target the most difficult to engage or troublesome clients, namely those who typically have or are developing PDs (e.g., George and possibly Joel).

Since treatment for people with PDs "is often given up prematurely" (Kendell, 2002, p. 112) and "few random allocation trials with adequate long-term follow up" have been conducted, other than in BPD, "research on cognitive models and treatment of PDs is virtually absent" (Arntz, 1999, p. S97). Nonetheless, the small amount of available studies "indicates that PDs are not a contraindication for cognitive-behavioural treatment of axis-I problems, and that there are even indications that PD pathology itself can be successfully treated using modified CBT methods" (Arntz, 1999, p. S97).

Finally, discussions of treatment modalities for PDs would not be complete without reference to principles of relationship management and the concepts of "depsychiatrization" and "no-therapy therapy" (see Dawson, 1988). That author noted three essential goals in working with patients having a PD, namely:

1. Do no harm.
2. Reduce chaos and curtail the distorted relationship between patient and health care institution.
3. Consider therapy.

The first two goals were based on the observation that patients with BPD often appear to reserve their worst behaviour for their relationships with health care professionals and services connected with their mental health. In this regard, George's attitude prior to the author's involvement, which included eating pencils and his despatch of several teacher's aids, guidance officers and mental health care professionals, was "borderline-like" in several respects, but BPD considerations were less pertinent in view of his age, gender and the lack of a definite sexual abuse history than the established behavioural disorders documented (ADHD, ODD and CD). In addition, George never oscillated between rejection and dependency, or denunciation and idealisation, in his treatment of care givers, a characteristic of BPD patients, but did display these characteristics in regard to his father. In general, George was quick to rebuff but loathe to rely emotionally on others, which appeared to be a survival strategy based on his father's unpredictability, unreliability and emotional detachment.

Patients with PDs, and BPD in particular, invariably polarise opinion on best practice regarding their care, leading to inconsistent treatment protocols and not infrequently reinforcing destructive behaviour patterns (e.g., self-harm in response to unmet needs), which eventually leads to increased morbidity and institutionalisation. Hospitalisation is considered a last resort for these patients in this model.

The third principle of no-therapy therapy (consideration of therapy) is governed by the "belief that it is not always better to do something rather than do nothing" (p. 123). The value of diverting patients with BPD to non-psychiatric settings or offering appointments with no proactive therapeutic elements (e.g., a regular time for coffee) was based partially on the reality that the controlled or disciplined environment within a private or public psychiatric unit cannot be maintained indefinitely, nor replicated

in the community. Protagonists of these relationship principles would argue that they may be misused expediently by the health system as a means of reducing contact with difficult patients, akin to the broader philosophy of deinstitutionalisation for patients with schizophrenia and affective psychoses.

Although active interventions were undertaken in the case of both George and Steve, the very act of establishing consistent contact was viewed as an achievement with therapeutic implications, given Steven's lack of previous, consistent follow-up and George's unwillingness to be engaged. For different reasons, both patients were, in hindsight, good candidates for regular therapy. Steve's obsessive-compulsive traits possibly assisted in his excellent punctuality and clinic attendance record, in spite of his extreme anxiety and agoraphobia, while George, although usually met by, rather than coming to meet, the author, had a good school attendance record and was therefore always potentially able to be regularly engaged, as occurred. In George's case, prearranged, consistent contact was essential in simply changing his view that adult males (based on his father's record) are unreliable, irrespective of what could be achieved in therapy in the short term. The fact that George engaged exceptionally well and made significant psychosocial gains during the intervention were clear bonuses.

When Not to Treat: The Psychopathic Personality

If APD is the psychiatric diagnosis considered the least amenable – or in fact impossible – to "treat", using conventional psychological or psychiatric protocols, adult psychopathy is almost universally acknowledged as impervious to therapeutic intervention (Hare, 1993; see also Dolan & Coid, 1993). Background dynamics and perturbations related to bezotzovschina (i.e., fatherlessness) were evident in the majority of adolescent offenders – including George – referred to the author via the AFHS, with extreme contemporary examples of ensuing psychopathy eclipsing, in the general public's consciousness, those encountered in routine clinical and forensic psychological practice or everyday life, as well described by Hare (1993) and Kirkman (2002).

A selection of the cluster of traits underlying psychopathy according to Hare's widely recognised categorisation, as adapted to early adolescence, was detailed in the context of the third research project The constellation of traits corresponding to the first factor (affective/ interpersonal qualities), such as callousness and shallow affect, separates psychopathy from APD, which is based almost exclusively

on antisocial behaviours. Key components of Factor 1 and 2 in psychopathy are displayed below.

Table 2 *Key Symptoms of Psychopathy Across Factors 1 and 2 (see Hare, 1993, p. 34)*

Factor 1: Emotional/ Interpersonal	Factor 2: Social Deviance
Glib/ superficial	Impulsive
Egocentric/ grandiose	Poor behavioural controls
Lack of remorse or guilt	Need for excitement
Lack of empathy	Lack of responsibility
Deceitful/ manipulative	Early behaviour problems
Shallow emotions	Adult antisocial behaviour

None of the qualities outlined above are conducive to affected patients acknowledging personal problems, being motivated to change or forming trusting, mutually beneficial, long-lasting personal or professional relationships, including therapeutic dyads. As well as potentially tying up or wasting limited resources, though, an even greater concern is reflected by Hare's (1993) view that therapy may be counterproductive in people assessed as psychopathic. Harris, Rice and Cormier (1991) actually found a greater rate of recidivism among treated (compared to untreated) psychopathic offenders following involvement in a community therapeutic program.

In sexual offender intervention programs, improved awareness of offending cycles may in fact impart alertness to means of evading detection and enhance expertise in already highly developed grooming behaviours. At the very least, psychopathic inmates' participation may be motivated by their desire to be seen to be "doing the right thing", or to secure an early release or transfer to a lower security penal facility, at which specialised programs often exist. It has been the author's practice to screen offenders interested in or referred for group therapy programs, with consideration given to such matters as motivation, the likelihood of a significant disruption of group dynamics and the formation of unhelpful post-group associations with other offenders.

Although "we know that individuals with DSPD [dangerous and severe personality disorder] constitute a group of patients whom psychiatrists do not like" (Sarkar, 2002, p. 7; see also Lewis & Appleby, 1988) and Cope (1993) found that most British forensic psychiatrists did not support

compulsory treatment of individuals with PDs, "a slim majority believed that this group was treatable" (Sarkar, 2002, p. 7). Presumably, the best chance of reducing or averting the development of adult psychopathy is by targeting the tell-tale precursors of this construct early in life. George and to a lesser degree Joel come to mind in this regard. A great problem is that the effects of absent and abusive fathers, or even those who withhold affection, tend to stay with and prime the young person (Walsh, Beyer, & Thomas, 1987), as was obvious in George's case. For Joel, paternal separation was permanent and seemingly unlikely to be resolved emotionally without an intensive, patient-driven intervention.

At the present time, Hare's Psychopathy Checklist provides the best available cross-sectional measure of psychopathy, with Gacono and Hutton (1994) outlining suggestions for the clinical and forensic use of this instrument. For a review and comparison of the historical development of the concepts of psychopathy and APD see Schade and Koerselman (1994) and Zágon (1995).

Impact of PDs on Patients' Motivation to Change

The three cases presented in Research Project 1 and 3 each illustrate different ways in which various personality traits influenced the rate and nature of therapeutic movement observed. Steve was initially reluctant and pessimistic about even the possibility of change. As noted, BDD patients "are generally regarded as difficult to treat or to engage in psychological therapies" (Veale et al., 1995, p. 724) due to comorbid depression and a range of characteristics (e.g., avoidant behaviour) that may be personality-related. Despite his natural predilection to avoiding even the notion of exposure therapy, Steve subsequently improved to the point he requested this modality of treatment. Furthermore, his obsessive-compulsive qualities may well have contributed to his diligence in following through with a range of homework tasks set by the author.

Alternatively, Joel was not compliant with his antipsychotic mediation and the paranoid elements of his personality structure contributed to a suspiciousness and resistance regarding the entire assessment process. Nonetheless, with reassurances and encouragement, he duly participated in each testing procedure, producing a valid, interpretable profile on the MMPI-2, which, in itself, may be used as a therapeutic intervention (Finn, 1996). In Joel's case, feedback was provided, leading to a degree of willingness to accept psychoeducation about the utility of CBT in modulating auditory

hallucinations, which could prove useful for Joel in future.

Finally, George displayed significant egotistic and narcissistic traits. These were harnessed in regard to engaging the young person in meaningful assessment (e.g., the WISC-R), which provided an opportunity to display intellectual abilities, several aspects of which proved to be exceptional, especially processing speed. Utilising the therapeutic value in George's narcissism offset the difficulties inherent in motivating a person with antisocial tendencies to adopt pro-social behaviours, unless there are apparent personal benefits.

Forming a Collaborative Relationship

The "establishment of a collaborative working alliance" between patient and therapist is considered essential by Barlow (2001, p. 316). In the author's experience with Steve and to an even greater extent George, the development of rapport, negotiated and mutually agreed to goals, clear boundaries and mutual respect were essential in generating therapeutic movement.

It was clear, prior to even meeting George, that a succession of experienced health care practitioners had, for various reasons attributed almost wholly to George's personality, failed to connect or engage with him in a meaningful way. Although George brazenly rejoiced in these failures, portraying them to his mother (and presumably his father) as a succession of victories, it may be assumed that, from a psychodynamic perspective, George was displacing anger regarding his parents to whichever adult dared to even try to understand him, or worse still, "help" him. Tragically, each supposed triumph George celebrated represented another missed opportunity to receive the professional involvement and input he desperately needed, as well as the learning opportunities associated with staying in school.

An interactive, working therapeutic relationship between George and the author was built on patience, persistence and the meaningful incorporation of George's pro-social interests (e.g., sport, conquering intellectual problems) into the assessment/ treatment process. There were advantages for the author in being removed from direct involvement in either the supervision or responsibility for George's Probation Order or his education in terms of disciplinary proceedings, notwithstanding a primary role in instigating his behavioural management plan. Of course, a degree of absolution from these responsibilities also conferred less relevance in terms of directly affecting George's day-to-day

life and therefore there were minimal consequences for George should he wish to avoid involvement in therapy altogether. Therefore, the development of a collaborative, working relationship, as advocated by Barlow (2001), indeed underpinned the promising elements of the author's intervention with George. A major aim was to coax, rather than coerce, George into playing a key role in therapy, empowering and rewarding the constructive, positive facets of his developing identity and ignoring, challenging or otherwise deterring the antisocial elements.

Ongoing liaison, consultation, cooperation and collaboration, both with George and all adults involved in his care and education, were the keys to developing and maintaining a viable therapeutic relationship. Within about six weeks of therapy, George had reached a stage in which he appeared to be comfortable raising or responding to a number of contentious issues, without fear of being judged harshly, although not necessarily expecting to be supported in all of his views, intentions or actions. In the case of Steve, development of a collaborative relationship was based upon negotiating goals that were challenging but not excessively distressing and constantly reviewing, validating, analysing and questioning the associations between his thoughts, feelings and behaviours.

Managing Challenging Behaviours: Aggression, Distorted Relationships and Splitting

Excellent reviews (Tishler, Gordon, & Landry-Meyer, 2000) and guides (Cherry & Upston, 1997) for managing violent patients now exist. To those unfamiliar with forensic environments (e.g., prisons, detention or custody centres) it is often assumed that therapy involving offenders may be especially dangerous. In fact, "working with criminals, contrary to popular expectation, is not a high-risk area of practice. The client is often docile (or co-operative), or is constrained by his or her situation, and has more appropriate targets for overt or covert violence" (Francis & Cameron, 1997, p. 155).

In the author's experience, recent employment in a hospital emergency department consultation-liaison psychiatry clinical psychology position has seemed to involve a greater risk to therapist than either community-based or penal correctional settings, an observation mirrored by others (Cherry & Upston, 1997). Where as psychiatric personnel at the hospital in question have been periodically assaulted by patients despite numerous preventative measures, no such assaults against health care practitioners occurred during four years spent by the author working at a maximum security prison or

the AFHS, although correctional personnel were often a target of inmate violence. The greater danger for psychologists working with offenders or patients with PDs is being drawn into distorted relationships.

An illustration of this phenomenon may be aided by the case study of George, who made derogatory comments to the author regarding his JJ worker and mother, each significant women in George's life. In this situation, a male therapist harbouring grievances against females, chauvinistic tendencies, a judgmental attitude to others involved with George or having the mind set of a "rescuer" may have been inclined to agree – tacitly or overtly – with the young person's sentiments, perhaps temporarily becoming "onside" with him, but ultimately compounding and reinforcing his distorted and unhelpful views. Although these possible therapist behaviours may seem grossly unprofessional, the subtle undermining of other professionals, often driven or facilitated by the patient with a PD (termed "splitting"), is a common occurrence in clinical practice involving unscrupulous, insecure or inexperienced therapists. Less blatant or immediately damaging, but ultimately detrimental, distortions tend to occur whenever the patient is permitted to set the boundaries of the therapeutic alliance.

Boundary Issues Impinging on Clinical Practice

Forming a collaborative relationship and concurrently managing the boundary issues that frequently arise in working with patients diagnosed with PDs is not straightforward. A good place to start is by developing self-awareness of the types of roles ordinarily taken on in one's relationships with others, including particular types of patients. For instance, an extremely distressed or hysterical patient may invoke different reactions in different psychologists. One psychologist may feel helpless and wish to transmit an empathic understanding of the patient's experiences by over-interpreting the situation or attempting to be a "mind-reader" (F. Dunne, personal communication, 2000). Another may experience distaste or even disdain and take on the role of persecutor, endeavouring to punish the misbehaving, excessively emotional or unjustifiably upset patient. Yet another psychologist may naturally take on the role of "rescuer", as alluded earlier, seeking to somehow save the patient from their circumstances or emotional pain. Patients with PDs may be especially skilful at appealing to the unhealthy or counterproductive roles human beings – including psychologists – may be inclined to adopt when under duress or burdened by patients' expectations, no matter how unreasonable.

In George's case, the threat of the young person experiencing secondary gains as a result of being permitted to revel in discussions of offending behaviour was ever present. Discussions of offending behaviour were therefore deliberately avoided except in the context of specific exercises undertaken to elicit clinically useful information or persuasively challenge distorted underlying cognitions.

Psychologist Self-Awareness and Personal Care

Self-monitoring is perhaps the most important skill of a psychologist in relation to self-care, as well as being essential a propos ethical practice and patient welfare. This issue was highlighted in the second research project concerning transference and countertransference processes and subtle boundary violations preceding patient-therapist sexual transgressions, a patent example of decidedly unethical behaviour by health care practitioners. In this regard, patients with PDs or offending histories, by distorting boundaries, may present a special challenge to clinical psychologists working in forensic environments (Thomas-Peter & Garrett, 2000). Interestingly, those authors found that "recent studies call into question the assumption that such abuse is the preserve of male staff" (p. 135).

In the author's experience in the prison setting, several instances of patient-therapist sexual contact (PTSC) involving female staff, including a probationary psychologist, a psychiatric nurse and also a correctional officer, came to public attention, ultimately leading to a substantiation of accusations of PTSC and dismissal in all cases. Numerous instances of blurred professional boundaries and poor self-care involving these staff was evident in their practice prior to events leading to the authentication of allegations, reports or video evidence of PTSC. The existence of prominent narcissistic traits and diminished self-awareness appeared to be a common denominator.

As Freud (1933) once stated, "No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed" (p. 184). Working as a clinical psychologist is in many ways a gruelling occupation, with significant stresses involved and weighty decisions often a part of everyday practice. Direct therapeutic work with patients diagnosable with PDs may be especially arduous, especially if one's expectation of the rate of therapeutic progress is set too high, one's distress tolerance is low, or the sense of self and personal-professional boundaries are underdeveloped.

Feedback and debriefing involving trained peers and consistent, ongoing clinical supervision by an experienced practitioner in the field of practice is very important in grappling and contending proficiently with these issues. Conversely, professional isolation is strongly discouraged (B. Healey, personal communication, 1998-2002).

Conclusion

The research placements undertaken during the clinical doctorate program provided a diverse range of valuable practical experiences in psychology. Common, related themes of PDs in clinical practice, boundary issues and psychologist self-care arose during each practicum and have been reviewed in this exegesis to highlight their significance in the routine practice of clinical psychology.

Related continuums across psychologist attitudes and behaviours and between boundary crossings and violations, as outlined in the second research project, and potential role blurriness germane to George's case (e.g., therapist or helper versus rescuer/ mind-reader/ persecutor, etc.), highlight the covert and overt precursors and therapeutic practices which typically precede gross transgressions such as PTSC. It was noted that, in working with offenders or patients with PDs, the greatest danger is in fact being drawn into distorted relationships, as opposed to the therapist being at direct risk of physical attack. Prevalence and awareness of PTSC, its impact on patients and the profession, benefits and possible pitfalls of the clinical-humanitarian dimension of therapist neutrality/ anonymity versus the humanistic/ egalitarian approach, sexualised transference and countertransference, characteristics of psychologists at risk of transgressing and challenges for clinical psychology sexual ethics training, were also reviewed in the second research project.

The case histories of Steve, Joel and George illustrated that patients with PDs are typically a very difficult and challenging clinical group to engage constructively and treat effectively in a way that may lead to enduring psychosocial improvement. A core reason for their universally observed impenetrability includes these patients' lack of motivation to change or belief that change is even necessary. Their distrustful, detached, intense, unstable or odious interpersonal style usually precludes deters, or repels professional investment and ongoing involvement. An understandable eagerness among health care professionals in generic or community-based clinics to divest their caseloads of patients with PDs was observed, with the author the recipient of several referrals in which Axis II

pathology was prominent (e.g., Steve and Joel) or fledgling psychopathy was apparent (e.g., George). The zeal attached to parting company with adolescent patients exhibiting Cluster B personality traits was even palpable in the paediatric forensic environment, in which precursory signs of PDs are ubiquitous and actually specifically targeted in early intervention programs.

George, the very first referral received during the child/ adolescent practicum, was described as the "most disturbed" adolescent that his juvenile justice worker had personally case managed in thirty years of experience, next to another (now adult) offender serving a life sentence for a school teacher's murder. Despite George's psychopathic personality constellation, a multi-pronged intervention proved to be successful in provisionally arresting his offending behaviours and presumed trajectory towards lifelong persistent antisociality and significantly improving his psycho-social functioning. This result agreed with clinical child psychologists' experiences of "moderate gains in psychotherapy [in psychopathic youth]... contrary to prevailing pessimism" (Salekin, Rogers, & Machin, 2001).

Joel, the young man referred to a community psychiatry clinic after his discharge from an inpatient psychiatric unit, was assessed as having a personality profile typical of offender groups. He was perceived by female clinic staff as having an odd affect but had not yet embraced a criminal lifestyle commensurate with his two-point code type. He was encouraged by the author to pursue his goal of further studies, which had been abandoned during his final year at high school, after which he had been hospitalised for a psychotic illness that may have been drug (cannabis) induced.

Steve was a middle-aged man with multiple psychiatric diagnoses, including Cluster C PD traits, and many previous inpatient hospitalisations who had his BDD treated by the author for the first time at the same clinic as Joel. He made impressive functional gains, marked by reduced anxiety and BDD behaviours during therapy. Personal communication with that service indicated that he had not been readmitted as an inpatient since psychological intervention.

Evidence presented in the case reports of this minor thesis demonstrate that, although PDs may complicate the clinical picture during treatment of Axis I pathology or psychosocial maladjustment – and many clinicians eschew involvement in these patients' care – the presence of Axis II disorders or traits need not necessarily sabotage the utility of carefully tailored clinical psychological interventions.

References

Akistal, H.S. (1996). The prevalent clinical spectrum of bipolar disorders: Beyond DSM-IV. *Journal of Clinical Psychopharmacology, 16* (Suppl. 1), 4-14.

Arntz, A. (1999). Do personality disorders exist? On the validity of the concept and its cognitive-behavioral formulation and treatment. *Behaviour Research & Therapy, 37* (Suppl. 1), S97-134.

Barlow, D.H. (2001). *Clinical handbook of psychological disorders*. (3rd ed.). New York: Guilford Press.

Barnett, J.E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research and Practice, 32,* 205-210.

Carpenter, D., Clarkin, J.F., Glick, I.D., & Wilner, P.J. (1995). Personality pathology among married adults with bipolar disorder. *Journal of Affective Disorders, 34*, 269-274.

Cherry, D., & Upston, B. (1997). *Managing violent and potentially violent situations: A guide for workers and organisations*. Victoria, Australia: Centre for Social Health, LaTrobe University.

Cope, R. (1993). A survey of forensic psychiatrists' views on psychopathic disorder. *Journal of Forensic Psychiatry, 4*, 215-235.

Dawson, D.F. (1988). Treatment of the borderline patient: Relationship management. *Canadian Journal of Psychiatry, 33* (5), 370-374.

Dolan, B., & Coid, J. (1993). *Psychopathic and antisocial personality disorders: Treatment and research issues*. London: Gaskell.

Eysenck, H.J. (1961). *Handbook of abnormal psychology: An experimental approach*. New York: Basic Books.

Finn, S.E. (1996). *Using the MMPI-2 as a therapeutic intervention*. Minneapolis, MN: University of Minnesota Press.

Francis, R.D., & Cameron, C. (1997). *The professional psychology handbook*. South Melbourne, Victoria: Australian Academic Press.

Freud, S. (1933). Fragment of an analysis of a case of hysteria. In *Collected papers of Sigmund Freud* (Vol. 3). London: Hogarth. (Original work published 1905).

Gabbard, G.O. (1997). Lessons to be learned from the study of sexual boundary violations. *Australian and New Zealand Journal of Psychiatry, 31*, 321-327.

Gacono, C.B., & Hutton, H.E. (1994). Suggestions for the clinical and forensic use of the Hare Psychopathy Checklist – Revised. *International Journal of Law & Psychiatry, 17* (3), 303-317.

Gallop, R., Lancee, W.J., & Garfinkel, P. (1989). How nursing staff respond to the label "borderline personality disorder" [comment]. *Hospital & Community Psychiatry, 40* (8), 815-819.

George, E.L., Miklowitz, D.J., & Richards, J.A. (1996, September). *Personality disorders among bipolar patients*. Poster presented at the 11th Annual Meeting of the Society for Research in Psychopathology, Atlanta, Georgia.

Hare, R.D. (1993). *Without conscience. The disturbing world of the psychopaths amongst us.* New York: Pocket books.

Kendell, R.E. (2002). The distinction between personality disorder and mental illness. *British Journal of Psychiatry, 180*, 110-115.

Kirkman, C.A. (2002). Non-incarcerated psychopaths: Why we need to know more about the psychopaths who live amongst us. *Journal of Psychiatric & Mental Health Nursing, 9* (2), 155-160.

Lewis, A. (1974). Psychopathic personality: A most elusive category. *Psychological Medicine, 4*, 133-140.

Lewis, G., & Appelby, L. (1988). Personality disorder: the patients that psychiatrists dislike. *British Journal of Psychiatry, 153*, 44-49.

Linehan, M.M., Armstrong, H.E., & Suarez, A, et al. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

Linehan, M.M. (1993). *Cognitive behavioural treatment of borderline personality disorder*. The Guilford Press: New York.

Linehan, M.M. (1993). *Skills training manual for treating borderline personality disorder*. The Guilford Press: New York.

Norcross, J.C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice, 31* (6), 710-713.

O' Connor, M.F. (2001). On the etiology and affective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice, 32* (4), 345-350.

Samuels, J., Eaton, W.W., Bienvenu, O.J., Brown, C.H., Costa, P.T., & Nestadt, G. (2002). Prevalence and correlates of personality disorders in a community sample. *British Journal of Psychiatry, 180*, 536-542.

Sarkar, S.P. (2002). A British psychiatrist objects to the dangerousness and sever personality disorder proposals. *The Journal of the American Academy of Psychiatry and the Law, 30* (1), 6-9.

Schade, A., & Koerselman, G.F. (1994). Psychopathy as diagnosis: Wrongly out of use? (Trans.). *Tidjschrift voor Psychiatrie, 36* (4), 265-277.

Tishler, C.L., Gordon, L.B., & Landry-Meyer, L. (2000). Managing the violent patient: A guide for psychologists and other mental health professionals. *Professional Psychology: Research and Practice, 31* (1), 34-41.

Thomas-Peter, B., & Garrett, T. (2000). Preventing sexual contact between professionals and patients in forensic environments. *Journal of Forensic Psychiatry, 11* (1), 135-150.

van Praag, H.M. (1996). Comorbidity (Psych) Analysed. *British Journal of Psychiatry, 168* (Suppl.), 129-134.

Veale, D., Gournay, K., Dryden, W., Boocock, A., Shah, F., Willson, R., & Walburn, J. (1995). Body Dysmorphic Disorder: A cognitive Behavioural model and pilot randomised controlled trial. *Behavior, Research & Therapy, 34* (9), 717-729.

Walsh, A., Beyer, J.A, & Thomas, A. (1987). Violent delinquency: An examination of psychopathic typologies. *Journal of Genetic Psychology, 148* (3), 385-392.

Zágon, I.K. (1995). Psychopathy: A viable alternative to antisocial personality disorder? *Australian Psychologist, 30* (1), 11-16.