The Treatment of Personality Disorder in Jamaica with Psychohistoriographic Brief Psychotherapy

FW Hickling

ABSTRACT

Objective: *To assess the clinical outcome of patients with personality disorder, receiving treatment with psychohistoriographic brief psychotherapy (PBP).*

Method: *Patients seen in the author's private practice from 1974 – 2010 with a Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR) personality disorder diagnosis were treated with PBP. Demographic, clinical responses and one-year clinical outcome measures were disaggregated and analysed, using SPSS, version 17.*

Results: *One hundred patients completed treatment with PBP, male:female 34:64; mean age of 35.86 ± 10.28 (range 16 – 66) years. Forty-five per cent were married, 73% were of predominantly African racial origin, with 59% from socio-economic class (SEC) I and 39% from SEC II and III. The presenting complaints were interpersonal conflict (35%), anxiety (21%) and depressed mood (20%). Major depression (30%), substance abuse disorder (18%) and generalized anxiety disorder (13%) were the most common Axis I diagnoses. Histrionic personality disorder (39%) and avoidant personality disorder (35%) were the main Axis II diagnoses. Psychohistoriography was completed with all patients, and charted by 96%. Transference variants were experienced by all patients and worked through with 87%. The quadranting process was completed by 42% with goal setting instituted by 96% and actualization scoring fully completed by 34%. A continuous exercise programme was instituted by all patients, and was maintained by 56% at one-year follow-up. Ninety-four per cent reported fair (10%), good (68%) to very good/excellent (16%) improvement on completion of PBP, with 72% assessed as maintaining fair to good clinical improvement by the therapist at one-year follow-up.*

Conclusion: *Patients with personality disorders showed clinical improvement one year after being treated with psychohistoriographic brief psychotherapy.*

Keywords: Jamaica, personality disorder, psychohistoriographic brief psychotherapy

El Tratamiento de Trastornos de la Personalidad en Jamaica con Psicoterapia Breve Psicohistoriográfica

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RESUMEN

Objetivo: *Evaluar el resultado clínico de pacientes con trastorno de la personalidad, que reciben tratamiento con Psicoterapia Breve Psicohistoriográfica (PBP).*

Método: *Pacientes vistos en la práctica privada del autor desde 1974–2010 con diagnóstico de trastorno de la personalidad sobre la base del Manual Diagnóstico y Estadístico de los Trastornos Mentales, cuarta edición revisada (DSM-IV-TR), fueron tratados con PBP. Las respuestas demográficas, clínicas y las medidas de resultado clínicas de un año, fueron desglosadas y analizadas utilizando SPSS, versión 17.*

Resultados: *Cien pacientes completaron el tratamiento con PBP, 34:64 hombres: mujeres; edad promedio 35.86 ± 10.28 años (rango 16–66). El cuarenta y cinco por ciento eran casados, 73% eran*

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de origen racial predominantemente africano, con el 59% de clase socio-económica (SEC) I, y 39% de SEC II y III. Los problemas presentados fueron: conflictos interpersonales (35%), ansiedad (21%), y estados de ánimo depresivo (20%). La depresión grave (30%), los trastornos por abuso de sustancias (18%), y los trastornos de ansiedad generalizada (13%) fueron los diagnósticos más comunes del Eje I.

Palabras claves: Jamaica, trastornos de personalidad, psicoterapia breve psicohistoriográfica

West Indian Med J 2013; 62 (5): 432

INTRODUCTION

The current Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR) personality classification (1) identifies a cluster-dimensional model which places personality traits into three main clusters: Cluster A (the withdrawn paranoid group), Cluster B (the flamboyant dissocial group) and Cluster C (the anxious, dependent and obsessive-compulsive group). Many psychiatrists are still dissatisfied by this method of classification as the concepts and traits are mainly drawn from a European sample and do not reflect worldwide cultural differences; and the model does not designate an identifiable path/strategy for treatment or outcome.

The treatment of personality disorder represents one of the *terra incognitae* of modern mental health practice (2). Psychopharmacological therapy, psychotherapy and behaviour therapy are the recognized modes of treatment of these disorders, although all three modalities have had limited reported efficacy, with psychotherapy having the most favoured reported outcome (3). Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with specific objectives (4). Some psychiatrists have suggested that black people, especially low-income blacks who are perceived as non-verbal, concrete and lacking in intelligence, are ill-suited for psychotherapy (5) and many studies have identified the paucity of psychotherapeutic in-terventions in the treatment of black patients in the mental health services of the developed countries such as the United Kingdom (6). In a study (7) in which mental health pro-fessionals were presented with research protocols identical except for the label of race, blacks were identified as being less suitable for insight-giving psychotherapy.

The University of the West Indies, Section of Psychiatry, Jamaica, has taken the lead in research into the diagnosis, epidemiology and treatment of personality disorder in the Caribbean (8, 9). The purpose of this paper is to assess clinical outcome of patients diagnosed as having DSM-IV-TR personality disorder with psychohistoriographic brief psychotherapy (PBP). This PBP model of brief psychotherapy that is being tested in this study was developed in Jamaica in the 1970s (10), and takes between ten and twelve sessions. The PBP model uses a dynamic model of social learning, actualization, language, interpretation, social interaction, culture, organization, with actualization through conscious activity. Insight, working through and conflict resolution are principles of the therapeutic interaction. The objective of this article is to assess the clinical outcome of patients with a diagnosis of DSM-IV-TR personality disorder receiving treatment with psychohistoriographic brief psychotherapy.

SUBJECTS AND METHOD

This was a clinical naturalistic outcome study. The sample was selected consecutively from a cohort of patients, with their consent, who was treated in the author's private practice with PBP during the period 1974 to 2010 and who was assessed as having a DSM diagnosis of personality disorder by the author. All the initial DSM III and IV personality disorder diagnoses were recoded to the DSM-IV-TR version of the classification by the author. The PBP technique that was conceived and conducted exclusively by the author (10) was based on the technique of life history mapping that has been called psychohistoriography. Historical facts obtained from information culled from clinical interviews and therapy sessions are charted on a graphic matrix, which are expressed on a two-dimensional chronological life history time graph (10). The detailed components and method of use of the psychohistoriographic chart can be reviewed in the published retrospective analysis of the life of Jamaican poet Claude McKay through a psychohistoriographic analysis of his writings (11). The therapist then worked through, with the patient, his or her reported life history events, making interpretive analyses of historiographic data culled from the analysis with the objective of achieving psychological insight into the patient's problems. All transference events, resistances and acting-out events were recorded, interpreted and worked through with the patient.

The psychohistoriographic analysis of the patient identified a number of insights in the analysis, which was then followed by the second phase of the process called quadranting, which is a technique that facilitates the working through process by assisting conflict resolution and crystallizing life goal actualization. By identifying the focal people and organizations in the individual's life in the quadrants of family, work, social and religious/political, the patient is assisted to create a goal hierarchy for each quadrant, and then

a task hierarchy for each goal, which then becomes the basis for systematic goal-directed behaviour modification. This is achieved by creating a performance score, based on daily diary keeping, of the task hierarchy. This is based on a Lickert numerical scoring technique from zero to five, which the patient learns to use continuously, called the continued actualization programme, on a spreadsheet on a prospective basis for a period of a minimum of one year (Figure). At the end of the formal therapeutic process, the patient and the therapist were independently required to score the patient's clinical outcome on a scale of zero to ten as to how they rated the clinical improvement at the end of the therapeutic process. This scoring process used another Lickert numerical scoring system, with a score of zero representing 'no change', five representing 'noticeable clinical improvement', eight representing resolution of 80% of the initial clinical symptom, and 10 representing resolution of all of the initial clinical symptoms as 'excellent' improvement. The demographic, clinical, therapeutic and outcome variables were collated and analysed using the SPSS statistical analytic software version 17.

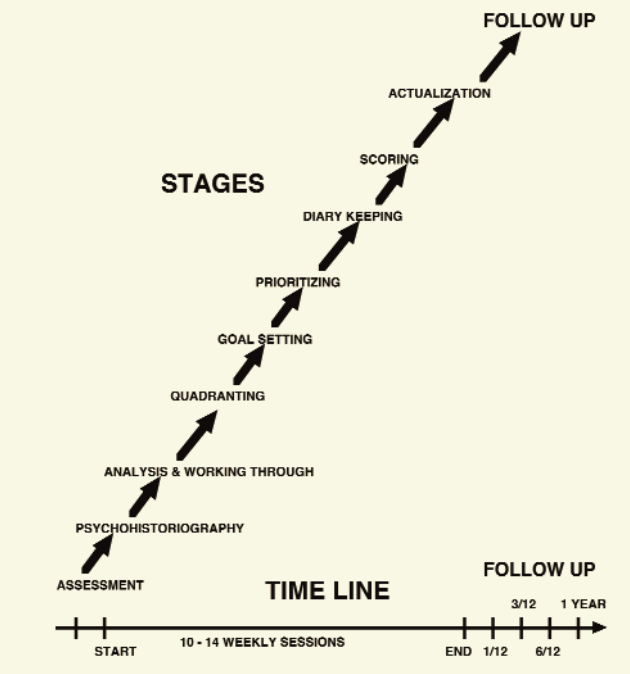

Figure: Stages of psychohistoriographic brief psychotherapy.

Reprinted with permission from Hickling FW. Psychohistoriography: a postcolonial psychoanalytic and psychotherapeutic model. Kingston, Jamaica: CARIMENSA Press, The University of the West Indies; 2007: 159. (10)

RESULTS

A total of 100 patients completed treatment with brief psychohistoriographic psychotherapy. As n = 100, recorded results have been facilitated as percentages. There were 64% females and 36% males, with a mean age of 35.86 ± 10.28 years (range 16 – 66). Most patients were married (45%), with 33% single and 22% divorced or separated. Of the cohort, 73% were of predominantly African racial origin, 26% were Caucasian, with 44% being of mixed race. Using the UK Registrar's General classification of social class by occupation, the majority was from socio-economic class (SEC) I (59%), with 22% from SEC II and 17% from SEC III. Seventy-two per cent were born and grew up in Jamaica, 11% from Europe, 10% from the United States of America (USA), six from Latin America and the Caribbean and 1% from Asia.

The presenting complaints were interpersonal conflict (35%), anxiety (21%) and depressed mood (20%), with pain (14%), confusion (6%) and substance abuse (4%) being the other main presenting complaints (Table 1).

Table 1: Presenting complaint

Presenting complaint	Male n = 36	Female n = 64	Total n = 100
Interpersonal conflict	14	21	35
Anxiety	3	18	21
Depressed mood	8	12	20
Pain	4	10	14
Confusion	4	2	6
Substance abuse	3	1	4

Pearson Chi-square = 10.105, df 5, $p > 0.07$ *n sig*

All patients presented with phenomenological findings consistent with the clinical triad identified in the diagnosis of personality disorder in Jamaica (9). These were sexual dysfunction (poor sex, 65%), no orgasm (18%), dependency issues, psychological (18%), physiological [alcohol and other substance abuse] (73%); all patients exhibited severe power struggles with partners (24%), with families (59%) and at work and in social situations (17%).

Table 2 shows the diagnostic breakdown for Axis I diagnosis, with major depression being predominant in 30% of the cohort, followed by substance abuse disorder (18%) and generalized anxiety disorder (13%), with the pattern of Axis I diagnosis being statistically significant between males and females. Many patients (37%) had no Axis I diagnosis.

Table 2: Diagnostic and Statistical Manual of Mental Disorders 4th edition, text revision (DSM-IV-TR) Axis I diagnosis

Psychiatric diagnosis	Male n = 36	Female n = 64	Total n = 100
Generalized anxiety disorder	1	12	13
Substance abuse disorder	11	7	18
Major depression	11	19	30
Schizophrenia	1	1	1
No Axis I disorder present	12	25	37

Pearson Chi-square = 13.312, df 5, $p < 0.02$ *sig*

There was greater representation of major depression and generalized anxiety disorder in the females, and greater representation of substance abuse disorder in the males ($p < 0.02$).

Table 3 shows the diagnostic breakdown for DSM-IV-TR Axis II personality disorder. There was a very significant statistical difference between males and females, with females exhibiting predominantly histrionic personality disorder (38%) and obsessive-compulsive personality disorder (8%). Males conversely exhibited predominantly avoidant personality disorder (20%), narcissistic personality disorder (8%) and antisocial personality disorder (2%).

Table 3: Diagnostic and Statistical Manual of Mental Disorders 4th edition, text revision (DSM-IV-TR) Axis II diagnosis

Diagnosis	Male n = 36	Female n = 64	Total n = 100
Cluster A			
301.0 Paranoid personality disorder	–	–	–
301.20 Schizoid personality disorder	2	2	4
301.22 Schizotypal personality disorder	–	–	–
Cluster B			
301.7 Antisocial personality disorder	2	0	2
301.83 Borderline personality disorder	–	–	–
301.50 Histrionic personality disorder	1	38	39
301.81 Narcissistic personality disorder	8	1	9
Cluster C			
301.82 Avoidant personality disorder	20	15	35
301.6 Dependent personality disorder	–	–	–
301.4 Obsessive-compulsive P D	3	8	11
301.9 Personality disorder NOS	–	–	–

Pearson Chi-square = 40.901, df 5, $p < 0.000$ *v sig*

Of the cohort, 59 patients had been treated previously for their clinical condition by their referring general practitioners prior to being started on PBP, mainly anxiolytics and antidepressants or a combination of both those medications. The females had received significantly more psychopharmacological treatment than the males (Chi-square 10.123, df 3, $p < 0.01$). No patient received psychopharmacological medications while being treated with PBP.

Table 4 itemizes the cohort response to the clinical stages of PBP and compares the gender responses to the clinical therapeutic tasks demanded by the process. All patients were guided through a personal retrospective and historical perspective of their life by the therapist and encouraged to make a two-dimensional record of this history on the psychohistoriographic chart described earlier (11).

Of the cohort, four patients refused to attempt the charting process, 10 patients partially completed the process while the remaining 86 completed the chart and used it as a daily 'life-map' as the therapeutic process progressed. All patients exhibited transference variants (12). During PBP, 46 patients revealed transference of defence, 49 displayed libidinal transference and five exhibited aggressive acting out behaviour. There were no gender differences in the display of transference variants, which were worked through (12) fully in 87 patients and partially in the remaining 13. The quadranting process was completed by 42 patients but not attempted by 58. Goal setting was fully completed by 87 patients and partially completed by nine others. Four patients did not attempt the goal setting process. The continued actualization-scoring component was fully completed by 34 patients and partially completed by 66 patients with the females showing a significantly higher propensity for completion than the males ($p < 0.02$). However, the males showed a significantly greater propensity ($p < 0.03$) for completing a continuous or a partial exercise programme throughout the PBP process.

Table 4: Psychohistoriographic brief psychotherapy stages

Psychohistoriographic brief psychotherapy stages	Male n = 36	Female n = 64	Total n = 100
Psychohistoriographic charting $p > 0.80$ *ns*			
Not attempted	1	3	4
Partial completion	3	7	10
Completed	32	54	86
Transference variants $p > 0.149$ *ns*			
Transferences of defence	21	25	46
Libidinal transference	13	36	49
Aggressive acting out	2	3	5
Working through $p > 0.674$ *ns*			
Partial completion	4	9	13
Completed	32	58	87
Quadranting $p > 0.371$ *ns*			
Not attempted	23	35	58
Completed	13	29	42
Goal setting $p > 0.298$ *ns*			
Not attempted	0	4	4
Partial completion	3	6	9
Completed	33	54	87
Actualization scoring $p < 0.02$ *sig*			
Partial completion	29	37	66
Completed	7	27	34
Exercise programme $p < 0.03$ *sig*			
Continuous exercise programme throughout programme	15	41	56
Partial, irregular exercise programme throughout programme	21	23	44

Table 5 lists the clinical outcome evaluation at the end of the completed PBP process as evaluated by the patient, and by the therapist, made usually at the end of 10 consecutive weeks of treatment. Table 5 indicates that 96% of the patients reported noticeable/fair (10%), good (71%) to very good/excellent (15%) improvement on completion of PBP, while the therapist reported noticeable clinical improvement in 98% of the patients in the cohort.

Table 6 compares the mean scores of the male and female patients for the number of therapy sessions completed,

Table 5: Patient's and therapist's Lickert scores of patient's clinical outcome

Score	Lickert clinical evaluation category	Patient's evaluation	Therapist's evaluation
0	No change in clinical symptoms	3	0
1	Slight improvement in some symptoms	0	0
2	Marginal improvement in some symptoms	0	0
3	Minimal improvement in some symptoms	0	1
4	Some improvement in most symptoms	1	1
5	Noticeable clinical improvement overall	4	4
6	Occasional symptoms; fair improvement	6	10
7	Occasional symptoms; good improvement	31	28
8	Rare symptoms; good improvement	40	40
9	Rare symptoms; very good improvement	12	14
10	Asymptomatic; excellent improvement	3	2

Table 7: One year follow-up rating

One year follow-up rating	Male n = 36	Female n = 64	Total n = 100
Good (mainly symptom free with affective improvement)	25	39	64
Fair (noted symptom reduction with affective improvement)	3	5	8
Poor (partial return of initial symptom profile)	1	4	5
Relapse (return of initial symptom profile)	0	4	4
Unknown (did not return for follow-up)	7	12	19

Pearson Chi-square = 3.080, df 4, $p > 0.5$ *not sig*

Table 6: Comparison of mean scores (male:female)

Category	Male n = 36	Female n = 64	Total n = 100
Number of therapy sessions	11.86 ± 6.243	11.61 ± 6.161	11.70 ± 6.16
Patient's self-assessment outcome evaluation score at the end of PBP process	7.50 ± 1.134	7.52 ± 1.208	7.35 ± 1.684
Therapist's outcome evaluation score of the patient at the end of PBP process	7.44 ± 1.182	7.52 ± 1.208	7.49 ± 1.93
Therapist's outcome evaluation score of the patient after one year follow-up	6.28 ± 3.739	6.80 ± 3.310	6.61 ± 3.461

the patient's self-assessment outcome evaluation score at the end of the PBP process, the therapist's outcome evaluation score at the end of the PBP process and the therapist outcome evaluation score after one year of follow-up.

The mean number of sessions completed by the cohort of 100 patients was 11.70 ± 6.160 (range 3−36) with no significant difference for gender. The mean self-assessment score by the patients of the outcome of PBP was 7.35 ± 1.684 while the mean assessment score of the patients' progress by the therapist was 7.49 ± 1.93; *ie* good improvement, with a range of residual symptoms after treatment of 'occasional to rare' (Table 7). This table also indicates that the therapist's evaluation of the patients' outcome after one year of follow-up was good (mainly symptom free with affective improvement) in 64 patients, and fair (noted symptom reduction with affective improvement) in eight patients.

The therapist's mean outcome evaluation score of the patients after one year of follow-up was 6.61 ± 3.461 with no significant gender difference (Table 6).

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DISCUSSION

Although classical psychoanalysis (13) has traditionally been of long term duration, Marmor (14) has identified the several schools of brief individual psychotherapy that have emerged in recent decades. Developed in Jamaica (10), PBP joins the worldwide tradition of brief psychotherapies, and this study demonstrates that the majority of patients with DSM-IV-TR diagnosis of personality disorder in this cohort in Jamaica treated with PBP of under 12 sessions duration have realized a good to very good clinical outcome after 12 sessions; this was sustained in the majority of patients after one year. The majority of this cohort was black persons of African-Jamaican origin, establishing the efficacy of psychotherapy in these black Jamaican people, contrary to previously held orthodoxy (5−7). The fact that 59% of the patients selected for this study had been treated unsuccessfully with a variety of psychotropic medications prior to embarking on the PBP process underlines the poor outcome of drug therapy for the treatment of patients with the range of clinical difficulties presented by this cohort and complicated with the diagnosis of personality disorder.

Rigorously evaluating the efficacy of psychotherapeutic methods in mental health populations has been notoriously difficult (2, 3). The problems created by the controversial models of diagnosis of personality disorder make the evaluation of psychotherapy in this category of patients increasingly difficult (3). Using a naturalistic patient clinical outcome method, this study suffers from the limitation of the

cohort not being randomized, and the outcome evaluation not being conducted in a blind fashion. The single therapist also indicates a further limitation. Future studies can address these limitations by instituting randomized blind selection processes from a cohort of personality disorder patients identified by multiple screening instruments and comparing outcomes of patients treated with alternative psychotherapeutic methods.

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