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To cite this article: Ora Nakash & Maayan Nagar (2018) Assessment of diagnostic information and quality of working alliance with clients diagnosed with personality disorders during the mental health intake, Journal of Mental Health, 27:4, 314-321, DOI: 10.1080/09638237.2017.1294740

To link to this article: https://doi.org/10.1080/09638237.2017.1294740

Published online: 01 Mar 2017.

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Assessment of diagnostic information and quality of working alliance with clients diagnosed with personality disorders during the mental health intake

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Abstract

Background: A primary purpose of diagnostic systems is to improve care, yet, little is known about how providers use it routine clinical care.

Aims: We investigated specific DSM-IV personality disorders (PDs) diagnostic information therapists collected during intake visits and the association between a therapist PD diagnosis and clients' and therapists' reports of the quality of working alliance during the intake.

Method: A total of 122 intakes \((n = 34, 27.9\% \text{ were diagnosed with PD})\) in four community mental health clinics in Israel were audiotaped. Immediately following the intake, clients and therapists completed the working alliance inventory (WAI). Independent clinicians coded the intakes using an information checklist.

Results: Despite the relatively high prevalence of PD in regular psychiatric care, very limited PD diagnostic information was directly assessed during the intake. Therapists evaluated the quality of the working alliance when they saw a client they diagnosed with PD as significantly lower than the rating of a client without a PD, while the clients' ratings did not differ as a result of their diagnosis.

Conclusions: Therapists do not collect sufficient explicit diagnostic information to base their PD diagnostic decisions. Yet, the presence of PD diagnosis affects their rapport with their clients as early as the intake.

Keywords

Personality disorder, diagnosis, intake, working alliance, assessment

Introduction

Diagnostic systems such as the DSM-5 (American Psychiatric Association, 2013) and ICD-10 (World Health Organization, 1992) are used in a variety of contexts (e.g. clinical, research, administrative, and educational) and thus should serve a variety of purposes (First et al., 2004; First & Westen, 2007). One of the primary purposes of diagnostic systems, as stated in the introduction to the DSM-5, is ‘‘… to assist trained therapists in the diagnosis of their patients’ mental disorders’’ and thus improve clinical care (American Psychiatric Association, 2013, p. 19). However, only few studies directly address the clinical use of the diagnostic systems in routine outpatient clinical care.

Similar to the previous versions of the diagnostic system (American Psychiatric Association, 2000), DSM-5 (American Psychiatric Association, 2013) prescribes a particular way of diagnosing personality disorders (PDs), namely making dichotomous judgments about diagnostic criteria and applying algorithms to determine whether a patient’s symptom picture crosses a diagnostic threshold. In clinical practice, following this procedure, an initial interview with a client would entail inquiring into diagnostic criteria necessary for each disorder. In fact, the DSM-IV and subsequent DSM-5 were expected to make substantial improvements to diagnostic formulation, and thus their reliability, by detailing the criteria for each disorder. These versions of the diagnostic system list identical criteria for polythetically defined PDs whereby therapists would determine whether enough criteria had been fulfilled to justify the diagnosis out of a checklist of symptoms (Spitzer et al., 1994).

Epidemiological studies documented high prevalence of PDs (ranging from 30 to 45%) among psychiatric outpatients (Zimmerman et al., 2005). Some studies suggest that PDs are underdiagnosed by therapists (Hillman et al., 1997; Oldham & Skodol, 1991), possibly as a result of the belief that PDs are particularly stigmatizing or that diagnosis of a PD would not substantially alter the treatment plan (Westen, 1998). Importantly, little research has examined the clinical use of the diagnostic system for PD in regular practice (Blais et al., 2001; First & Westen, 2007; Mezzich, 2002), thus providing...
almost no information about how therapists actually go about collecting diagnostic information and applying the DSM definitions for PDs.

Researchers have long debated about the most valid method of assessing PDs (Westen, 1997). Although PDs can be assessed in a variety of methods (including questionnaires and structured interviews), the validity of structured diagnostic interviews to assess PDs has been challenged (Westen, 1997). Structured diagnostic interviews, which rely on direct questions to ascertain the presence or absence of the PD criteria, seem to differ from the methods therapists use to diagnose PDs (Westen, 1997). Therapists typically use a lifetime perspective to determine the presence or absence of a PD, and their judgments are based on the real life vignettes clients describe during the treatment sessions, rather than relying on direct questioning at a single interview (Westen, 1997).

Fundamental to understanding how clinicians reach diagnoses in actual clinical practice is the need to determine whether they accept and use a formal diagnostic system (First et al., 2004). Though limited, research to date on the use of the psychiatric diagnostic systems for PDs has focused on surveys of therapists’ self-reported use and attitudes toward various editions of the DSM and ICD classifications (Westen, 1997). Most commonly, studies examined recorded chart diagnoses with little information about the process leading to the diagnostic decision (Zimmerman et al., 2008). Importantly, no research to date had examined the explicit diagnostic information therapists actually collect during naturalistic settings to establish PD diagnosis and how these diagnosis may impact the quality of the working alliance during the initial intake session.

Therapeutic alliance refers to the degree to which the client and therapist are engaged in collaborative, purposive work (Bordin, 1979; Hatcher & Barends, 2006; Horvath & Luborsky, 1993; Nakash et al., 2015b). A pan-theoretic definition of the alliance includes an agreement on the goals and tasks of therapy in the context of a positive affective bond between the client and therapist (Bordin, 1979; Horvath, 2001). The therapist’s ability to form a good alliance is considered a core ingredient of psychotherapy (Norcross & Lambert, 2011) with studies documenting a moderate-low but stable correlation ($r = 0.28$ 95% CI 0.25–0.30) between early alliance and treatment outcomes regardless of therapy orientation, alliance measure, rating perspective and time of assessment (Horvath et al., 2011). Strong therapeutic alliance directly affects improvement in symptoms and health status as well as satisfaction with- and retention in care (Falkenström et al., 2013; Flückiger et al., 2012; Horvath et al., 2011).

Because of the problems in forming healthy relationships, individuals with PDs are expected to have more difficulties forming strong therapeutic alliances than patients without PDs. Indeed, the limited research examining the therapeutic alliance with clients diagnosed with PDs has shown that therapists tend to report lower quality of working alliance and more negative attitudes to toward PD clients (Colli et al., 2014; Lingiardi et al., 2005; Smith et al., 2014). Studies further show that therapeutic alliance evaluations are strong predictors of treatment dropout among PD clients (Lingiardi et al., 2005). Yet, no study to date has examined the relationship between a clinician diagnosis of a PD and quality of working alliance during the mental health intake.

This paper focuses on therapists’ clinical use of the diagnostic symptom assessment of PDs during mental health intakes in community mental health clinics. The mental health intake is often the first point of contact between clients seeking mental health services and therapists. Two of the main goals of the intake are establishing diagnosis, which serves as the basis for treatment planning, and building strong working alliance which is a significant factor in client retention in care (Flückiger et al., 2012; Hilsenroth & Cromer, 2007; Nakash et al., 2009; Nakash & Saguy, 2015; Turner et al., 2003).

In the current study we examined: (a) the specific DSM-IV PDs diagnostic information explicitly collected during the intake visit (usual clinical care using unstructured interviews); (b) the association between a therapist PD diagnosis and clients’ and therapists’ reports of the quality of working alliance during the mental health intake.

**Method**

**Setting and participants**

The study was conducted in four public mental health clinics in Israel that offer free services to all legal residents under the Israeli National Health Insurance Law. De facto, however, the majority of clients who actually seek services at these public clinics come from lower and middle socioeconomic strata. All clinics offer a variety of mental health services, including assessment, psychotherapy (including different treatment modalities tailored to client’s presenting problem, such as cognitive–behavioral therapy, psychodynamic therapy, crisis intervention, group therapy and family and couples therapy) and psychopharmacology. Access to care does not necessitate medical referral and walk-ins are welcome. All new clients are first scheduled to complete an intake session. At each of the clinics, clients are consecutively allocated to therapists for intake session. The primary goal of the intake session at each participating clinics was to gather information about the presenting problem and psychosocial history of the client to inform diagnosis and treatment plan. None of the participating clinics used a structured intake protocol. Based on the information collected during the intake the clinic staff decided whether the services provided at the clinic were suitable for client and tailored the treatment plan to address the client’s specific needs. Thirty-eight therapists agreed to take part in the study (for full project description see Nakash et al., 2014 2015a). The majority of therapists were born in Israel (58%), females (84%), ages ranged from 28 to 64 ($M = 45.2, SD = 10.8$). Thirty-seven percent were psychologists, 16% psychiatrists, and 47% social workers, with the overwhelming majority (75%) having more than five years of clinical practice ($M = 14.6, SD = 11.5$).

Clients ($N = 300$), who presented consecutively for a first-ever or a repeated new episode of care in in these clinics completed questionnaires in Hebrew upon contacting the clinic. The questionnaires included measures of stigma towards mental health care, emotional distress, demographic information and treatment history (Nakash et al., 2015b). Clients were scheduled to intake session 7–10 days following...
the initial contact with the clinic. A randomly selected sample of the clients (n = 153, 51% of the original sample) was invited to participate in the second part of the study that included a recording of the intake session and completion of additional measures assessing the quality of the working alliance immediately following the intake session. Of the 153 clients who were invited to participate in the second part of the study, 122 (41% of the original sample) agreed to participate (31 clients declined to participate: 21 were not able to stay for additional time following their intake to complete the research protocol; 3 did not feel well enough to participate; 7 did not want to have the intake session recorded).

All participating clients were Israeli Jews who were fluent in Hebrew. The majority of client participants were born in Israel (73.5%), females (68.9%), ages ranged from 19 to 81 (M = 41.8, SD = 16.4). Two-thirds of the sample (66%) had less than 12 years of education and 60% were unemployed. Approximately, 70% reported a personal yearly income of less than 15,000US$.

Procedure
To ensure the diversity of the sample, we invited therapists to participate only up to five times in the current study (with five different clients; M = 3, SD = 1.6). Intake visits ranged between 14 and 99 min (M = 51.5, SD = 17.8). Participation in the study included three parts: (a) clients completed survey measures prior to intake which included demographic information, and measures assessing emotional distress and stigma toward mental health services (for full list of measures see reference Nakash et al., 2014); (b) audio-recording of the intake session; (c) Immediately following the intake session clients and therapists completed a survey measure that included a measure assessing the quality of the working alliance. Therapists also completed a form detailing the client’s diagnosis according to DSM-IV immediately following the intake session. All aspects of the study were approved by the appropriate Institutional Ethics Committees at each participating clinic and data collection was in compliance with all human subject protocols.

Measures
Demographic questionnaire was administered to both clients and therapists. Clients’ information included gender, age, years of education, marital status, employment status, religiosity and income, and previous mental health treatment. Therapists’ information included gender, age, discipline and years in clinical practice.

The general health questionnaire (GHQ-12) (Goldberg, 1972)
This 12-item scale is a well-documented screening measure for common psychiatric disorders and assesses symptoms in the last month. It has been subject of tests in many countries (Kessler & Ustun, 2008), including Israel (Nakash et al., 2013). Items are rated on a four point Likert scale. Final score was computed as the summary for all items, where higher scores indicate increased emotional distress. The overall internal consistency reliability for the scale was good (Cronbach’s α = 0.88).

Working alliance inventory (WAI) short, client and therapists version (Tracey & Kokotovic, 1989)
This 12 item self-report scale measures the client’s and therapist’s view of the quality of the working alliance (Horvath & Greenberg, 1989). It has been widely used in studies on therapeutic outcomes in many countries, including Israel (Shelef et al., 2005), to assess therapeutic alliance in treatment and during a single therapy session (Nakash et al., 2015c). The measure has corresponding versions for clients and therapists relatively parallel in their questions. Both versions have shown good reliability and validity (Tracey & Kokotovic, 1989). The measure includes three original scales: (a) task (e.g. ‘‘the therapist/clients and I agree about the steps to be taken to improve my situation’’), (b) goals (e.g. ‘‘We are working towards mutually agreed upon goals’’) and (c) bond (e.g. ‘‘I believe the therapist/client likes me’’) that are considered elements of good alliance. Each item was rated on 7-point scale ranging from 1 (not at all) to 7 (very much). Final score included mean score for all items with higher score reflecting better therapeutic alliance. Internal consistency for therapist and client measures was good (Cronbach’s α =0.93 and Cronbach’s α =0.80, respectively).

Client’s diagnoses
Therapists were asked to list all axis I and axis II diagnoses according to the DSM-IV, including rule out diagnoses for each client.

Coder information checklist-revised (Alegría et al., 2008; Nakash et al., 2015b) was used to code each unit of information exchanged during the intake directly from the recorded sessions. The checklist was designed in a previous study by Alegría et al.(2008), and was expanded to include diagnostic information on PDs according to DSM-IV as well as additional socio-demographic information relevant to Israeli context (e.g. compulsory military service). The checklist includes 220 items and more than 100 sub items that cover potential information that might be discussed during the intake session. Items covered symptoms related to DSM-IV major axis I disorders as well as axis II PDs. All items originated from the diagnostic criteria in the DSM-IV-TR (American Psychiatric Association, 2000). In addition, the measure included items concerning personal history and socio-cultural background, physical symptoms and disabilities, family history of mental health disorders, and mental health treatment history (Darghouth et al., 2012; Nakash et al., 2009; Rosen et al., 2012).

Previous studies provide evidence for the construct validity of the information checklist (Alegría et al., 2008; Nakash et al., 2015a). For example, in a study comparing the intake-therapist’s diagnosis to the one established by an independent interviewer who conducted a structured diagnostic interview with the client (the MINI; which served as the gold standard for diagnosis) immediately following the intake, the information checklist was used to document the symptomatic information that was assessed during the intake. Sensitivity analyses significantly improved with increasing number of symptoms assessed, with highest value documented for the assessment of six or more symptoms (81%) while specificity somewhat decreased with the assessment of increasing
number of symptomatic information as documented in the information checklist (62.5%; Nakash et al., 2015a). Each item on the checklist was coded for whether it was discussed during the intake either as a result of the therapist’s question or as a result of the client’s initiation (yes/no; M = 43.62, SD = 13.3 information units were discussed in each interview). Diagnostic information was coded independent of a disorder. As a result, nonspecific symptoms such as sleep disturbances were coded under all relevant disorders (i.e. depression, anxiety, and bipolar disorders). Three independent raters, blind to study goals and hypotheses, coded the audiotapes of the intakes (all raters were licensed clinical psychologists). Following the training, which lasted approximately ten hours and included gaining familiarity with the coding measure and practicing the coding, all coders independently coded randomly selected five tapes. Inter-rater reliability was calculated using a software by Geertzen (2012). Agreement among the coders across the five tapes was good (κ = 0.81). To prevent coders’ drift we assessed inter-rater reliability by having all raters code additional two randomly selected tapes after coding 25% (30 tapes, κ = 0.77), 50% (60 tapes, κ = 0.80), 75% (90 tapes, κ = 0.70), and 100% (120 tapes, κ = 0.76) of the total tapes. Overall inter-rater agreement was high, κ = 0.78.

Statistical analysis

Analyses were performed using the SPSS version 20.0 (SPSS Inc., Chicago, IL, USA). Socio-demographic and clinical characteristics of clients in both groups (diagnosed and not-diagnosed with PD) were compared using χ² test for categorical variables and Independent samples t-tests for continuous variables. Mixed-model ANOVA was computed in order to examine differences between clients diagnosed with PD and clients not diagnosed with PD in quality of working alliance as self-reported by clients and therapists.

Results

Socio-demographic and clinical characteristics of sample by PD diagnosis

Socio-demographic characteristics of participants who were diagnosed with PD by their therapists following the intake session (n = 34) and those who were not diagnosed with PD (n = 88) are presented in Table 1. Participants not diagnosed with PD had more years of formal education as compared to participants diagnosed with PD. While the majority of participants diagnosed with PD reported being separated/divorced or widowed, among participants not diagnosed with PD approximately equal number of participants were single, married or separated/divorced/widowed. There were no other significant socio-demographic differences between the groups.

Clients diagnosed with a PD by their intake-therapist presented significantly higher levels of emotional distress at entry to the intake session as compared with those who were not diagnosed with PD. There were no significant differences in the number of co-morbid axis I disorders diagnosed by therapists between the groups, with the most prevalent one being major depressive disorder.

Therapists’ assessment of DSM-IV criteria for PD during the intake session

Table 2 presents DSM-IV diagnostic information that was explicitly assessed during the intake session for each PD among all clients (i.e. number and percentage of intakes in which at least one criterion of each PD was discussed as well as the most common criterion discussed for each PD). As can be

Table 1. Socio-demographic differences between clients diagnosed and not diagnosed with PD during the initial intake session (N = 122).

<table>
<thead>
<tr>
<th>Personality disorder diagnosed (n = 34)</th>
<th>No personality disorder diagnosed (n = 88)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age; mean (SD)</td>
<td></td>
<td>t(117) = -1.27, n.s.</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>χ²(1) = 0.13, n.s.</td>
</tr>
<tr>
<td>Males</td>
<td>11 (32.4%)</td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>23 (67.6%)</td>
<td></td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
<td>χ²(1) = 0.30, n.s.</td>
</tr>
<tr>
<td>Israel</td>
<td>22 (68.8%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>10 (31.2%)</td>
<td></td>
</tr>
<tr>
<td>Years of education; mean (SD)</td>
<td></td>
<td>t(110) = 2.43, p &lt; 0.05</td>
</tr>
<tr>
<td>Family status</td>
<td></td>
<td>χ²(2) = 8.37, p &lt; 0.05</td>
</tr>
<tr>
<td>Single</td>
<td>10 (29.4%)</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>6 (17.6%)</td>
<td></td>
</tr>
<tr>
<td>Separated/divorced/widowed</td>
<td>18 (52.9%)</td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td>χ²(1) = 2.82, n.s.</td>
</tr>
<tr>
<td>Employed</td>
<td>9 (26.5%)</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>25 (73.5%)</td>
<td></td>
</tr>
<tr>
<td>Religiosity</td>
<td></td>
<td>χ²(2) = 0.53, n.s.</td>
</tr>
<tr>
<td>Secular</td>
<td>12 (37.5%)</td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>12 (37.5%)</td>
<td></td>
</tr>
<tr>
<td>Religious</td>
<td>8 (25.0%)</td>
<td></td>
</tr>
<tr>
<td>Emotional distress; mean (SD)</td>
<td></td>
<td>t(118) = -3.27, p &lt; 0.001</td>
</tr>
<tr>
<td>Number of co-morbid axis I disorders</td>
<td></td>
<td>t(118) = 0.63, n.s.</td>
</tr>
<tr>
<td>diagnosed by therapists, mean (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.9 (0.8)a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0 (0.8)a</td>
<td></td>
</tr>
</tbody>
</table>

*Most common comorbid disorder was major depressive disorder.
seen in Table 2, the most prevalent diagnosis of PD was borderline PD followed by narcissistic PD. Paranoid, schizotypal, dependent, and obsessive compulsive PDs were diagnosed in less than one percent of the sample. Additionally, the most common PD that at least one DSM-IV criteria was explicitly assessed during intake session was Borderline PD, for which approximately third of the intakes included an assessment of at least one diagnostic criterion. Less than 5% of intakes included a direct assessment of at least one diagnostic criterion for Narcissistic PD and Obsessive compulsive PD. On average each intake included direct assessment of less than 0.5 PD symptoms, indicating that very limited diagnostic information on PD was collected explicitly during the intake sessions. In addition, no significant differences were found between patients diagnosed with PD and not diagnosed with PD in intake time ($M = 51.3, SD = 18.2$ and $M = 51.2, SD = 18.0$, respectively).

**Differences in quality of working alliance as reported by clients and therapists**

Results revealed a significant main effect of PD diagnosis, $F(1,117) = 18.41$, $p < 0.001$, Partial $\eta^2 = 0.14$. Such that for clients that were diagnosed with PD reports of WAI were lower ($M = 4.4$, $SE = 0.12$) than clients that were not diagnosed with PD ($M = 5$, $SE = 0.07$). Additionally, the analysis revealed main effect to person reported WAI (client or therapist), $F(1,117) = 4.91$, $p < 0.05$. Partial $\eta^2 = 0.04$. Such that therapists reported lower WAI ($M = 4.6, SE = 0.10$) as compared to clients ($M = 4.9, SE = 0.08$). Most importantly, the analysis revealed an interaction effect between diagnosis of PD and report of WAI, $F(1,117) = 4.52$, $p < 0.05$, Partial $\eta^2 = 0.04$. In order to reveal the source of interaction, two independent samples t-tests were computed, with PD diagnosis as the independent variable and clients’ and therapists’ reports on WAI as the dependent variable (Bonferroni correction for multiple comparisons was applied, $\alpha < 0.025$). The analysis revealed significant differences between clients diagnosed and not diagnosed with PD in therapists’ reports on WAI, $t(118) = 4.21, p < 0.001$, Cohen’s $d = 0.86$, such that for clients diagnosed with PD therapists reported significantly lower WAI ($M = 4.1, SE = 0.2$) than for clients not diagnosed with PD ($M = 5.0, SE = 0.1$). There was no significant difference between clients diagnosed and not diagnosed with PD in clients’ reports on WAI ($M = 4.7, SE = 0.1$).

### Table 2. Number and percentage of clients diagnosed with personality disorders, personality disorders DSM-IV criteria discussed during the intake session and most common criteria discussed ($N = 122$).

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Diagnosed with disorder $n$ (%)</th>
<th>At least one DSM IV criteria discussed among all clients $n$ (%)</th>
<th>Mean number of DSM IV criteria discussed among all clients Mean (SD)</th>
<th>Most common DSM IV criteria discussed during the intake session among all clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid PD</td>
<td>1 (0.8)</td>
<td>11 (9)</td>
<td>0.12 (0.42)</td>
<td>Reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her ($n = 4$) (criterion 301.0.A.3)</td>
</tr>
<tr>
<td>Schizoid PD</td>
<td>3 (2.5)</td>
<td>8 (6.6)</td>
<td>0.11 (0.46)</td>
<td>Lacks close friends or confidants other than first-degree relatives ($n = 8$) (criterion 301.20.A.5)</td>
</tr>
<tr>
<td>Schizotypal PD</td>
<td>1 (0.8)</td>
<td>17 (13.9)</td>
<td>0.21 (0.66)</td>
<td>Odd thinking and speech (vague, circumstantial, metaphorical, or stereotyped) ($n = 7$) (criterion 301.22.A.4)</td>
</tr>
<tr>
<td>Anti-social PD</td>
<td>3 (2.5)</td>
<td>18 (14.8)</td>
<td>0.26 (0.78)</td>
<td>Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations ($n = 8$) (criterion 301.7.A.6)</td>
</tr>
<tr>
<td>Borderline PD</td>
<td>9 (7.4)</td>
<td>33 (27)</td>
<td>0.49 (1.0)</td>
<td>Inappropriate, intense anger or difficulty controlling anger (frequent displays of temper, constant anger, recurrent physical fights) ($n = 27$) (criterion 301.83.A.8)</td>
</tr>
<tr>
<td>Narcissistic PD</td>
<td>6 (4.9)</td>
<td>5 (4.1)</td>
<td>0.06 (0.30)</td>
<td>A sense of entitlement (unreasonable expectations of especially favorable treatment or automatic compliance with his/her expectations) ($n = 2$) (criterion 301.81.A.5)</td>
</tr>
<tr>
<td>Histrionic PD</td>
<td>4 (3.3)</td>
<td>7 (5.7)</td>
<td>0.07 (0.32)</td>
<td>Has a style of speech that is excessively impressionistic and lacking in detail ($n = 6$) (criterion 301.50.5)</td>
</tr>
<tr>
<td>Avoidant PD</td>
<td>2 (1.6)</td>
<td>14 (11.5)</td>
<td>0.19 (0.67)</td>
<td>Inhibited in new interpersonal situations because of feelings of inadequacy ($n = 7$) (criterion 301.82.5)</td>
</tr>
<tr>
<td>Dependent PD</td>
<td>0 (0)</td>
<td>8 (6.6)</td>
<td>0.11 (0.48)</td>
<td>Needs others to assume responsibility for most major areas of his/her life ($n = 4$) (criterion 301.6.2)</td>
</tr>
<tr>
<td>Obsessive–compulsive PD</td>
<td>1 (0.8)</td>
<td>6 (4.9)</td>
<td>0.06 (0.27)</td>
<td>Shows rigidity and stubbornness ($n = 6$) (criterion 301.4.A.8)</td>
</tr>
</tbody>
</table>

Diagnoses were given by therapists immediately following the intake session. Eleven participants (9%) were diagnosed with unspecified personality disorder.
length of intake and WAI reports by clients. Furthermore, no significant correlation was found between $p = 0.049$, Cohen’s $d = 0.38$. Results are presented in Figure 1. Furthermore, no significant correlation was found between length of intake and WAI reports by clients ($r(117) = -0.16$, ns) and by providers ($r(116) = 0.17$, ns).

Since the data were hierarchically nested within therapists we further examined our results using multi-level modeling, in these analyses we had to exclude therapists who participated with only one intake session (nine therapists) due to lack of within therapist variance. Results did not significantly differ from the non-nested model.

Discussion

In the current study, we examined the PD diagnostic information therapists explicitly collect during naturalistic settings and how PD diagnoses impact the quality of the working alliance during the initial intake session. Our results are consistent with other clinical epidemiological studies showing that PDs are frequent among clients in community mental health clinics (Zimmerman et al., 2005). Our findings further show that despite the relatively high prevalence of PDs in routine outpatient clinical care, very limited PD diagnostic information is directly assessed during the mental health intake. Our findings suggest that therapists tend to underuse the diagnostic system, not collecting sufficient explicit diagnostic information to base their PD diagnostic decisions.

Previous studies which were based primarily on therapists’ reports of their diagnostic assessment process documented that regardless of theoretical orientation, therapists reported that they do not exclusively or even primarily rely on asking explicit questions about specific PD diagnostic criteria (Westen, 1997) which is consistent with our findings. However, no study to date has examined the actual diagnostic information therapists explicitly collect during the mental health intake, or the way it was applied to reach diagnoses. Our findings, which were based on actual recording of therapists’ assessment process during the mental health intake show that therapists base their PD diagnostic decisions on very limited diagnostic information, and that the problem of missing diagnostic information may underlie the poor reliability of clinical diagnostic decision process (Nakash & Alegría, 2013; Westen, 1997).

Despite the importance of conducting explicit assessment of diagnostic information to increase reliability and reduce bias in diagnostic decisions (Dawes et al., 1989; Stickle & Weems, 2006), some researchers have questioned the utility of relying solely on direct questions because they can substantially be affected by biases related to insight and motivation. Explicit and direct forms of collecting diagnostic information are particularly disputable in assessing PDs, which are ego syntonic by definition, and require judgments that clients might lack the objectivity to make (Gritti et al., 2016; Westen, 1997; Westen & Weinberger, 2004). In addition, explicit information processing might also hinder the assessment of implicit motivations that represent enduring personality patterns that are not consciously accessible to the client (McClelland et al., 1989).

Findings from past studies have shown that therapists do not tend to rely on explicit and direct questions. Instead, therapists use diagnostic procedures that rely more on clients’ narratives describing themselves and their social history. They also tend to utilize observations of the client’s nonverbal communication and in-session interaction with the therapist (Alegría et al., 2008; Nakash & Alegría, 2013; Westen, 1997). Some research suggests that implicit clinical procedures are particularly clinically useful for assessing personality structure and pathology as well as for evaluating a wider range of interpersonal problems (e.g. chronic fear of abandonment) and personality conflicts (e.g. chronically feeling guilty) for which clients report seeking treatment. In contrast, a more explicit mode of assessment might be better suited in evaluating depressive and anxiety disorders that are more consciously available to the client (Nakash et al., 2015a; Westen & Arkowitz-Westen, 1998). Unfortunately, no study to date has examined the validity of basing a PD diagnostic decision on implicit and/or observational information. This is pertinent, in light of our findings documenting the scarcity of explicit diagnostic information that is actually collected and the impact the diagnosis may have on the working alliance between PD clients and their providers.

Our findings further show that there was a significant gap in the evaluation of the therapists’ working alliance between clients who were diagnosed with PD during the initial intake session and clients who were not diagnosed with PD, while no significant differences emerged in the evaluation of the clients’ working alliance. Therapists evaluated the quality of the relationship when they saw a client they diagnosed with PD as significantly lower than the evaluation of a client not diagnosed with PD.

PDs, by definition, involve dysfunctional schemas of the self, others and relational interactions. These patterns of relating often appear in the therapeutic relationship, drawing the therapist into the client’s enduring maladaptive patterns of relating (Colli et al., 2014; Lingiardi et al., 2005). As our findings show, this is evident as early as the intake session in the worse therapeutic alliance and may have implications to the client’s retention in care.

The current study has several limitations. First, the data were collected before the publication of the DSM 5. However, since the categorical basis for the diagnostic system has not
changed in this recent version, nor has the criteria for PDs, we believe that our findings regarding the clinical use of the diagnostic system can be extrapolated to the current version. Second, although past studies found differences in the association between quality of working alliance depending on the specific PD (Smith et al., 2014), due to small sample size we were not able to examine such differences. Third, although it is highly likely therapists’ diagnostic decision making process is complex and is often based on direct verbal as well as observational and behavioral information; in the current investigation we collected information only on direct verbal communication between clients and therapists. Future studies should continue to explore how therapists integrate different sources of information (i.e. explicit and implicit information, as well as personal attitudes and beliefs regarding PDs) to reach a diagnosis, and to examine how specific behaviors during the mental health intake explain the connection between PD diagnosis and working alliance.

Our findings have important implications for research as well as clinical work as they highlight the importance of systematically evaluating therapists’ assessment process in routine outpatient clinical care to improve the utility of the diagnostic process. Our data suggest that bias in clinical diagnostic assessment for PD (Alegria et al., 2008; Nakash et al., 2015a) can be a result of the limited direct diagnostic information that is collected in regular practice. Furthermore, our findings regarding the quality of the working alliance call for the therapist’s early recognition of the client’s needs, including how good alliance can be developed and sustained as early as the initial intake session.

Acknowledgements

This work was supported by the Israeli National Institute for Health Policy and Health Services Research grant 2006/6 to Prof. Nakash.

The authors gratefully acknowledge Dr. Eli Danilovich, Dr. Daphne Bentov-Gofrit, Dr. Ido Lurie, Dr. Henry Szor, Dr. Evelyn Steiner Dr. Shiri Sadeh-Sharvit, and Prof. Itzhak Levav for their support during data collection as well as all participating clients and therapists. Without their support this study would have not been possible.

Declaration of interest

No conflict of interest exists.

This work was supported by the Israeli National Institute for Health Policy and Health Services Research grant 2006/6 to Prof. Nakash.

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