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An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences.

by

Liesl Thandi Morris

Minor dissertation (article format)

submitted in partial fulfilment of the requirements for the degree MASTERS (CLINICAL PSYCHOLOGY) in the

FACULTY OF HUMANITIES

at the

UNIVERSITY OF JOHANNESBURG
Supervisor: Dr Melissa Card

Date of submission: 30 January 2019
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Summary

An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences.

The South African population is exposed to multiple forms of violence on a daily basis either through personal experiences or vicarious exposure, with researchers suggesting that, the general public is at high risk for developing trauma-related mental health problems. The importance of understanding the type and extent of trauma experience and its link to the development of pathology, including personality disorders (PDs), is evident in many research studies (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Perkonigg, Kessler, Storz, & Wittchen, 2000; Robertson, 2013; Williams et al., 2007; Yen et al., 2002). However, there appears to be dissonance between 1) the recognized importance of the link between trauma experiences and 2) the development of personality pathology and 3) the lack of focus or importance this link is given during intake sessions with patients.

The present study is qualitative and uses phenomenological exploration to gain insight into psychiatrists’ perceptions of the link between trauma experience(s) and the development of PDs and how this may impact their interaction with patients who have experienced trauma and have a possible PD diagnosis. The sample size was limited to a homogenous group of four HPCSA registered psychiatrists. Semi-structured face-to-face interviews were conducted between the researcher and each psychiatrist. Interpretive
Phenomenological Analysis (IPA) was used to analyse the data collected through the interviews.

After analysing each transcript, seven themes and one subtheme were identified: 1) defining trauma; 2) impact of trauma; 3) holistic understanding of patients and the subtheme, building trust; 4) presenting symptomology; 5) socialisation and support, 6) bias or sensitization and finally 7) awareness and training.

Findings indicate that the psychiatrists’ definition of trauma extends that seen in literature, indicating that trauma is not seen as only one traumatic event, but also lifelong exposure to traumatic experiences such as rejection and/or abandonment and abuse. Additionally, the psychiatrists report an increased emphasis on the possible effects of trauma experiences, during their academic training and registrar placements, which contradicts the limited attention paid to trauma experience reported in literature.

The psychiatrists’ experiences and perceptions are enriched by their individual personalities, previous experience and training, which enhanced the understanding of the known link between trauma experience and the development of PDs.

**Word count:** 340

**Keywords:** mental health, personality disorders, psychiatry, trauma, trauma impact; experiences
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1. Preface

1.1. Article format

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1.2. Selected journal

The targeted journal for publication is the *South African Journal of Psychology*. A shortened version of the manuscript will be submitted to the journal in accordance with the journal’s guidelines. The referencing style and editorial approach for this manuscript is in line with the Publication Manual of the American Psychological Association (6th edition, 2009), except where otherwise specified by the *South African Journal of Psychology*’s guidelines.

For the purposes of this mini-dissertation, the pages are numbered consecutively. For submission to the above-mentioned journal, pages will be numbered according to the journal’s requirements and thus start from the title page of the manuscript.

1.3. Permission from co-authors

A letter of consent signed by the co-authors, in which they give permission that the manuscript; *An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences*, may be submitted for the
purposes of a mini-dissertation by the first author, Liesl T. Morris, appears on the next page.
Letter of Consent

I, the co-author, hereby give consent that Liesl T. Morris may submit the manuscript *An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences* for purposes of a mini-dissertation in partial fulfilment for the degree Master of Arts in Clinical Psychology. It may also be submitted to the *South African Journal of Psychology* for review.

______M. Card_______

Dr M. Card

Co-author and Supervisor
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An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences.
2.1. Instructions to authors

Target journal: South African Journal of Psychology

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2.2. Manuscript
AN EXPLORATION OF MENTAL HEALTH CARE WORKERS PERCEPTIONS OF THE LINK BETWEEN PERSONALITY DISORDER DIAGNOSES AND TRAUMA EXPERIENCES.

An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences.

Liesl T. Morris* & Melissa Card

Department of Psychology, University of Johannesburg, South Africa

* Corresponding author
Ms. L. T. Morris
c/o Dr M Card
Department of Psychology
University of Johannesburg
P O Box 524
Auckland Park
2006
South Africa
Tel. +27 11 559 2916
lieslmorris@gmail.com
Abstract

For decades researchers have impressed the importance of understanding how trauma experiences could be linked to the development of pathology, including (PDs). However, there appears to be dissonance between the recognized importance of the link between trauma experiences, and the development of personality pathology, and the lack of focus given to this link in intake sessions with patients.

This study highlighted the importance of the link between trauma exposure and the development of PDs and aimed at highlighting the possible need to change the approach of mental health workers’ in treating patients who have experienced trauma or have a personality pathology diagnosis. The hope is that this leads to greater attention paid to gaining a thorough assessment into past trauma exposure during intake as well as taking into account the role of trauma in making a psychiatric diagnosis.

Through IPA, seven themes and one subtheme were identified: 1) defining trauma; 2) impact of trauma; 3) holistic understanding of patients and the subtheme, building trust; 4) presenting symptomology; 5) socialisation and support, 6) bias or sensitization and 7) awareness and training.

Findings indicate the psychiatrists’ extended the definition of trauma seen in literature, including lifelong exposure to traumatic experiences such as rejection, abandonment and abuse. Moreover, the psychiatrists report an increased focus on the effects of trauma
experience in the course focus of registrar training placements. The use of IPA allowed for a richer understanding of the psychiatrists’ personal experiences and perceptions.

**Word count:** 241

**Keywords:** mental health, personality disorders, psychiatry, trauma, trauma impact, experiences
Introduction

The South African population is exposed to extremely high rates of violent crime, sexual violence and domestic abuse is regarded as having one of the highest levels of urban crime internationally (Kaminer, Grimsrud, Myer, Stein, & Williams, 2008; Gilbert, 1996). Thus, South Africans are exposed to multiple forms of violence on a daily basis either through personal experiences or vicarious exposure (Kaminer, et al., 2008; Williams et al., 2007). Due to the high levels of traumatic exposure in South Africa, the country is considered one of the most stressful societies in the world (Masuku, 2002). Consequently, it is thought that the general public is at high risk for developing trauma-related mental health problems (Masuku, 2002).

Trauma

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5), defines trauma as the exposure to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2014). This exposure can occur in one or more of the following ways: directly experiencing the traumatic event/s, witnessing, in person, the event/s as it occurred to others, learning that the traumatic event/s occurred to a close family member or close friend, experiencing repeated or extreme exposure to aversive details of the traumatic event/s (American Psychiatric Association, 2014).
According to Terr (1991) trauma can be divided into two distinct categories: acute or single-incident trauma and chronic or repetitive trauma, also referred to as Type I trauma and Type II trauma, respectively. Although acute or single episodes of trauma can cause significant problems for a child, the symptoms often resolve if the child is in a stable and supportive caregiving environment (Terr, 1991). Therefore, there is less chance of serious long-term complications, such as PTSD, to develop. However, Stirling, & Amaya-Jackson (2008), mention that regardless of whether a child lives with their birth parents, foster families or adoptive families, long-term behaviour problems seem to occur.

Chronic trauma involves either sustained or repetitive traumatic experiences and typically occurs in an environment where there is little healthy caregiving or support from an adult (DeMartino, 2006; Terr, 1991). When trauma deliberately inflicted on a child by a parent or caregiver, the intentional quality of that experience exacerbates its severity (DeMartino, 2006).

**Trauma and mental health/illness**

Given the presumed burden of trauma in South Africa, as discussed above, it is important to establish an understanding of the rates of trauma, and links to mental health. Several studies have explored the link between trauma and the development of PTSD and indicated that exposure to and being victimized by violence is more likely, than other forms of trauma, to be associated with posttraumatic stress disorder (PTSD) (Kaminer, et
al., 2008; Williams et. al., 2007). According to the American Psychological Association [APA] (2017), traumatic events can result in serious stress and detrimental consequences for survivors and their families, and although the majority of individuals will be able to overcome the trauma over time, many survivors will experience long-lasting problems. Williams et al., (2007) confirm this in their study which unpacks the sociodemographic risk of trauma and the association between trauma and distress: that experiencing criminal victimization, partner violence, child abuse, disasters, threats to life and trauma of close others were significantly related to high distress. Psychological disorders such as depression, anxiety, alcohol/substance abuse problems and potentially PDs may also occur in conjunction with posttraumatic stress (Williams et al., 2007).

**Trauma and personality disorders**

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5), defines a Personality Disorder (PD) is an

“*enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment*” (American Psychiatric Association, 2014, p. 645).

Personality disorders (PDs) are grouped into three clusters based on descriptive similarities. Cluster A PDs include paranoid, schizoid, and schizotypal personality disorders. Cluster A PDs usual present with odd or eccentric behaviour. Individuals with Cluster B PDs often appear dramatic, emotional, or erratic and these PDs include
antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C PDs include avoidant, dependent and obsessive-compulsive personality disorders and individuals with Cluster C PDs often appear anxious or fearful.

The role of trauma in the development of a PD and especially for Borderline Personality Disorder (BPD) has been widely researched (Goodman, New, & Siever, 2004; Hernandez, Arntz, Gaviria, Labad, & Gutiérrez-Zotes, 2012; MacIntosh, Godbout, & Dubash, 2015; Tyrka, Wyche, Kelly, Price, & Carpenter, 2009; Zhang, Chow, Wang, Dai, & Xiao, 2012). While recent studies suggest that BPD is not a trauma-spectrum disorder and that it is biologically distinct from posttraumatic stress disorder (Goodman, New, & Siever, 2004), high rates of childhood abuse and neglect do exist for individuals with personality dysfunction (Zhang et al., 2012). Spataro, Mullen, Burgess, Wells, and Moss (2004) examined the association between sexual abuse in childhood and psychopathology in adulthood: victims of abuse were more susceptible to developing PD than the general population. A more recent study by Hernandez et al. (2012), found that the BPD criteria were associated with higher scores on emotional and sexual abuse.

There have been numerous studies that have examined the associations between trauma exposure, posttraumatic stress disorder (PTSD), and axis I disorders (Acierno et al., 1999; Kessler et al., 1995; Perkonigg et al. 2000), as previously categorised in the DSMIV-TR (APA, 2000). However there has been much less focus on gaining empirical knowledge
on the complex interactions between trauma, PTSD, and PDs (Yen et al., 2002). The majority of empirical epistemological research has been conducted in the United States, Europe and Australia (Ekselius, Tillfors, Furmark, & Fredrikson, 2001; Jackson, & Burgess, 2004; Samuels, et al., 2002; Torgersen, Kringlen, & Cramer, 2001) and the investigation of PD epistemology in Africa and South Africa has been neglected (Suliman, Stein, Williams, & Seedat, 2008).

The South African Stress and Health Study (SASH), provided an opportunity to estimate the prevalence of PDs in the South African population (Herman, Stein, Seedat, Heeringa, Moomal, & Williams, 2009). As part of the South African Stress and Health Study (SASH), with a population-representative sample of South African adults aged 18 years and older, Suliman, et al. (2008), found a prevalence of any PD in the community to be 6.8% and the prevalence of cluster B disorders to be 1.5%. However, there has not been similar research exploring the relationship between PDs diagnoses and exposure to trauma experiences in South Africa (Robertson, 2013).

The importance of understanding the type and extent of trauma experience and its link to the development of pathology, including PDs, can be seen in research studies both internationally and to a lesser degree domestically (Acierno et al., 1999; Kessler et al., 1995; Perkonigg et al. 2000; Robertson, 2013; Williams et al., 2007; Yen et al., 2002).
AN EXPLORATION OF MENTAL HEALTH CARE WORKERS PERCEPTIONS OF THE LINK BETWEEN PERSONALITY DISORDER DIAGNOSES AND TRAUMA EXPERIENCES.

However, the importance of this link does not appear to have translated into the functioning of psychiatric units in South Africa.

The lack of importance was noted when assessing the intake and discharge summaries of patient files at a tertiary hospital in Johannesburg. Patient files were assessed as part of a larger research project, which aims to obtain archival information from patient files regarding diagnoses and course of treatment. When assessing the above-mentioned files, it was noted that very little information is elicited regarding past trauma, as defined by the DSM-5, experienced by patients on intake. This suggests that little attention is paid to trauma experienced by patients, during the intake session, which may point to the perception that it lacks importance in the clinical assessment and diagnoses process.

This lack of focus was noted in a study by van Zyl, du Toit and Joubert (2017), which investigated the extent of trauma exposure as reported by adult patients across all diagnostic categories referred for psychological services at the Free State Psychiatric Complex (FSPC), in Bloemfontein. In their study van Zyl, Nel, du Toit & Joubert (2017) note that findings reflecting the potential underdiagnosing of PTSD in a psychiatric setting where the trauma exposure did not necessarily form part of the presenting problem, may be due to the absence of trauma-sensitive questions during the standard psychiatric intake interview used at the study sites.
McFarlane and Van Der Kolk (2007) state that the absence of thorough assessment into past trauma exposure may be due to the marginalisation of the role trauma exposure has on the development of psychopathology. The reality of trauma in people's lives is often ignored, which is evident in the limited attention paid to the possible presence of trauma-related disorders in patients during the training of medical students and psychiatric residents (McFarlane & Van Der Kolk, 2007; van Zyl, Nel, du Toit & Joubert, 2017). Subsequently, the immediate and long-term treatment and management of patients is impacted by a discord between the known importance of the link between trauma experience and the development of psychopathology and the lack of emphasis this link is given in intake sessions with patients.

Furthermore, according to a study by Eren and Ahin (2016) in which they investigated the difficulties Mental Health Care Professionals (MHCPs) in Turkey experience while working with people with PDs and how MHCP’s define those difficulties, and their attitudes to people those diagnosed with PDs. It was found that MHCPs experience difficulty in working with, and have negative attitudes towards, individuals with PDs who frequently present with repetitive suicide attempts, self-harm behaviours and behaviours intending to harm others (Eren & Ahin, 2016). Moreover, individuals with PDs are described as being coercive, threatening, manipulative and offensive, and have difficulty in recognizing boundaries (Eren & Ahin, 2016). Many MHCPs tend to interpret these
behaviours as deliberately manipulative that trigger negative feelings in MHCPs, making it difficult to develop a positive treatment relationship (Eren & Ahin, 2016; Rossberg, Karterud, Pedersen, & Friis, 2007). Furthermore, in a survey concerning mental health care practitioner’s management of clients with a diagnosis of BPD, it was found that 84% of MHCP participants stated that it was more difficult to provide treatment and care for patients with a diagnosis of BPD compared with other patient groups (Cleary, Siegfried & Walter, 2002). Consequently, this difficulty experienced by MHCPs does not facilitate an understanding of the difficulties the patients experience, thereby affecting the treatment process negatively (Eren & Ahin, 2016).

These negative attitudes of MHCPs when working with individuals with PDs as well as the lack of importance placed on the link between trauma experience and the development of pathology, including PDs, may affect the quality of MHCP’s service or interaction with patients.

There appears to be dissonance between the known importance of the link between trauma experience and the development of psychopathology and the lack of emphasis this link is given in intake sessions with patients. Furthermore, negative attitudes and experiences of MHCPs working with individuals presenting with personality pathology may impact the quality of MHCP’s service or interaction with patients. Consequently, MHCPs experiences and reactions to individuals with PD diagnoses or traits as well as the lack of
AN EXPLORATION OF MENTAL HEALTH CARE WORKERS PERCEPTIONS OF THE LINK BETWEEN PERSONALITY DISORDER DIAGNOSES AND TRAUMA EXPERIENCES.

focus of trauma in training (van Zyl, Nel, du Toit & Joubert, 2017), may affect their exploration into past trauma exposure and in turn the potential treatment of said trauma in relation to the development of a PD.

The potential impact of treatment and the exploration of trauma in relation to the development of a PD, highlights the need to determine the perceptions of mental health workers, particularly psychiatrists, regarding their experiences of working with individuals with PDs and their understanding of the link between trauma exposure and the development of PDs.

**Aim of study**

The study aimed to highlight the importance of the link between trauma exposure and the development of PDs because the lack of importance given to this link impacts psychiatrists’ approach to treating individuals who have experienced trauma and/or display personality pathology. Furthermore, the study aimed to highlight the possible need to change psychiatrists’ and other mental health workers’ approach and responses to treating patients who have experienced trauma or have personality pathology. Finally, the hope was that the emphasis of the importance of the link between trauma exposure and the development of PDs leads to greater attention being paid to gaining a thorough assessment into past trauma exposure during intake as well as taking into account the role of trauma in making a psychiatric diagnosis such as a PD.
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In order to meet these aims, the researchers posed the following research question: ‘What are the perceptions and experiences of psychiatrists on the link between the experience of trauma and the development of personality pathology?’

**Methodology**

The study is qualitative and used phenomenological exploration to gain insight into psychiatrists’ perceptions of the link between trauma experience(s) and the development of PDs, and how this might impact their interaction with patients who have experienced trauma and have a possible PD diagnosis.

Interpretative phenomenological analysis (IPA) was used in this study. IPA is an approach to qualitative research which has been informed by the concepts of phenomenology, hermeneutics and idiography. Phenomenology is the study of structures of consciousness as experienced from the first-person point of view and understands a person as being embodied, embedded and immersed in the world (Frost, 2011). Hermeneutics is a theory of interpretation and is a prerequisite to phenomenology. Hermeneutics has been said to exist in the manner in which human existence is interpreted. Therefore, from this perspective the understanding and interpretation of an event or person is already contextualised through previous experience in the given context and any existing knowledge the individual has (Frost, 2011). Finally, idiography aims for an in-depth focus on gaining a detailed analysis of actual life and lived experience (Frost,
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2011). A detailed study offers the opportunity to learn a great deal about a particular person and their responses to particular situations (Frost, 2011). Therefore, IPA is the detailed examination of the personal lived experience of practical engagement with the world and aims to explore how participants make sense of their ‘lived experience’ (Frost, 2011). Furthermore, it recognises the researcher’s role in making sense of the participants’ lived experience and focuses on detailed examination of particular instances, allowing for the use of a small sample of participants (Frost, 2011).

The use of IPA enabled rigorous exploration and a rich complex description (Finlay, 2009) of psychiatrist’s personal and professional perceptions and experiences of the link between trauma experience and the development of PDs, thereby gaining a detailed understanding of the psychiatrists’ lived engagement with their patients, their method of practice as well as the influence their years of practical experience had on their current approach and understanding.

**Sample**

The primary concern of IPA research is gaining a detailed account of an individual experience; therefore, the sample size was limited to a homogenous group of four Health Professions Council of South Africa (HPCSA) registered psychiatrists. This allowed for sufficient in-depth engagement with each individual case and reduced the possibility of becoming overwelled with the vast amount of data generated by a qualitative study. Each participant involved in the study is an HPCSA registered psychiatrist with clinical
experience working in government hospitals either at a registrar or consultant level, and currently practising in private practice or at private or government hospital level in the KwaZulu Natal Region. Finally, the psychiatrists have been working for a minimum of 3 years and have experience working with PDs and/or trauma. The sampling technique used for this study is purposive and convenience sampling. The psychiatrists were selected based on specific sampling criteria, see below, and the availability and willingness of psychiatrists to participate. Due to the homogeneity of the sample group as well as the focus on a specific topic of experience, data saturation occurred after interviewing four psychiatrists, and further data collection was unnecessary.

**Procedure and method of data collection**

Semi-structured face-to-face interviews (see appendix A and B for demographic questions and prompt sheet) were conducted between the researcher and each psychiatrist, with individual interviews taking between 45 and 60 minutes. All interviews were audio-recorded and then transcribed by a transcriber. Each psychiatrist was asked to sign a consent form allowing the interviews to be audio-recorded and transcribed by a transcriber. The researcher listened to and read through each transcript several times to ensure the researcher become familiar with the information from the interview. Additionally, this allowed the researcher to check the accuracy of each transcribed interview. When transcribing and reporting on the information gathered, pseudonyms were used in order to ensure the confidentiality of the psychiatrists. The transcribed
interviews were sent through to the psychiatrists, providing them with an opportunity to verify/elaborate on their responses.

Trustworthiness

In order to ensure the validity and quality of the study the characteristics of good qualitative research as explained by Yardley (2000) were adopted. The first characteristic is sensitivity to context (Yardley, 2000). It was imperative to be well versed in the topic of study, ensuring that the researcher was able to engage fully with the psychiatrists. Furthermore, sensitivity to context was demonstrated through the use of direct quotations from the psychiatrists. The second characteristic is commitment and rigour (Yardley, 2000). Commitment was established by becoming immersed in the relevant literature as well as attentively engaging with the psychiatrists and what they said. Rigour was demonstrated by thorough engagement with the interview transcripts during the analysis phase of the research, using direct quotations to link the themes found and the psychiatrists’ transcripts. The third characteristic is transparency and coherence (Yardley, 2000). Transparency was demonstrated by an explanation of the study to psychiatrists in the information sheet (See appendix C) as well as the opportunity for the psychiatrists to ask questions. Furthermore, due to the possibility that psychiatrists may feel that their view or responses have been misrepresented or lacking context (Richards & Schwartz, 2002), the psychiatrists were given the opportunity to alter their responses in a second interview phase. Coherence was established through the interrelatedness of each step in
the research process. Finally, the validity of the study was strengthened by direct supervision throughout the study.

**Reflexivity**

Continuous personal reflection during the research process was essential in order to limit person bias as well as to understand my own personal experience of the interview process and interaction with the psychiatrists.

With each interview my confidence increased, this influenced the level of engagement I had with the psychiatrists involved. It was important for me to be aware of this increased confidence in order to prevent over-involvement in the psychiatrist’s story. During my interactions with the psychiatrists, I was also aware of my own personal knowledge of psychiatry. This known knowledge was also assumed by the psychiatrists influencing their choice of language and level of description during the interview process. Finally, following each interview I reflected on the experience, noting any significant experiences and topics of discussion.

**Ethical Considerations**

The research received ethical clearance from the University of Johannesburg (Ethics no: REC-02-0012-2018). Each psychiatrist signed a consent form (See Appendix D), agreeing to take part in the study. The use of a transcriber reduced the anonymity of the psychiatrists; therefore, the psychiatrists were informed of the possible use of a transcriber before the interview and in the information letter. Moreover, the transcriber signed a
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confidentiality agreement (See Appendix E). In order to ensure the confidentiality of the psychiatrists’ pseudonyms were used in transcripts as well as in the reporting of the results and discussion.

Analysis of data

IPA was used to analyse the data collected through the interviews. IPA is fluid, interactive and multi-directional and the analysis process involves four distinct stages (Frost, 2011). The initial stage involved thoroughly reading the transcripts several times and becoming familiar with the language used. During this stage any observations and reflections from the interview were added to the transcript (Frost, 2011). The second and third stages involved returning to the transcripts and transforming the initial notes into emerging themes and clustering these themes together according to conceptual similarities (Frost, 2011). The final stage involved creating a table of themes; alongside the identified themes an extract or quote from the transcript was provided (Frost, 2011). This analysis process was repeated for each transcript. Once all transcripts were analysed, a final table of themes was constructed for the study as a whole (Frost, 2011).

Results

Participants

The study involved interviews with four psychiatrists. Dr Jerome has extensive experience in both private and government hospitals and has been practicing as a
psychiatrist for over 50 years. He has a special interest in child psychiatry. Dr Prisha is a relatively newly qualified psychiatrist and has experience working in both government and private hospitals. Dr Mandy has been a qualified psychiatrist for over ten years and has spent the majority of her psychiatry career in private practice. Finally, Dr Harold has been practicing psychiatry for over 30 years. He has special interest in biological psychiatry and psychiatric assessments.

Pseudonyms have been used in order to ensure confidentiality of the psychiatrists.

After analysing each transcript, the following seven themes and one subtheme were identified across the four interviews. The themes include; 1) defining trauma; 2) impact of trauma; 3) holistic understanding of patients and the subtheme, building trust; 4) presenting symptomology; 5) socialisation and support, 6) bias or sensitization and finally 7) awareness and training.

Theme One: Defining trauma

When describing their interactions and experiences working with trauma, the participants all provided their own understanding and definition of trauma, a traumatic event or experience. The psychiatrists indicated that the definition of trauma or what it involves, influences their approach in addressing the possible impact of said traumatic event or experience.
As said by Dr Jerome:

> Ya let’s say that the several that I’ve had I always ask about their childhood because then it gives you an idea like or it could be that, or later on in life as adults when they have, if its emotional trauma. So, having grown up where parents are fighting with each other maybe father is a[n] alcoholic and you find that... that affects again the presentation that the chi ... if it’s a child it affects their presentation because you find response to treatment is determined by their sort of background. Those that turn up from fairly stable backgrounds do better in therapy than those who come from traumatic backgrounds...

Dr Prisha, highlights this definition saying,

> ... alright... and be it sexual trauma, be it trauma revolving around a breakdown of a family, be it trauma around exposure to a parent with an addiction problem, that does tend to influence personality disorder development or trait development. ehm there’s been a lot of links ... ah well I feel between exposure to sexual trauma ...

Dr Mandy takes this definition further, bringing in violence and secondary trauma;

> Yes, I think it’s something that we see ehm hijackings, armed robberies, people waking up in the middle of the night with somebody in their house of somebody or somebody threatening them. Also, sometimes people that have been a witness or
has been secondarily involved. I saw somebody yesterday whose relative was murdered and she had to go and identify the body, do the official identification.

Similarly, Dr Jerome incorporates physical trauma;

Yes, those you’ll find… The ones that I’ve come across, they’ve had for an example, frontal lobe injuries, and those seem to be… the ones that I’ve seen… the one lady for example had an aneurysm that burst here in the left frontal area. She became apathetic and totally disinterested towards everything social.

Finally, Dr Prisha further differentiates between chronic and acute trauma,

Ahm in terms of trauma … right… ah, I think it’s nice to differentiate what type of trauma we looking at, whether it’s acute trauma, whether it’s chronic trauma. (interviewer: Okay and how would they differ?)…Em so I mean an acute traumatic event would be a hijacking or an acute traumatic event would be exposure to a house robbery… right … Ahm you know it generally doesn’t … which I haven’t found contributory in terms of … (interviewer: …personality …) … personality… but when you look at chronic trauma and depending at the stage of development that the individual is in… it turns to be more contributory … alright…
So, traumas were defined not only as violent crimes or personal attacks on individuals, but also as emotional and physical experiences. In addition, trauma can either be experienced chronically or acutely.

**Theme Two: Impact of trauma**

Further, each participant’s definition of what trauma, traumatic events or experiences are, influenced their view on its impact on personality development. i.e. how trauma is defined determines whether the trauma experience impacts personality development or presentation.

Dr Prisha explains that trauma, particularly sexual abuse impacts an individual’s personality development.

*Ah the other area that I found interlinked with trauma and personality development, was how trauma more especially sexual abuse in the male population at a young age sensitizes them in terms of sexuality and how that influences the development of their personalities.*

Dr Harold highlighted the difference between traumatic experiences such as rejection or lack of attachment during childhood, and traumatic events, indicating that experiences rather than events have an impact on an individual’s personality development.
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…I don’t think events as such but certainly experiences... rejection for example. Rejection is an experience it’s not an event, eh being beaten the shit out of you is an event. Being deprived of food and stuck in a room for three weeks without food is an event. But the other things can just be experiences and one needs to perhaps look at that because some things in relationships are not events, they are just experiences. My wife she sleeps in a separate bedroom, it’s not a shared event but it’s an experience of rejection, an experience of being not good enough, and being inferior, being somehow unaccepted...

As Dr Prisha explains trauma experienced during childhood was seen to have a greater impact on an individual’s personality development than trauma experienced during adulthood when their identity is more stable;

I would say so, alright, later life experiences, less likely, personality more likely to present with acute Axis I psychiatric disorders. Right, because by then they’ve developed a sense of their coping skills and their self-identity etcetera. If you had to look at Erikson’s and etcetera, they would have already come to a sort of... (Interviewer:... a sort of identity...) ... ya some sort of identity, but there are certain types of trauma that you can undergo that may impact so... ah for example someone who loses a child or through whatever traumatic experience be it cancer,
be it a motor vehicle accident they may develop dependency traits on their other kids...(interviewer: ah ... they might... oh... so...?)...ya but that’s more a sense of being driven from a fear of loss or they attach excessively etcetera. But adult trauma per say I don’t think it influences as much the development of a personality. But we always evolving, we always changing. And then I think the other thing that we must look at is in terms of personality and impact is, what could the possible effects of the substances be?

Sexual trauma and trauma experienced during childhood are seen to have greater impact an individual’s personality development. Furthermore, the experience of an event as being traumatic influences personality development rather than the event itself.

**Theme Three: Holistic understanding of patients**

A prominent theme in all four interviews was the importance of gaining an in-depth, holistic understanding of a patient before attempting to settle on a final diagnosis.

As Dr Jerome explains;

*I don’t know how they manage that because usually I devote an hour for the first consultation because there’s so much to be obtained and sometimes it might be*
Dr Prisha highlights the complexity of understanding a patient and the importance of delaying making a formal diagnosis.

.... Ahm but it’s very complex sometimes teasing out part of the Axis I, what’s actually sitting on Axis II. It’s complex and sometimes you need to know your patient for quite a while before you can ascertain... before you commit to a label should we say...

Dr Harold adds on to this, highlighting the importance of not only gaining a full history but taking all factors and investigations into account.

... getting a history ... and you’ll see on the [lecture] slide, get proper history, do a physical examination, do special investigations. So, personality in this lady’s case was clearly one that she was quite... she probably did have a mildly anxious personality, but she did something about it. Instead of just listening to the doctor who had done no test or anything. Her personality flavored the whole triangle. By saying I want to know, check it out, on top of the history, check out the special
investigations and tell me, is it really psychiatric?... So and you’ll see when I look at the causes of these type of illnesses I write there about the psychodynamic causes. And at that stage when I wrote it I didn’t quite have the insight and perhaps the persuasion that this book [The Divided Mind] has brought about in me.

The psychiatrists highlighted the importance of delaying a final diagnosis until a full understanding of their patients has been established and gaining a holistic understanding of a patient may take some time.

**Subtheme: Building Trust**

To ensure a complete understanding of a patient, the psychiatrists highlighted the importance of establishing trust with a patient during this initial phase before enquiring about trauma experience.

Dr Mandy describes the importance of ensuring that a patient feels safe enough to open up about past trauma experiences;

Yes, and therefore I think it’s very important for the patient to feel that you spending enough time with them. You know it’s easy to… ask the easy questions, have you had an operation, have you got any medical conditions and that, you
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know just to tick on your intake but your patient mustn’t feel that they can’t tell you if you asked about trauma that it must just be a yes or no answer or if you’ve asked about family history just a yes or no answer it’s good to get the important facts.

Dr Harold also explains the importance of limiting confrontational questions until the patient feels comfortable to delve into these topics;

...No! no! no! no! no! no! no! that I do not do. That I do not do.

With more probing questions Dr Harold was able to provide more information.

It’s too early, too early, too early. I need to get to know them. This is the genogram and the whole story... childhood neurotic behavior? Nil. Happy loved and had friends... and nothing confrontational, nothing confrontational. Only now after we’ve established what’s actually happened to them, am I starting to delve into those certain things.

Therefore, it is important to ensure trust is established with the patient before enquiring about confrontational topics such as trauma experience.

Theme Four: Presenting Symptomology
The psychiatrists reported that their initial approach as well as the management of a patient is frequently influenced by the current clinical picture, presenting symptomology and reason for referral:

As Dr Harold explains;

_“No! No, no the clinical picture will do that. For example, these girls here, their clinical picture told me they had experienced a very traumatic event recently.”_

Dr Prisha explains this further;

_Eem but normally you see as a psychiatrist you tend to see those that are floridly ill, so what we are dealing is people with major symptoms and so it’s either depression, or psychotic state or phobic state or whatever it is, and from that they start to find a personality will emerge._

She goes on to highlighting the importance of addressing the prominent symptomology such as depression, before attempting to address the underlying personality traits or structure.

..._alright... so if they are reporting current a lot of trauma generally the focus will be on working with and processing the trauma, and then seeing what sits under_
that. Otherwise you can get a distorted picture because of the symptomology that they will be presenting with.

So, in order to prevent a skewed view or understanding or an individual’s personality presentation, it is important to allow the clinical picture to focus their immediate interventions. Thereby allowing a more accurate picture of a patient’s personality presentation to emerge.

Theme Five: Socialisation and support:

The influence of socialization and the available support structure of the patient influences their response to trauma experiences. The psychiatrists reported that the type of environment, community and lifestyle of an individual, impacts their response to trauma.

Dr Harold iterated that the interaction between the individual’s social environment and their personality presentation influences their response to trauma experience;

…and what the psychosocial environment does to link with a person’s personality, and therefore allows the personality ... well the illness to be perpetuated...

(Interviewer: yes...) So if I have somebody who is traumatized and they are now falling apart and they have to be put into a life threatening situation like DB or
prison or something, you’d find that they would garnish they would gather as based on their personality and function probably better than they are functioning in their social environment.

Dr Mandy elaborates by discussing the possible influence of an individual’s social and spiritual community on their personality development and response to trauma;

... my sense... well we know that personalities are ... your of family origin and their values and things also influence your personality development. So, I think spiritual things and the way that your family and how safe you feel and how connected you feel make a big difference. So, I often ask about religious and spiritual experiences as well when we talk about trauma. You know did you get any help from your church, or did you pray about this? Did you did you have any special ceremonies to try and help you deal with it? So, I think that’s the other thing that we mustn’t forget to ask about and to refer patients to. Its fine to refer them to a psychologist, its fine to give them a prescription for medication but sometimes what they need is to commit with the spiritual support structures as well.
Dr Prisha calls attention to the importance of an individual’s support structure on their response to trauma;

... ya especially in childhood and adolescence and development of anxiety in certain personalities. Right... and ahm I think exposure to social circumstances will determine how a personality develops. Right, but in addition to the traumatic experience, one has to look at what support structures were there. (Interviewer: ...at the time...?) ... at the time the experience occurred....

Dr Harold reiterates the influence of their social environment and the response from those around them.

So their personality was able to link to psycho social factors in both these cases... the three cases, there are psycho social factors which operate as well. These girls are completely pampered, they are completely pampered if they had lived in a different side of the social environment where the father said listen get your act together you will now stop this nonsense. You come back to work next week and if you can’t come back to work next week I’m moving you out of the house and you are going to move in somewhere else, end of story. That would have helped them to garner their personality... aspects of their personality to overcome the problem.
Theme Six: Bias or sensitization:

The psychiatrists reported that their sensitization to the possible impact and effect of trauma experience and the development of PDs is influenced by current theory as well as previous training experiences. Individuals with particular personality traits or structure are more likely to seek out psychiatric or psychological intervention, therefore mental health professionals become more sensitized to identifying and working with said personality types.

As experienced by Dr Prisha,

... right. Ahm within the public sector I think we may have seen more of the ... again the Cluster Bs are more of the anti-socials come in, because you’d have the involuntary admissions because of aggression, substances etcetera, etcetera. And were the actually committed. But again, it depends on the unit. So [in a psychotherapeutic ward] you see a fair amount of the borderlines, the dependence, the Cluster Cs also start to come in there. Also the Cluster Cs I feel
they are under diagnosed in our setting, the private setting. We are more
sensitized with the Cluster B so we tend to pick them up more. It’s what we more
sensitized in.

Dr Mandy explains this sensitization further,

Academically we know that if we’ve got somebody with a borderline personality
disorder we often ask about childhood trauma. And if somebody reports childhood
trauma especially sexual abuse and that sort of thing we often maybe more alert
to ... I mean even displaying some borderline traits then you might ask more in
the line of questions... you know relationships, self-harm and that sort of thing.
So I think as I said from my academic point of view the two often go together but
maybe we explore it more because we expect it...

The psychiatrists reported that the link between trauma experience, particularly sexual
trauma, and the development of BPD, is extensively discussed in research. This in turn,
leads to bias when treating a patient with past sexual trauma, mental health professionals
often tailor their questioning towards determining the possible presence of BPD traits.

Theme Seven: Awareness and training:
The psychiatrists indicated that training institutions have increased the focus and emphasis in their training, on the effects of trauma, as well as the possible presence of PDs. As a result, the psychiatrists reported that the increased awareness of the effects of trauma, as well as the possible presence of PDs, gained through their training, has led to greater focus on how to work with and understand these patients.

From Dr Prisha’s experience;

*I think there’s quite extensive training on trauma and personality and links because in state practice you tend to have a lot of admissions for suicide attempts and self-harming. And you go back, and you look at self-harming behaviors, triggers for self-harming etcetera, links between trauma and self-harming later on in life... So, I think academically there’s quite a lot of focus, ahm because even if you look at other types of self-harming, ahm eating disorders very often there’s a trauma model that...* 

Registrar placement and experience were reported to have further influenced their approach and way of practice. As Dr Jerome highlights the expected patient presentations seen during registrar training and following that, in government hospitals;
... possibly you see the thing is those coming to government hospitals or public hospitals don’t seem to always... you know most of them are psychotic so the even schizophrenic or bipolar, you know that range of patients so those... some... personality disorders we seldom see.

Further, Dr Mandy explains;

But in all of our time when we did orientations through [a psychotherapy ward] there was a lot of family interviews, there was a lot of one on one time with the patients. The patients all had individual therapists, they often had OT assessments and that sort of thing as well. So definitely a lot of detail on their past history and how that was impacting on their future. So, I think we were specifically trained to consider all aspects of the patient’s presentation not just while its clear bipolar disorder or you know they are just having a panic attacks or something not just to put that lid over them and that just all over...

Consequently, the psychiatrist’s perception of the link between trauma and personality development is greatly influenced by their training institutions and the practical experience they gained during registrar training. The psychiatrists reported that their specific training and experience influenced their level of awareness of trauma and its possible link to PDs.
Discussion

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*), defines trauma as the exposure to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association [APA], 2014). Moreover, the APA (2014) states, that secondary trauma such as witnessing an event or learning of the traumatic event/s occurring to a close friend or relative is also defined as trauma. In this study, the psychiatrist’s definitions of trauma, which include sexual abuse, hijacking and head injury, appear to coincide with the definitions given above. However, the psychiatrists extended this definition of trauma by identifying experiences such rejection or belittling as traumatic experiences. Therefore, adverse childhood experiences, such as, exposure to early toxic stress, including maltreatment, family violence, and parental instability (Alegría, Green, McLaughlin, & Loder, 2015), are also included in the psychiatrists understanding of trauma. Furthermore, in agreement with Terr (1991), the psychiatrists reported that trauma can be divided into two distinct categories: acute or single-incident trauma and chronic or repetitive trauma. Indicating that trauma is not seen as only one traumatic event, but that lifelong exposure to traumatic experiences such as rejection and/or abandonment and abuse can influence PD development.

Consequently, although the psychiatrist’s definition of trauma coincides with the theoretical definition of trauma, they take their definition a step further. They emphasize
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the importance of lifelong exposure to trauma on PD development, as well as the experience of an event as being traumatic influencing PD development, rather than the event itself.

This study indicates that the psychiatrists’ definition of trauma or traumatic event influenced their interaction with and views of trauma effects on their patients and possible personality development. Trauma experienced during childhood can have long-lasting effects on a child and the possible development of psychopathology;

‘The stress suffered by an abused child can disturb the development of the child’s brain architecture, impairing cognitive, behavioural and physical development...

...It can impact on behaviour and relationships, including risky or harmful sexual behaviour, delinquency, crime and poor parenting.”

(Allnock & Hynes, 2012, p. 5)

As the above quote illustrates, abuse often has severe and lasting consequences for a child’s psychological and social development (DeMartino, 2006). The psychiatrists reiterate this; ‘But adult trauma per say I don’t think it influences as much the development of a personality.’ (Dr Prisha), indicating that trauma experienced during
childhood is seen to have a greater impact on an individual’s personality development than trauma experienced during adulthood when their identity is considered more stable. Furthermore, trauma related disorders and PDs very often run a chronic course, as a result, a short follow-up period, such as 6 months or 1 year, will probably not be able to show significant changes (Schiltz & Schiltz, 2016). This indicates the importance of understanding the trajectories of pathology in patients with trauma-related disorders and PDs. Therefore, as echoed by the psychiatrists, trauma experienced at various periods in a person’s life may manifest differently, stressing the importance of determining the time at which trauma was experienced.

Consequently, identifying the time frame in which trauma was experienced is essential as it affects the focus and importance placed on this reported trauma by psychiatrists when making possible diagnoses, particularly PD diagnoses. This is particularly important when determining its association to the development of possible personality pathology, thereby pointing to possible vulnerabilities and vulnerable periods in an individual’s life.

When faced with traumatic events some individuals show significant vulnerability to psychological distress and develop chronic clinical psychological problems (Edwards, Sakasa, & Van Wyk, 2005). Developmentally, individuals become more resourceful and less vulnerable with age. On the other hand, infants and small children may be protected
from the full implications of traumas because they have limited understanding of what is happening (Edwards, Sakasa, & Van Wyk, 2005; Masten & Coatsworth 1998) due to the lack of cognitive development. This not only points to the level of vulnerability associated with age, it further emphasizes the importance of determining the age and the time at which trauma was experienced, as indicated in the discussion above. The psychiatrist’s views and experiences of working with patients have also indicated this. The personality types and structures of an individual influences their possible vulnerability to trauma as well as the extent to which the trauma is experienced.

Edwards, Sakasa, & Van Wyk (2005), argue that those with a history of previous trauma, and in particular those exposed to sexual or physical abuse and other forms of trauma as children, are more vulnerable. It was found in a study by Koopman, Gore-Felton, Classen, Kim, and Spiegel (2001), that highly vulnerable women who had been sexually abused in childhood, developed symptoms of PTSD after experiencing relatively minor events like, an argument with a partner, or a critical remark from a family member experienced as traumatic. Although the above research looked at vulnerability to the development of PTSD, Edwards, Sakasa, & Van Wyk, (2005) state, that significant losses or traumas, or failures of early parenting, render individuals more vulnerable to emotional distress in adulthood.

This vulnerability is noted by psychiatrists, that past childhood traumatic experiences such as rejection may lead to underlying, unconscious vulnerabilities that are...
triggered by later trauma experience, thereby impacting a person’s reaction to the later traumatic event or experience. Thus, it could be assumed that significant trauma during childhood can cause underlying vulnerabilities for psychopathology in general.

As previously mentioned, trauma can be divided into two distinct categories: acute or single-incident trauma and chronic or repetitive trauma (Terr, 1991). Although acute or single episodes of trauma can cause significant problems for a child, the symptoms often resolve if the child is in a stable and supportive caregiving environment (Terr, 1991). Therefore, there is less chance of serious long-term complications developing. Chronic trauma which involves either sustained or repetitive traumatic experiences typically occurs in an environment where little healthy caregiving or support is given by an adult (DeMartino, 2006; Terr, 1991). This draws attention to the role an individual’s current social environment and support structure has on their experience of trauma.

The importance of social support in an individual’s reaction and the potential effect of trauma was stressed by the psychiatrists. The extent and type of emotional support that is received by the individual affects their response to trauma experience. Emotional and social support can be given from the individual’s family, their peer group or other individuals outside the family (Edwards, Sakasa, & Van Wyk, 2005). Moreover, access to assistance from institutions and organisations such as schools, religious institutions or mental health professionals, such as psychologists or counsellors
influences the individual’s response (Edwards, Sakasa, & Van Wyk, 2005). The presence or lack of the above-mentioned sources of support can contribute towards resilience in the face of hardship (Masten & Coatsworth, 1998) and can specifically protect against the development of clinical problems resulting from the trauma (Litz, Gray, Bryant & Adler, 2002). Thus, gaining the knowledge of an individual current and past social environment and support structure assists the psychiatrists in this study in determining the possible response an individual may have or has had to previous trauma.

McFarlane and Van Der Kolk (2007) stated, that the role trauma exposure has on the development of psychopathology has been marginalised, resulting in the absence of thorough assessment into past trauma exposure. This does not however translate into the practice of the psychiatrists interviewed in this study. The psychiatrists indicated that it is essential to ensure that they gain an in-depth intake and understanding of their patients. This involves gaining holistic knowledge of their patient’s lived experiences, social circumstances and possible trauma experience. Furthermore, as one participant described; “Part of understanding anybody and any condition, it’s almost like a painting where the way in which the paint is used, that intensity of it, the texture of it, is the personality.”

Subsequently, understanding a patient’s personality presentation is intricate and multifaceted. It is extremely important to gain an in-depth understanding and picture of a patient before attempting to understand the personality traits displayed or the PDs present.
Therefore, each person is assessed based on their own experiences and interpretations of events in their lives. The importance of gaining a personalised understanding of an individual is indicated in Beyond the DSM: The Perspectives of Psychiatry Approach to Patients by Peters, Taylor, Lyketsos and Chisolm (2012), in which they state that taking the Perspectives approach allows a MHCP to perform a comprehensive evaluation which ensures a more personalized and nuanced treatment plan.

This speaks to a possible explanation for the contradiction between the reported emphasis placed on gaining an in-depth understanding of their patients during intake sessions by the psychiatrists in the study and reports in literature of the apparent absence of thorough assessment by MHCP into past trauma exposure. Indicating that literature and theoretical understanding of psychiatric practice does not necessarily take into account the personal and individualised approaches taken by some psychiatrists, as seen in this research study.

In recent studies it is suggested that BPD is not a trauma-spectrum disorder and that it is biologically distinct from posttraumatic stress disorder, however high rates of childhood abuse and neglect do exist for individuals with personality dysfunction (Goodman, New, & Siever, 2004). A study by Hernandez et al., (2012), found that the BPD criteria were associated with higher scores on emotional and sexual abuse. The influence of literature
highlighting the association between BPD and sexual trauma, has been described by the psychiatrists as influencing their experience and the understanding of the trauma and personality link. The psychiatrists admitted that the extensive presence of this link in literature leads to a bias when treating a patient with past sexual trauma. This results in the psychiatrists tailoring their questioning towards determining the possible presence of BPD traits, as this has become synonymous with past sexual trauma. The reported influence and sensitization through literature, as reported by the psychiatrists, raises the question of possible circular influence in this regard; the assumed high correlation found in literature prompting an increase in the identification of this correlation in practice or vice versa.

In the *DSM-5*, it is advised that many of the specific criteria for the PDs describe features (e.g., suspiciousness, dependency, insensitivity) that are also characteristic of episodes of other mental disorders (APA, 2014). Consequently, distinguishing PDs from persistent mental disorders such as persistent depressive disorder that have an early onset and an enduring, relatively stable course, may be particularly difficult (APA, 2014).

The approach the psychiatrists reportedly take when initially engaging with a patient falls in line with the above caution. The psychiatrists reported that their initial approach as well as the management of a patient is frequently influenced by the current clinical picture, presenting symptomology and reason for referral. They highlighted the
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importance of addressing the prominent Axis 1 symptoms such as depression, before attempting to address the underlying personality traits or structure. This is important to prevent a skewed view or understanding of an individual’s personality presentation as there is the possibility of the two experiences and diagnoses being experienced at the same time. Thereby limiting incorrect diagnoses or labelling of patients due to the skewed view of their presentation.

Literature reports that limited attention is paid to the possible presence of trauma-related disorders in patients during the training of medical students and psychiatric residents (McFarlane & Van Der Kolk, 2007; van Zyl, Nel, du Toit & Joubert, 2017). However, reports from the psychiatrists contradict this. The psychiatrists have experienced a change in the amount of focus and emphasis that training institutions put into their courses. They reported that the increased awareness of the effects of trauma, as well as the possible presence of PDs, gained through their training, has led to greater focus on how to work with and understand these patients. It appears that as a result, this increased awareness has led to a reduction of the dissonance between the known trauma experience, the development of psychopathology and the emphasis placed on trauma experience and personality development during intake sessions with patients.
Finally, literature discussed above indicates that despite the known impact trauma has on personality development, this known importance did not translate into practice during intake interviews with psychiatric patients. However, as explained by the psychiatrists, this may be due to the sensitive nature of the topic of trauma. The psychiatrists emphasised the importance of an extended exploration period, ensuring sensitive investigation of possible trauma experience. Consequently, this may result in little investigation into trauma experience during initial intake sessions.

Limitations
Within the study and interview process there are certain factors and research limitations, that may limit the reliability and trustworthiness of the research findings.

The person of the interviewer, as a trainee psychologist, may have influenced the way in which psychiatrists answered the questions and interacted with the researcher. Finally, the methodological approach used the limited number of psychiatrists interviewed, thereby reducing the generalisability of the data retrieved.

Areas for further study
It would be interesting to explore the perceptions and experiences of other mental health care professional in this regard. In particular; medical officers and primary health care nurses who are often the first contact with patients at district level as well as psychologists
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who are often viewed as the professionals who have the most contact with individuals with PDs and trauma experience.

Conclusion

This study indicates that the psychiatrists perceive the link between trauma experience and the development of personality pathology as an important aspect to consider when understanding their patients. They emphasised the importance of gaining a holistic understanding of an individual before making diagnoses, particularly PD diagnoses, however, they also reported that the initial psychiatric focus is directed by the presenting symptomology rather than specifically trauma experience or personality presentation.

Significantly, although the psychiatrist’s definition of trauma coincides with the theoretical definition of trauma, they take their definition a step further; indicating that trauma is not seen as only one traumatic event but that lifelong exposure to traumatic experiences such as rejection and/or abandonment and abuse, which can influence PD development. The psychiatrists also report an increased awareness of the effects of trauma, as well as the possible presence of PDs in the course focus of training institutions and registrar placements. This reported focus contradicts reports in literature which indicate that limited attention is paid to the possible presence of trauma-related disorders in patients during the training of medical students and psychiatric residents.
A phenomenological understanding of psychiatrist’s own experiences provides a much richer understanding of the psychiatrist’s perceptions and experiences than could be gained through literature. The psychiatrist’s experiences are enriched by their individual personalities and previous experience and training. This enriched experience and knowledge brings an enhanced and greater understanding of the known link between trauma experience and the development of PDs. Subsequently influencing the psychiatrist’s practical approach to individuals who have experienced trauma and display PD traits.

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APPENDIX A: Demographic Questions

1. How many years have you been working as a psychiatrist?

2. How many of those were you working in government hospitals?
   a. If in private practice: how long have you been working in your private practice?

3. Where do you currently work?

4. How long have you been working at your current place of work?

5. Do you have any particular area of interest?

Any points or areas of particular interest will be followed and discussed with the participant.
APPENDIX B: Prompt sheet

The focus themes of the interviews will include:

1. What is your experience of working with individuals with a PD diagnosis or traits who have experienced trauma?
2. Do you take into account trauma experience when working with patients with PD diagnoses or traits?
3. What is your perception or view regarding the link between the experience of trauma and the development of personality disorders?
4. What is your perception of the importance of taking this link into account when treating patients?
5. When considering the possible experience of trauma in individuals with PD diagnoses or traits, is this consideration made with a select few PDs (e.g. Borderline) or with PDs in general?
6. Do you consider the specifics of the trauma experience when assessing and seeing patients: time of trauma (childhood, 7 years ago, etc) and number of traumatic experiences when treating a patient?
7. What is your perception regarding the lack of information regarding the time of trauma experience as well as the number of trauma experiences within patient files?
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APPENDIX C: Information Sheet

FACULTY OF HUMANITIES, DEPARTMENT OF PSYCHOLOGY

Study title: An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences.

Dear prospective participant

Invitation to participate in a research project

My name is Liesl Morris and I am conducting research to obtain a Masters in Clinical Psychology at the University of Johannesburg. I would like to invite you to participate in my study.

This research project aims to gain an in-depth understanding and description of psychiatrist’s perceptions and experiences of trauma experience and the development of
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PDs in patients, i.e. how psychiatrists interact or engage with patients who have experienced trauma and have a possible PD diagnosis.

I would appreciate an opportunity to conduct an interview with you in order to obtain first-hand understanding of a psychiatrist’s experience and perception of the link between personality pathology and trauma experience. Participating in this study will involve a face-to-face interview with me, the researcher. With your permission, the interview will be recorded with a recording device in order to ensure accuracy in the information captured. The interview will be scheduled at a venue convenient for you which provides privacy and convenience and at a time that is suitable for you.

Participation in this research is completely voluntary and there will be no advantage or disadvantage in any way for choosing to partake or not in the study. It is not foreseen that participation in this study will be harmful in any way.

All of your responses will be kept confidential and identifying information will not be included in the dissertation. The interview material (recordings of the interview) may be transcribed by an external professional transcriber, however the transcriber will sign a confidentiality agreement, agreeing to keep anything they hear confidential. The materials
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will be stored in a secure, password-protected location that only myself and my supervisor may access.

If you have any further concerns regarding the study or if additional information is required, please contact me via email at: lieslmorris@gmail.com.

Kind Regards,

Liesl Morris

Supervisor Details:

Intern Clinical Psychologist
MA Clinical Psychology
University of Johannesburg
lieslmorris@gmail.com

Dr Melissa Card
Clinical Psychologist
University of Johannesburg
mcard@uj.ac.za

Please complete the consent form on the next page.
I consent to participating in this study which aims to obtain first-hand understanding of a psychiatrist’s perception of the link between personality pathology and trauma experience. I understand that my interview will be recorded with a recording device in order to ensure accuracy in the information captured and transcribed, with the possible use of a professional transcriber. I understand that I can pull out of the research study at any point and that my name will be replaced by a pseudonym.

I have read the above participant information sheet and I am fully aware of what the study requires from my participation. I agree with all the conditions outlined in the participation information sheet and I have independently decided to volunteer to take part in this research study.

________________________ Signature of participant

________________________ Date
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APPENDIX E: Confidentiality Agreement for use with Transcription Services

FACULTY OF HUMANITIES, DEPARTMENT OF PSYCHOLOGY

Research Study Title: An exploration of mental health care workers perceptions of the link between personality disorder diagnoses and trauma experiences.

1. I, ______________________________ transcriptionist, agree to maintain full confidentiality of all research data received from the research team related to this research study.

2. I will hold in strictest confidence the identity of any individual that may be revealed during the transcription of interviews or in any associated documents.

3. I will not make copies of any audio-recordings, video-recordings, or other research data, unless specifically requested to do so by the researcher.

4. I will not provide the research data to any third parties without the client's consent.
5. I will store all study-related data in a safe, secure location as long as they are in my possession.

Transcriber’s name (printed): _______________________________________

Transcriber's signature: _______________________________________

Date: _______________________________________

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