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Rescuing personal meaning and humanity in a medicalised
society: A counselling psychology approach to understanding and
working with traumatic experiences

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Portfolio submitted in fulfilment of DPsych Counselling Psychology,
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September, 2010

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Table of Abbreviations

APA	American Psychiatric Association
BPD	Borderline Personality Disorder
CAT	Cognitive Analytical Therapy
CBT	Cognitive Behavioural Therapy
CDA	Critical Discourse Analysis
DBT	Dialectical Behavioural Therapy
DOH	Department of Health
DP	Discursive Psychology
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders. 4 th Edition Text Revision
FDA	Foucauldian Discourse Analysis
MBT	Mentalisation-Based Treatment
NCCMH	National Collaborating Centre for Mental Health
NHS	National Health Service
NICE	National Institute of Clinical Excellence in Health
NSF	National Service Framework
PD	Personality Disorder
PTSD	Post Traumatic Stress Disorder
SFT	Schema Focused Therapy
TFT	Transference Focused Therapy

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Last, but by no means least to my long suffering family and friends. To my dad for his wise words and being my testing ground for all things 'critical theory', and for vital computer maintenance. To my mum and Tèrese for their English language guidance over the years and for being my test readers. To Marianne for indulging me when I needed distracting. Without their unfailing support I would not have been able to juggle everything to completion. To my very closest friends for understanding, listening and offering distractions when required. Finally, to Mr H for living it with me, inspiring me, having faith in me and never failing to be interested, but mostly just for being you.

Declaration

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A: Preface

A.1 Preface to Portfolio of Work

The overall theme of this doctoral portfolio is the importance of meaning and humanity. How as human beings our pursuit and desirability of achievements, conformity and knowledge can often cause us to lose sight of the bigger picture. This is no less true in relation to traumatic experiences as it is to experiences generally. As therapists we are invited into people's lives in a variety of ways and asked to assist them in making sense of things that happen, by virtue of our positioning as 'experts'. However, against a backdrop of medicalisation, naturalism, enterprise capitalism and bureaucracy, we can become quickly caught up in attending to problems and solutions, small parts of a whole, essentially disregarding experiencing and the importance of meaningful relationships. Fontana and Rosenheck (2005) identify the need to understand the *role of loss of meaning in the pursuit of treatment* by those experiencing trauma. We all, help-seeker and helper alike, can lose sight of this in responding to the symptomatology. Further, van der Kolk (2009) reflects on how despite advances in knowledge about treatment and aetiology, as well as societal advances in terms of technology, we still appear to have missed knowledge and advancement in relation to understanding of the importance of context. He reflects that economic and social concerns appear to be concentrated upon the discovery of biological components of psychological distress rather than upon the prevention and amelioration of the long-term impact of adverse experiences, often occurring in childhood (van der Kolk, Crozier & Hopper, 2001).

The pieces of work within this portfolio seek to underline the importance of retaining compassion and humanity within a system which, as a whole, seeks to deny the very essence of being human: A system that instead attempts to attribute formal logic and simplistic understandings to complex problems, tangential with a medical model of psychological health. In our desire to do this we can lose sight of the dialectical relationships between all things, the importance of the whole, and hence the ability to understand and provide meaning to things which would otherwise be inexplicable. Strawbridge and Wolfe (2010) state that attempting to use a single meta-narrative to understand and explain complexity is not only improbable but also impossible. Therefore, we must look beyond this and integrate effectively; human science must be approached with openness and inquisitiveness, such that dogmatism may be resisted.

All too often those with the most extensive experiences of trauma are viewed pathologically, and are further abused by a system founded on individualism. Individuals who are essentially denied what Haigh (2004) identifies as a fundamental human right to secure attachment

relationships, and further denied the opportunity for this in adulthood within the mental health system, labelled with one of many possible 'disorders', and consequently in need of 'cure' at the expense of compassion and understanding. Further, these are quite often the same individuals for whom traditional cures elude and are hence considered treatment resistant, challenging, difficult, manipulative, malingering or untreatable; rather than viewing the system as challenging, difficult, manipulative and in opposition to the needs of the individual who has experienced trauma.

The work that I have selected and will summarise below, draws together different aspects of considering traumatic experiences in relation to the reasons that people seek out the assistance of mental health services. I bring together professional practice examples of working with traumatic experiences in primary and secondary care settings, with empirical research examining the discourse of individuals diagnosed with borderline personality disorder that have experienced extensive childhood trauma, and critical review of literature examining where we are in understanding the needs of those experiencing complex trauma. As a counselling psychologist I hope that I have evidenced the humanistic values of the profession, beyond technological competence and psychological theory. A discipline that requires of its practitioners the ability to bring critical reflection to bear on all the knowledge that we take for granted and to involve ourselves in debates of our time to which we can bring an alternative perspective (Orlans, 2009). My choice of theme for this portfolio comes from compassion. Compassion for the individuals whom I have been brought into contact with and who have been unable to internalise compassion for themselves, as described by Lee (2005); and compassion for the many professionals whom become caught in the medicalisation of psychological problems, and struggle to disentangle themselves. I hope that in the future as a society we may be able to view individuals not in terms of manipulative behaviours but as individuals expressing needs and desperate for understanding.

A.1.1 Empirical Research

Strawbridge and Wolfe (2003) highlight the emphasis within counselling psychology upon subjective experience, meaning, qualitative experiences, focus upon individual 'truth' as opposed to objective 'truths', the importance of allowing practice to inform research and knowledge generation, and not simply research informing practice. Lane and Corrie (2006) identify that counselling psychology originally combined science and reflection in a way uncommon to other applied psychology traditions. The qualitative research that I undertook sought to combine science and reflection in this way.

When I first became aware of the diagnosis of borderline personality disorder I was already working with individuals who may later go on to be diagnosed as such. They were individuals first and foremost, and it seemed incredulous to me that as professionals we could disregard their experience so flippantly. I believed it to be a matter of increasing understanding and compassion. As a result I decided to explore the diagnostic label by qualitative research. The aims of the research, from a social constructionist and critical realist stance, were to identify how individuals with a diagnosis of BPD constructed: their experience of the problems labelled as 'BPD'; their understanding of the diagnosis; positioned themselves and considered themselves positioned by the diagnosis of BPD. By using Critical Discourse Analysis I identified three dominant discourses and discuss the implications of these with regard to current ideology and improving treatment experiences of individuals diagnosed with BPD. As Courtois (2004) identifies there are significant similarities between the clinical profile of individuals having experienced complex trauma and the symptoms profile of BPD. Further there are opinions within the field that reconceptualising BPD as a complex trauma reaction would reduce stigma, encourage greater empathy and result in more positive attitudes by clinicians to those individuals.

A.1.2 Professional Practice

The two cases that I have chosen to present in this portfolio had both experienced childhood trauma. The experiences were different and they manifested in adulthood in different ways. While the individuals were seen in very different settings and required different therapeutic approaches, the importance of the therapeutic relationship was significant. Further I chose these cases because I saw them at the beginning and end of my doctoral training respectively, and they consequently provided different challenges. I believe they reflect my ability to demonstrate my competence as a practitioner working with trauma in different settings and with different therapeutic approaches, requiring skills as a scientist and capacity for reflection on the process and my self as part of that process.

Strawbridge and Wolfe (2010) further identify that within the counselling psychology profession importance is placed on the therapeutic relationship, an awareness beyond manuals of psychological theory, ethics and socio-political understanding, as well as ongoing inquiry and reflection as paramount to the philosophical values of the discipline and integrity of the practitioners. Beyond this O'Brien (2010) identifies that integration within therapy requires reflection, theoretical knowledge and understanding, and continual awareness of the reasons for using particular strategies within the framework of therapy. This involves ensuring work is both informed by, and informing of, research. This relies upon an ability 'to be' with a

client regardless of therapeutic tradition. Within work with complex trauma the uniqueness of the presentations and the current state of knowledge within the field rely upon one's ability as a practitioner to integrate effectively.

A.1.3 Critical Review of Literature

Since commencing work as a trainee counselling psychologist with a particular interest in traumatic experience, I was aware of a lack of consensus with regard to best practice. That is, when trauma was actually identified and acknowledged as an underlying problem, which certainly in my experience within secondary care services was often resisted, there was a tendency to avoid exploring meaning and humanity and simply 'treat' the problem. As a direct consequence I wanted to examine how far the field had progressed with regard to establishing best practice recommendations for working with adult survivors of childhood abuse experiencing complex traumatic reactions. Within this literature review I also identify the gaps and methodological difficulties, as well as identifying the significance of counselling psychology's contribution to the field.

Ford and Courtois (2009) identify a whole person approach as important to the treatment of complex trauma. This is accomplished within counselling psychology through a therapeutic outlook founded on well-being and not pathology. Collaboration is seen as essential to the process, clients are not viewed as being required to 'comply' and 'submit' to treatment as expected within a medical model view. Strawbridge and Wolfe (2010) define this as the difference between '*doing something* to clients' (p.10) and '*being with* them' (p.11) (italics in original). As such counselling psychology offers not a different method but a different philosophy and attitude to therapeutic work. Hence, the reason for considering complex trauma in adult survivors of childhood abuse through the lens of counselling psychology. Herman (2009) identifies that while it is too early to identify which treatment approaches might be most helpful for which individuals and when, there are some emerging constants which can be identified and I consider these within this review.

A.1.4 Reflections

In 1995 I made a life-changing decision, one which led directly to me writing this preface today. Having spent many years training *to be* a musical theatre performer I decided to hang up my dancing shoes and train *to be* a psychologist. Now suddenly I find myself nearing the point at which one might measure the attainment of that goal, and reflecting on what it means *to be* a psychologist? Upon embarking on this professional training journey I had an

approximate idea of what that meant, however, the way I see myself now as a professional is captured in this quote by Goldstein (2010):

[Counselling psychologist is]an ethical position, which demands something of its practitioners well beyond competence. We must *profess* – in the original religious sense – these values in all that we do and we must put these values before the public, before they realise they have been mistreated by (health) technologies and then ask us why we did not do more to help (p. 680)

The DOH (2007) implicitly promotes CBT as the treatment of choice for psychological problems, despite acknowledgement that a range of approaches are important (DOH, 2004). However, an alternative to the medical model foundations of CBT is the human science model, as suggested by Strawbridge and Wolfe (2010), emphasising humanistic values and positioning the individual as having choice and personal responsibility outside of internal and external causes, enabling self-awareness and reflection. Furthermore there is a view of the individual as a whole and ever developing self. My foundations are in psychodynamic theory, although I believe in applying the appropriate technological expertise for both the individual and the context in which they exist, for some this means CBT. However, ultimately the ability to determine this relies upon an ability *to be with* the client and apply evidence-based theory beyond evidence-based technology, where the goal is attendance to individual needs rather than economical ones.

During the course of my doctorate I have had some amazing opportunities which have reminded me of the reasons I went into psychology in the very beginning, I mention but a few here. In November 2009 I attended the International Society for Traumatic Stress Studies (ISTSS) Conference in Atlanta, Georgia. I sat in a ballroom amongst 1000 other professionals for the keynote address and was struck by the warmth and connection between that vast group of diverse individuals from all across the globe, one might suggest a highly positive and alternative perspective on the definition of globalisation. I experienced an overwhelming sense of belonging despite being a lone traveller. Since then I have been afforded the opportunity to implement Lisa Najavits (2002) *Seeking Safety* programme as part of an innovative and forward-thinking redevelopment of our local drug treatment system. This is an incredibly exciting venture which I hope will enable me bring a new perspective to the treatment and understanding of traumatic experiences locally. Also this year I set up a new service within a local remand prison to provide a pilot structured day care programme, while this is small scale it has afforded me the opportunity to return to my roots and employ a service model

incorporating the therapeutic community principles for effective team working, as identified by Haigh (1999), and the possibilities of implementing a variation on a therapeutic community model within a prison, as discussed by Cullen (1997).

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B: Empirical Research

The enigma of borderline personality disorder: a critical discourse analysis of interviews with individuals diagnosed with the 'disorder'

B.1 Chapter 1: Abstract

The purpose of this empirical research was to conduct a qualitative study of the discourse of individuals diagnosed with Borderline Personality Disorder (BPD) as identified in DSM IV-TR (American Psychiatric Association [APA], 2000). This is a diagnosis surrounded by controversy and debate with regard to its validity and reliability as a construct, its identification as a personality disorder, its nosological terminology, and its treatability. From a social constructionist and critical realist stance the aims of the research were to identify how language was used to construct positions, experiences and roles for those with a diagnosis of BPD; how these social constructions of reality may have been influenced by the ideology of the mental health community; and consequently, how the ideology and social constructions impact upon the individuals. I conducted semi-structured interviews with 7 females and 1 male diagnosed with BPD who were not currently involved in psychotherapeutic treatment. Their interview transcripts were then examined using Fairclough's (2009) model of Critical Discourse Analysis. This led to the identification of three dominant discourses: Blame, Stigma and Recovery which were dialectically related and together further constructed the disorder as an enigma. The ideology of the mental health community and Western culture and society more generally were found to be apparent within the discourses, demonstrated by dialectical dilemmas, or ideological struggles as defined by Fairclough (2001a). The ways in which this ideology acts to maintain the positioning of individuals as 'abnormal' and impacts upon their prognosis are discussed. I further discuss the use of social constructionist approaches to therapy and alternative conceptualisations as a way of navigating a path of change for individuals with a BPD diagnosis. The limitations of qualitative research are raised including consideration of how this research addresses the issues of quality, transferability and usefulness of findings.

B.2 Chapter 2: Introduction

B.2.1 Introduction to Chapter

Within this chapter I begin by identifying my reasons for conducting this research and my epistemological and ontological positions in relation to this. The literature review that follows provides an overview of Borderline Personality Disorder (BPD¹) from a range of perspectives. This includes the current theoretical representations and the associated treatment models identified as 'effective' for BPD. I also identify its historical and cultural origins and construction within the psychiatry diagnostic system. Within this I present the dilemmas of the diagnosis of BPD and identify how this drives my choice of Critical Discourse Analysis as methodology for the research. I then conclude the section by discussing the transferability, impact and importance for counselling psychology of studying BPD discourses.

B.2.2 Research Rationale

After my first degree, I was fortunate to begin my career in Psychology in a Therapeutic Community² for Older Adolescents. Within the therapeutic community, individuals had the opportunity to establish a secure base, learn to effectively manage their emotions, address underlying issues, learn life skills and return to their previous lives with a sense of self that had been constructed in an environment of care and safety. This experience provides the foundation for my research.

As my career progressed, I entered a world of categorisation and classification of people and problems through the criminal justice and mental health systems. I began to hear individuals described in pejorative ways and lotteries taking place with regard to who was going to 'take' the next 'PD'³. I learned that BPD was the diagnostic label that would have been used to describe many individuals from the Therapeutic Community. This label also described the individuals with whom I had established good therapeutic relationships within the criminal justice and mental health systems. These, it appeared, were the individuals with whom few staff wished to work, preferring to use pejorative labels to distance themselves and to suggest

^{1,3} Throughout all the chapters in this research I use abbreviations for Borderline Personality Disorder (BPD) and Personality Disorder (PD); this is to ease the flow of the chapters. However, these abbreviations themselves represent social constructions; where possible I tried to avoid the objectification of the constructs in my language. I identify this point to highlight my awareness of the difficulty of using abbreviations; this is not intended to imply the existence of the constructs.

² Refer to B.2.5 for an overview of the treatment approach of Therapeutic Communities.

that they were 'untreatable' rather than attempting to gain an understanding of their unique ways of responding and interacting. This was something that left me feeling discontented and uneasy; however, only through conducting this research have I really come to understand why.

It seemed to me that the distinct difference in treatment approach between the Therapeutic Community, mental health and criminal justice systems was the way individuals were constructed and positioned. Diagnostic labels were not commonly used in the therapeutic community, whereas in other parts of the mental health and criminal justice systems, individuals were predominantly referred to in this way. In fact without a label the door to mental health and support services was closed; worse still with the label of PD the doors were firmly closed. The problems were located within the individuals; all responsibility was removed from society. I wondered if this was why 'treatment did not work'; if the identity that had been constructed for these individuals resulted in them responding as they were expected to, in 'socially unacceptable' ways. The very labels that were alleged to assist were perhaps preventing alternative ways of being in the world

Beginning my career in a therapeutic community, my social and cultural context, grounded my view that labelling was unnecessary and counterproductive; adding to an individual's confusion about their being in the world. This led the way for identifying my social constructionist epistemology - general views and beliefs about 'knowledge' - and critical realist ontology - 'being' or what it exists.

B.2.3 Epistemological and Ontological Positioning of the Research

At its simplest Burr (2003) identifies that the concepts of knowledge, reality and truth are created by humans through language with language arising out of sociocultural, historical and political contexts. Essentially the words that we use to represent or construct our knowledge, reality and truth are determined by our experiences; using language as a familiar way to communicate with other members of our social groups, further identifying a social and cultural context with common beliefs, values and ideals. This way of viewing knowledge, reality and truth is identified within **social constructionism**. Thus, Burr identifies this as concerned with the ways in which psychology and other disciplines construct 'knowledge' through language according to historical, social and cultural contexts. Further, this construction of knowledge leads to the mistaken assumption that what we describe through our language actually exists i.e. is a 'fact' rather than just one way of representing or understanding something. This way of representing is affected by the purpose of the representation and the underlying ideologies of

the construction; where ideology is a system of shared beliefs, values and assumptions with common goals.

Critical realism refers to how we understand what exists in the world beyond the constructions of our knowledge of it. Norrie (2010) explains that a natural and social world exists in which, irrespective of how we understand it, things occur as a result of their natural entity and the effect upon them by other things; the existence or non-existence of things will continue being whether we create or use language to describe them or not. This represents 'reality' but how we understand this 'reality' is dependant upon our perceptions and sensations which are determined by our historical, cultural, political and social context (Hruby, 2001). The 'critical' aspect of realism is challenging the concept of 'truth' about 'reality'. From this position we can never know the 'true' natural entity of the thing or the effects upon it; we can only come to understand it in a way which enables us to make sense of it given our construction of knowledge at the time. However, as Willig (1999) points out the constructions that are available to us depend upon the natural entity of the thing, thus there are limits brought about by the thing we are trying to describe. Consequently, critical realism requires us to challenge the idea of one 'truth', or a higher order of 'truths', and the pursuit of this, positing that all 'truths' can only ever be theories about what does and does not exist. Therefore, when this 'truth' about 'reality', created by 'knowledge', is shaped by ideologies promoting the position of the most powerful groups or individuals, we need to challenge this positioning and identify how this version of 'truth' and 'reality' impacts upon the experiencing of the less powerful.

During conversation we can be positioned by dominant others, as well as position ourselves according to our construction of authority, dependence and powerfulness within the context of the situation (Locke, 2004). The Mental Health System is a discourse community⁴ in which there is potential for this to occur, due to the ideologies upon which the system is built. The social constructionist perspective can begin to identify the ways individuals, who find themselves categorised and classified by psychiatric diagnoses and the mental health community, are positioned by those diagnoses, the professionals and themselves; how this impacts on treatment and affects their being in the world.

B.2.3.1 Research Aim

In summary the intent of this social constructionist approach is to provide information or 'knowledge' which could lead to the alteration of systems which create or maintain social inequity (Fairclough, 2001a). My aim within this research is to identify and understand how

⁴ See B.3.3 For an explanation of 'discourse community'

language is used to construct positions, experiences and roles for those with a diagnosis of BPD; how these social constructions of reality impact upon the individuals; what this presents with regard to the mental health community; and to identify the origins of the constructions through social analysis. The way an individual constructs their being in relation to self and others affects the way they behave and dictates their interactions with others (Bajaj & Crawford, 2010). Discourse analysis, defined in B.3.4, aims to identify how language/text comes to be constructed and the enabling/disabling factors involved (Cheek, 2004). Text is placed within and understood through the socio-political, cultural and historical context. As such this is particularly relevant in the field of BPD due to the ongoing controversy around the diagnosis, including the 'symptoms' that result in the diagnosis being made. In B.3.6 I identify the specific questions used to guide my analysis.

B.2.4 The dilemma of the diagnosis of BPD

There exists a great deal of debate about the utility and appropriateness of diagnosis generally, and PD diagnosis in particular, with BPD having undergone more research than most of the other PDs' (National Collaborating Centre for Mental Health [NCCMH], 2009). Hodges (2003) highlights the extent of interest in BPD as being apparent from the abundance of articles, books, and presentations on the subject; she also notes that this, more often than not, has a negative perspective. The controversy occurs within a variety of domains: the validity of BPD as a diagnosis; choice of nosological term; the position within the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a PD; the treatability; and the aetiology. Based on the current construction of BPD, taken from DSM IV-TR (APA, 2000), the latest prevalence data for England suggests that BPD 'affects' 0.5% of the general population, comparatively psychotic disorders in the same survey were identified as affecting 0.4% (McManus et al., 2009).

Prevalence rates do vary however, with mental health samples being markedly higher. As such, Kernberg (2009) suggests that BPD presents a significant public health concern characterised by lack of recognition, treatment, funding and extensive stigma emanating from within the mental health community.

As implied by Table B.2-1, BPD is considered to impact upon all aspects of an individual's life although there are some exceptions where individuals are considered to function at a high level. It is often co-morbid with affective disorders and often confused with bipolar disorder (NCCMH, 2009). NCCMH (2009) investigating the treatment and management of BPD commissioned by the National Institute for Health and Clinical Excellence (NICE), identified a variable course of BPD; while most will demonstrate 'symptoms' by late adolescence, it is possible that they will not be seen in services until much later. Zanarini, Frankenburg, Hennen

and Silk, (2003) suggest that 68.6% of the people in their sample had improved over a period of six years, to the extent that they met the criteria for remission.

Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment.

Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

Table B.2-1 Current diagnostic criteria for BPD from DSM-IV-TR (APA, 2000, p.710).

Based on the criteria identified in the previous version of DSM III, Stone (1990) identified 93 ways in which an individual could meet the criteria for the diagnosis. More recently, Hoffman (2007) identified over 200 possible presentations of the disorder; the addition of criterion 9 in DSM-IV is thought to have caused this increase. Thus the diagnosis of BPD is applied to a markedly heterogeneous group of individuals, which impacts upon outcomes both academically and clinically. Generally, medical diagnosis can only be applied reliably to homogenous groups because of its essentialist approach. The BPD diagnosis tends to be given without use of standardised instruments or structured interviews (British Psychological Society [BPS], 2006). Partly because no single psychometric test or assessment schedule has been

found to be more efficacious for making the diagnosis (NCCMH, 2009), this is perhaps not surprising given its heterogeneity. In their investigations, NCCMH (2009) identified that most clinicians will make a diagnosis based upon a description by a client of their interactions with others and through behavioural observation.

B.2.4.1 Validity

Despite a wealth of research there remains little consistency pertaining to the validity or reliability of BPD as a construct (Becker, 2000). While research demonstrates overlap in BPD with Axis I affective disorders, this is determined to be evidence of the complex nature of BPD rather than a differential diagnosis. For example, one study of nearly 500 patients identified 56% of those meeting diagnostic criteria for BPD also met PTSD criteria (Zanarini et al., 1998). However, this was viewed as co-morbidity rather than lack of construct validity in either diagnosis. In fact, Becker (2000) describes BPD as: "Shorthand for a difficult, angry female client certain to give the therapist countertransference headaches" (p.423). In support of this suggestion Adler, Drake and Teague (1990) found that men with identical problems as women with a BPD diagnosis were most likely to be labelled with Anti-social Personality Disorder rather than BPD.

Further, Becker (1997) states that poor treatment response by, and negative therapist responses to, the individual are used as evidence for the existence of BPD. In his role as teacher of medical residents Paris (2008) suggests that it is too easy to make a BPD diagnosis based on one or two details without reference to the explicit guidelines and criteria identified within DSM. Instead he argues that the problems with BPD lay in the lack of specificity of the diagnosis, it lacks validity according to the criteria laid out by Robins and Samuel (1970, as cited in Paris, 2008). Thus long-term Paris suggests that what we have come to know as BPD, may in effect turn out to be a cluster of symptoms without common origins, development or effects. In an attempt to apply the diagnosis to a more homogeneous group, Paris applies stringent criteria with regard to the domains of the disorder.

Tyrer (2010) highlights that

...[PD] is a highly unpopular dichotomous diagnosis. According to current diagnostic practice people either have this nasty condition that no-one in their right mind could derive any satisfaction in having or you are squeaky clean with no personality disturbance at all...(p.33).

He furthers Paris' argument with regard to specificity, identifying that historically too much emphasis has been placed upon the creation of diagnostic categories that lack specificity and are created through a combination of dominant belief systems and expert opinion, rather than evidence. His suggestion is that where there is a lack of valid and reliable empirical evidence for a 'syndrome' it should be identified through the use of a dimensional rather than categorical system; this is something which is being considered for the next version of DSM.

Approaching the diagnosis with regards to its sociocultural context, Millon (1996) argues that while PD can be assessed, it cannot be diagnosed. His argument rests on several assumptions underlying a systems model of personality. He positions that the terms 'normal' and 'abnormal' are value-laden, and unscientific, and that the use of 'disorder' similarly fits with this value-laden and unscientific model when identified in conjunction with personality. While nomothetic approaches enable us to gain an understanding of some of the constructs of personality they do not identify how different people can be and how every personality will be created by a different 'formula'. That is, a unique sequence of historical, cultural, familial and social factors along with biological and genetic factors which create an individual blueprint never again repeated. Therefore, we are unable to truly determine what is 'normal' personality and, consequently, 'abnormal' personality. Rather, personality must exist on a continuum, irreducible to distinct categories. Essentially, the diagnosis of PD ignores the idiographic perspective of personality, emphasising only the nomothetic perspective (Millon, 1996). Uniqueness is lost at the cost of reductionism, as within-group similarities are overemphasised without consideration of variables extraneous to the diagnosis.

B.2.4.2 Pejorative Labelling

Lewis and Appleby (1988) found attitudes towards individuals with PD diagnoses to be judgemental, rejecting and pejorative. A survey of 14 service users' views determined that the label PD can leave individuals feeling stigmatised by society and professionals (Department of Health [DOH], 2003). Stigma related to BPD appears to be connected to connotations of attention-seeking (Nehls, 1998). Many service users identify having been called "time-wasters, difficult, manipulative, bed-wasters or attention-seeking" (DOH, 2003, p.20). Blackburn (1988) suggests PD diagnoses are simply a way of disguising moral judgements by mental health professionals, demonstrating a lack of empathic understanding for this group of individuals (Nehls, 1998). In addition, Lewis and Appleby (1988) found upon surveying psychiatrists, that 240 of those surveyed believed those with a PD diagnosis were less deserving of mental health services than individuals with non-personality disorder diagnoses.

Dr Rex Haigh (2006), in his forward to a collection of writings about living with BPD, identifies his position in relation to the stigma of the diagnosis:

Personality disorder is a ghastly term for a very common disposition: the very juxtaposition of words reveals its authoritarian subtext. It suggests that 'these people' are not like us; their characters are flawed and there is probably very little that can be done about 'it'. This is clearly nonsense: 1 in 20 people cannot be written off as faulty human beings, suffer great distress and anguish, and yet be undeserving of suitable mental health services... (p.9).

Stobbe (2006) agrees that the stigma surrounding BPD is driven by mental health professional attitudes, unlike the societal stigma surrounding other mental health problems. Allen (2004) highlights the extent of the problem, how mental health professionals use the label of BPD without formally recording it, or providing the information to the client, identifying a lack of transparency surrounding BPD as a diagnosis. That mental health professionals tend not to share it with clients preferring to talk about it through the use of different terminology, acts to maintain the stigma. Allen raises the important question as to whether we, as mental health professionals, should be applying diagnostic labels to people that we are not willing to share with them, calling into question the underlying paternalism of the system (Baltrušaitytė, 2010). There are lobbying groups who campaign for a change of name, however, Hodges (2003) is not alone in highlighting that changing the name of BPD would not prevent its use as a pejorative label. Paris (2008) identifies that until we actually know more about the construct itself changing the name would be irrelevant and pointless.

Attempts have been made to suggest that a more correct diagnosis would be complex Post Traumatic Stress Disorder (PTSD) (Herman, 1992); this being suggestive of less negative connotations for the individual being labelled (Becker, 2000). However, trauma is not, on its own, sufficient to cause the problems underlying the current diagnosis of BPD. In fact only 25% of those experiencing trauma are thought to go on to develop BPD (Werner & Smith, 1992). However, for those who have a childhood trauma history, a BPD diagnosis may act as further abuse (Shaw and Proctor, 2005). Hodges (2003) compares BPD and PTSD as diagnostic categories, identifying BPD as holding pejorative associations, unspecific criteria and suggestive of character flaws, while PTSD is identified as an effect of circumstances. However, Becker (2000) suggests that both BPD and PTSD are the most indiscriminately used diagnoses to be applied to individuals without the use of valid instruments.

In addition to stigma, Horn, Johnstone and Brooke (2007) found that the label BPD brought a feeling of others power, both negative and positive, something also identified by Ramon, Castillo and Morant (2001). Further considering the research the DOH (2003) identified service users believing themselves to be untreatable. This issue of 'treatability', for a long time, was part of the unofficial diagnostic criterion for PD (Alwin et al., 2006), individuals not responding to conventional methods of treatment being labelled 'untreatable'. When you examine the diagnostic criteria the language actually infers this, through its use of the terms 'pervasive' and 'persistent'.

According to recent research by Horn et al. (2007), BPD results in "internalised views of the self, where the individual can come to behave and think in disempowered and devalued ways consistent with the label" (p.257). Earlier Miller (1994) had conducted interviews with 10 inpatients with a diagnosis of BPD to identify how they experienced the world in relation to their social context, treatment and the disorder itself. She found the similarity between accounts to be striking with key themes of estrangement, inadequacy and impairment; they described "struggling through life" (p.1216).

B.2.4.3 Social Order and Psychiatric Classification

Pilgrim and Rogers (2005) identify that the effect of the psychiatric classification system is to create a series of checklists for 'disorder' which removes the contextual experience of the individual from understanding. As a consequence Lucy Johnstone (2010) states that we need to determine whether BPD would be better conceptualised as an understandable response to the problems of living and the conflicts experienced as a result of socially imposed gender roles. She suggests that BPD has, in fact, replaced early female diagnoses of hysteria. In summing up current thinking on BPD, Gunderson (2009) highlights that it remains highly stigmatised. He highlights a need to further understand the neurobiology and a need to explore the questions about its conceptualisation as a PD. He believes that its validity has begun to be established; however, he also acknowledges the importance of positioning the individual's historical and cultural contexts in order to enhance meaning, understanding and acceptability.

Tyrer (2009) in a discussion article posited that BPD should be removed as a PD diagnosis and be redefined and reclassified. Mulder (2009) concurs that Tyrer's concerns need to be addressed with similar conclusions being reached by NCCMH (2009). Tyrer identifies that BPD is the only PD that is not trait-based but 'symptom' based and as such cannot be defined in terms of personality. He highlights that as it stands it involves arbitrary differentiation between

normal personality and abnormal personality. Paris, Silk, Gunderson, Links and Zanarini (2009) agree that the diagnosis is hampered by an extensive number of potential 'symptoms' calling into question the validity of the current diagnostic criteria, however it does not mean it should be reclassified as a mood disorder or abolished altogether. They believe it should be retained such that it provides a treatment guide, as is the intention with all psychiatric diagnoses.

One of the main criticisms and controversies regarding the BPD diagnosis generally is the concern that this is a diagnosis of behaviours which are considered socially undesirable, or a diagnosis to justify the reason for non-response to mental health treatment (Bajaj & Crawford, 2010). There is increasing pressure from the political arena for social order which can be rephrased as socially appropriate behaviour, and there is continued pressure for this to be policed by mental health services (Allen, 2004). However, Becker (2000) discusses this in relation to women, to whom the diagnosis is most frequently applied, in particular stating that "Medicalisation contributes to the social control of women through expansion of madness, and leads us in pursuit of cures for the 'disease'" (Becker, 2000, p.430). In her discussion regarding what feminist psychologists can offer to psychiatric diagnosis, Johnstone (2010) identifies the contradictions and conflicts experienced by women in relation to modern gender roles, positioning mental distress as an understandable response. However, she highlights that the pathologising of these social role problems has prevented us from considering alternative conceptualisations. Similarly, Allen (2004) highlights the cultural and social pressures upon women to provide selfless nurturing; when they expect this in return this is seen as 'abnormal'. There is, potentially, an additional stigma for men who are diagnosed with BPD, due to it being seen as a 'female disorder' and the inference of feminine attributions of excessive emotionality, lack of consistency, and reliance upon relationships. Gaines (1992) highlights this as identifying the 'Germanic' Western values underlying PD within DSM that opposes emotional expressiveness and interdependence and promotes independence and emotional repression.

Szasz (1960), in his article *The Myth of Mental Illness*, suggested that our construction of 'mental illness', in general, is incorrect and acts to pathologise the problems of everyday life. He suggested that 'diagnosis' is merely a moral judgement by a psychiatrist on the way that an individual conforms to society's norms and social practices. Szasz identifies that we must consider who the diagnoser is 'working for' and, consequently, how they are positioned and then subsequently construct their assessment. As well as the ways in which their personal ideologies influence their assessments, he suggests that it would not be realistic to think that they are not influenced by their own experience of the world. He maintains that, erroneously,

psychiatry responds to problems which are socially and culturally constructed, with medicine. The diagnosis results from establishing deviance from psychosocial, ethical or legal norms. Thus the psychiatrist as diagnoser is constrained by what they consider to be 'reality' based in their own value system or ideology. Further, Szasz identifies that we fail to acknowledge that human interactions are constructed of complex processes. He comments that diagnosis depersonalises the individual, removing meaning. Importantly Szasz identifies that for most people life is a struggle but as a result of human values, not an internal biological abnormality that can be corrected. In accordance with this Hodges (2003) suggests that reliance upon the biomedical model of classification of psychological difficulties symbolises our need to label that which we do not understand as a way to create understanding.

Concordantly with Szasz, Johnstone (2010) considers the criteria identified by DSM as containing implicit assumptions of 'normality', thus inferring thoughts, feelings and behaviours which are socially 'appropriate'. She also highlights that the criteria make explicit reference to cultural norms but, nonetheless, are stated as medical symptoms. The importance of considering the social and cultural influences of those who determined the criteria are raised within her article. When a man or woman deviates from the socially and culturally expected norms of thoughts, feelings and behaviours they are thus at risk of being classified as 'ill'. Further if a woman rejects her expected social role she is putting herself at risk of being pathologised. Gaines (1992) further damns diagnosis by suggesting that it supports the values and attributes required for the maintenance and progress of a capitalist economy.

Equally, we must be minded that while psychiatry is vested with the power for making such diagnoses the institution itself exists within a social environment and as such is created and maintained by society. Davies and Bhugra (2004) identify that evident within western society and the lay model of psychopathology, is the tendency to refer to behaviour that we are unable to fathom as 'abnormal', with use of language that is derisive enabling separation to be created between self and others. Throughout history policy-makers have not only shaped but been shaped by the demands of society to 'control' behaviour that exists outside the prevailing social and cultural norms. Thereby, this responsibility currently rests with psychiatry.

Psychiatry is a modernist idea, drawing on essentialist, and reductionist ideologies (Bracken & Thomas, 2006) and is currently dominated by a biomedical model of 'disease', or biology. Medicine is concerned with the identification of 'syndromes' which are hypothetically constructed from 'knowledge' and intuition (Bebbington, 2010). The idea, as described by Tyrer (2010), being to reduce a pattern of symptoms to a single diagnostic category

(reductionist) which can be investigated and treated, while simultaneously identifying the cause, the intrinsic qualities of the problem, the symptomatology, the prognosis, and the likely outcome; these are implicitly deemed to be independent of context and universal for individuals with a particular diagnosis (essentialist). By applying a medical model alone the social aspect is excluded. Bebbington (2010) states that psychiatry is a social endeavour; thus where psychiatry falls down is in the exclusion of social aspects of diagnosis through the dogmatism of biological interpretations, despite the obvious social construction of the diagnoses themselves. Bolton (2010) in his discussion of the *Social, biological and personal constructions of mental illness* similarly suggests that the problems lie in the desire to reduce psychiatry to naturalism, to find a matter of fact, to separate the social and psychological aspects of a person's experience and constructions to that which can be identified as evolutionary. However, in describing dysfunction, psychiatry is unable to do so without including social and psychological factors and, as such, both enacts and is influenced by social and moral norms of the current culture. In essence psychiatry becomes dominant in the policing of social order.

In defence of the psychiatric system of diagnosis, Tyrer (2010) identifies the importance of classification of 'syndromes' for the efficient operation of psychiatric services. He states that without such classifications we would lack the ability to communicate about 'patients' with efficiency. Every individual would require lengthy discussions identifying all the presenting difficulties, possible attributors, range of potential 'treatment' options and there would be no shorthand for this. Indirectly he identifies the increased economic costs of such an approach. However, he identifies that the system is hampered by the difficulty in obtaining diagnostic validity due to the lack of external measures of the presence of 'syndromes'. Johnstone (2007) argues that given the heterogeneity of human experience diagnoses can never categorise people accurately or provide meaning to individuals about their experiences and the impacts of them. Further, Masterson (1990) holds that the diagnostic classification system reduces psychological problems to 'symptoms', the superficial aspects of a problem and, therefore, presents only an external view of the individual. This approach fails to take into account the internal experience of the individual and provides a subject position for the individual of being 'abnormal'.

Powers (2002) advocates that diagnosis prevents voices of oppression from being heard and that this is justified through scientific, and medical discourses, despite PD being the most vulnerable to social, cultural and political changes due to its lack of similarity to other diagnoses (Kroll, 1988). Further, Horn et al. (2007) reinforce the suggestion that PD is actually a

consequence of professional discourse. Similarly, Cheek (2004) states that: “at any time in history, certain discourses will operate in such a way as to marginalize or even exclude others” (p.1143). Throughout the history of medicine, the underlying feature of discourse has been one of unrivalled concrete truth, essentialism, unquestioning of the societal control underlying, in particular, individuals who do not conform to societal norms (Cheek, 2004). This may in part be maintained, at least, through the lack of requirement of professionals using the biomedical model to be self-critical, to challenge assumptions and judgements, or to reflect upon the efficacy of their practice (Bracken & Thomas, 2010; McLaren, 2011). In fact, McLaren (2011) highlights that such critique is implicitly discouraged amongst traditional psychiatry.

Demonstrating the idea of unrivalled concrete truth and essentialism further, the British Journal of Psychiatry recently published a special article written by 37 members and fellows of the Royal College of Psychiatrists, calling for a renewed focus upon the biomedical model of treatment for mental health problems (Craddock et al., 2008). They highlighted a “creeping devaluation of medicine” (p.6) as “damaging to both the standing and the understanding of psychiatry in the minds of the public, fellow professionals and the medical students who will be responsible for the specialty’s future” (p.6). These statements highlight the disciplinary imperialism, the belief that one discipline is most superior and positions their views as the correct ones, within the field of mental health, which reflects the struggle for power and supremacy. They suggest that the move away from biological medicine to psychosocial methods of treatment is political but has been ‘allowed’ by psychiatrists. The article presents medicine as holding the only ‘truth’ with regard to the ‘treatment’ of severe mental health problems. They suggest that focusing on the provision of psychosocial interventions disadvantages ‘patients’, and contributes to stigma through the denial of effective medical interventions. They also position themselves as ‘the most appropriately skilled and experienced professional on the team’ (p.7).

Woolfe (1996) identifies the Western biomedical model of viewing psychological problems as ‘diseases’ and locating them within an individual enables the application of pharmaceutical ‘treatment’ to ‘symptoms’ (Fletcher, 2010). This is driven by economics, which enable outcomes to be measured and the costs to be quantifiable. NCCMH (2009) identify that the economic costs of PDs in general are high, and that in terms of healthcare costs, BPD places a higher demand upon acute and mental health services which results in higher approximated costs than other diagnoses such as depression. Healthcare services are dominated by the drive to reduce costs and deliver ‘effective’ treatments in the shortest time-frames. This not only disadvantages treatments which have been developed to address the underlying problems of

the individual rather than the 'symptoms' of distress (Fletcher, 2010), it also changes the focus of the services, seeing individuals diagnoses as needing to be 'cured' with the minimum amount of money and in the shortest time frame; an inherent effect of Capitalism. Allen (2004) highlights further the problems of mental health services, identifying the constant change that has been imposed over many years, and the strain that has been placed on resources, resulting in a lack of consistency and fragmentation of the services that are available, as well as demoralised staff groups. I will consider further the reasons for the dominance of the biomedical model following reviewing the historical and cultural origins of BPD within B.2.6.1.

My position with regard to the diagnosis of BPD in this research is that it is legitimised through medically constructed discourse; the diagnosis of 'disorder' creating social cognition which is negative, implying a need for a 'cure'. This then creates stigma which may be apparent in the attitudes of staff and society as a whole (DOH, 2003). For example, Forsyth (2007) identified that staff were less likely to employ helping behaviours to those labelled with BPD. Further research suggests that generally staff are often patronising and demeaning in their manner towards those diagnosed with PD (DOH, 2003).

B.2.5 Aetiology, theory and treatment of BPD

Gunderson (2009) identifies how the recent decade has seen a focus on discovering the aetiology of psychiatric 'disorders' generally, a reawakening of reductionism and essentialism at the heart of psychiatry. He suggests the research findings indicate a degree of heritability to BPD, as well as the possibility of recovery. Gunderson claims that BPD has been established during the decade 2000-2009 as a 'brain disease'. However, in outlining the aetiology of BPD Joel Paris (2008) identifies that there are a number of risk factors for its development; with no single cause of BPD, it is a complex problem and as such requires consideration of social, psychological and biological factors. Equally, there is no combination of factors that can accurately predict the development of the diagnosis although it may be possible to identify an increased risk. Thereby, theoretical models which encompass a nature/nurture interaction appear to demonstrate the most likely course of the diagnosis.

In the UK, theoretical insights into the development of borderline psychopathology have been contributed by Winnicott in the 1950's, Bowlby in the 1970's and 1980's and, latterly, Fonagy commencing in the 1990's (as cited in Gunderson, 2008). They all consider early attachment relationships to be influential in the aetiology of BPD. Livesley (2003) identifies the basic assumptions underlying all theories of personality disorder to be: the result of unfavourable experiences during personality development causing a psychosocial disorder; and that

personality is flexible, influenced by therapeutic intervention. However, he identifies that generally these assumptions are simplistic and fail to take into consideration the influence of biological and genetic factors.

Lis, Greenfield, Henry, Guile and Dougherty (2007) reviewed the neuroimaging and genetics research into BPD. Their findings suggest that when an individual, with a BPD diagnosis, experiences emotionally traumatising events, such as the prospect of abandonment, there is an alteration in brain activity and this alteration is potentially associated with anatomical changes within the brain. They highlight the conflicting evidence that appears and suggest that this may be a result of the relative youth of the technology or the behavioural characteristics of the client groups, potentially preventing a high degree of accuracy in results. They propose that differences may be explained by different experiences of childhood trauma, for example chronic versus acute. More recently, Berdahl (2010) has identified a testable hypothesis for a neural network simulation of the reactions in BPD behaviours.

Linehan (1993) identified a biosocial theory of BPD, bringing together the experimental work of biological psychiatry, psychology and sociology to produce an understanding of the problems experienced. The theory states that an individual is biologically predisposed with an emotional vulnerability which, within an invalidating social environment, causes an inability to self-regulate with regards to emotions, relationships, attention and basic needs. The individual then internalises the invalidating social environment and continues to repeat patterns of invalidation, viewing life simplistically. This results in unachievable goals, and standards, and extremes of emotions and experiences causing problems in major life domains, with the individual experiencing an overwhelming sense of uncontrollability. The theory draws on cognitive-behavioural, biological, social learning and Zen theories in tandem with dialectical theory to provide a principle-driven approach to treatment and understanding of the problem.

Therapy involves a balance between acceptance, validation, compassion and challenge on the part of therapists and clients. As a whole these aspects are modelled by a team of therapists such that a client may internalise them, while also creating a tension which enables them to resolve dialectical dilemmas or contradictions. Swales, Heard and Williams (2000) highlight that the use of the diagnostic term BPD, in dialectical behavioural therapy (DBT), is purely a means of referring to a collection of behaviours. Once these behaviours are no longer present, the diagnostic term is redundant. Thereby, they emphasise that the treatment approach does not have a belief in the diagnosis, as such, but believes it to be assistive if used appropriately. More recently, Crowell, Beauchaine and Linehan (2009) proposed an elaboration of Linehan's

(1993) original model, incorporating further biological factors including the role of genetics, neurotransmitters, the endocrine system, and the autonomic nervous system. They also include new evidence with regard to the role of family psychopathology, attachment relationships, environmental factors, and sociocultural influences. They propose a number of hypotheses that require testing and identify that continued work is necessary to fully understand social and cultural influences.

Dialectical theory is the world-view, philosophical basis, and the approach strategy of DBT. Swales and Heard (2009) outline the three principles of dialectics with regard to the concept of reality and human behaviours: interrelatedness and wholeness; polarity or opposition; and continuous change. Interrelatedness and wholeness, refers to the assumption that we live in a system and that we exist only in relation to that system. Therefore, to attempt to examine a part of that system without reference to the whole system will, in effect, provide an inaccurate view of reality. Polarity, or opposition, refers to the assumption that reality is dynamic and contains a continuous sequence of opposing forces, or contradictions. Upon synthesis of these forces or contradictions there is a new contradiction of force apparent within the new synthesis, such that nothing is reducible to a single part. Hence a dialectical view of BPD holds that within any dysfunction there must be function, understanding this can transform a therapist's view of the client with a BPD diagnosis. This leads directly to the final principle that interrelatedness and polarity result in evolution, or constant change. Linehan (1993) highlights that the dialectical theory of change fits with both psychodynamic and cognitive behavioural perspectives, however, there is an implied tension of bringing about change which is at odds with client-centred therapy which relies on an 'unfolding' of an individual's potential and does not require tension for this to occur.

Moorey, Davidson, Evans and Feigenbaum (2006) define psychodynamic models of Personality Disorder as conceptualising the problems experienced as being a result of disturbances of the individual self with regard to continuity, coherence, agency and affectivity. The development of self occurs early in life as a result of attachments to care-givers. The effectivity of the self being dependant upon key processes such as mentalisation and memory, such that the self can also be experienced in relation to others. Mentalisation refers to the ability to manage the experience of mental states of the self and others including recognising, tolerating and responding to them as required (Moorey et al., 2006). This is further dependant upon the ability for self-reflection to moderate affect, impulses, interpersonal interactions and the agency of self. Fonagy (2000) identifies that 'knowledge' of the way the mind works is learned through secure attachment where an infant has the opportunity to explore the workings of the

attachment figures mind and thus learn about their own. Mentalisation-based treatment (MBT) has been established as an effective intervention for BPD (Gibson, 2006) and involves developing skills in mentalising.

Other models which have been explored with regard to treatment have had variable outcomes. Transference Focused therapy (TFT) is a manualised and structured form of psychodynamic therapy. Schema Focused Therapy (SFT) is based in cognitive theories of personal disorders that suggest biological predisposition is influenced by the environment, and together determine the individual's schema's or scripts for different events that occur within their lives influenced by the social and cultural setting (Moorey et al., 2006). Also explored has been Cognitive Analytical Therapy (CAT) which involves a combination of psychodynamic and cognitive theories (NCCMH, 2009).

Another model of treatment which has been applied as an alternative to traditional psychiatry is the Therapeutic Community; a residential or day programme in which the social environment or community is considered the main therapeutic tool (Haigh, 2002a). Day-to-day running of the community is shared between its members including staff (Dolan, 1997). The therapeutic community operates according to a democratic style of interaction, reality confrontation and accountability for actions, with tolerance of mistakes. In principle not only the therapeutic groups but the interactions outside of them are considered to re-enact the social and cultural world in a safe environment. Medication is not used. The idea is to alter interpersonal interaction by enabling it to be displayed in the community and challenged, consequently adapting psychosocial functioning (Dolan, 1997). This is a longer term facility of 1-2 years, generally using psychodynamic principles (NCCMH, 2009). In this approach the therapists, or staff, are not positioned as 'all-knowing experts' but as senior members of the community acting as collaborators, facilitators or participant observers.

NCCMH (2009) identify that there are relatively few studies on the effectiveness of treatment which are comparable due to methodological problems, including the level of heterogeneity within the diagnosis of BPD meaning that 'symptoms' are difficult to target specifically. From the limited evidence DBT and MBT have demonstrated the most promising outcomes and NCCMH conclude that short interventions of less than three months are not found to be effective. They also highlight that the evidence on cost effectiveness is limited. They identify Therapeutic Communities to be more expensive than general psychiatric care but to provide more benefits, with cost effectiveness being difficult to measure. A review by Zanarini (2009) found that DBT, MBT, SFT and TFT all reduce the severity of the problems experienced by

individuals with BPD. However, she highlights the need to develop less intensive and costly forms of treatment. Interestingly, NCCMH (2009) identify that while there is evidence to suggest that pharmacological treatments may assist in the alleviation of co-morbid problems, such as depression or anxiety, no drug has been found to be beneficial.

Despite the wealth of research relating to the prevalence and treatment of BPD, the lack of availability of effective treatments, due to resourcing issues, appears to have led to further support for the label of 'untreatable' (Nehls, 1998) amongst this group of individuals. Manning (2001) highlights the delays that invariably occur between what is learnt through scientific investigation and what is occurring in clinical practice; and how classifications inevitably develop at either end of the spectrum of experience, impeding progress in the development of effective treatments.

B.2.6 Historical and Cultural Origins of BPD

Borderline as a construction first came into psychiatric language during a time when psychiatry was dominated by the psychoanalytic paradigm and the classification system simply reflected an individual's compatibility with analytical approaches (Gunderson, 2009). Manning (2001) identifies how the term 'moral insanity' was used in the English speaking world until the early 1900's to describe what would perhaps now be classified as PD. The borderline diagnosis is generally traced to the work of Adolph Stern in 1938, a psychoanalyst, who noticed that some of his patients disregarded the usual therapy boundaries and did not fit into either the psychosis or neurosis conceptualisation of 'patients', and thus described these individuals as 'borderline' (Manning, 2001).

Later Kernberg (1967) and Grinker, Werble and Drye (1968) furthered the concept with classifications of 'Borderline Personality Organisation' and 'The Borderline Syndrome' respectively. In 1968, the second version of DSM appeared with an even heavier influence from psychoanalysis than the first version of 1952, with 'hysteria' replacing 'conversion reaction' and 'dissociative reaction'. It was in the 1970's that BPD became objectified and was the label ascribed to those clients whom professionals found most difficult. The inability of psychoanalysis to 'treat' this group of clients was located within the clients themselves (Gunderson, 2009).

Following the work of Gunderson and his colleagues between 1969 and 1979 (as cited in Gunderson, 2008) the criteria of the BPD diagnosis, first appeared in DSM III in 1980. Tyrer (2009) states that the introduction of PD as a separate axis within DSM occurred as a

bargaining tool to enable DSM III to be introduced. As such the inconsistencies with it remain. With DSM III came a reigniting of the positivist paradigm of the 19th century for psychiatry (Pilgrim & Rogers, 2005). What followed was an explosion of interest in BPD, evident in the academic and clinical publications, and much debate about its cause and prognosis. The publications went from being psychoanalytically oriented to focusing on other theories and models of the disorder (Gunderson, 2008). During the 1980's and 1990's psychiatry's focus shifted to become more concerned with the establishment of its place as a medical specialism, turning its attention to neurological and biological origins of psychiatric 'diseases' as opposed to social ones (Pilgrim & Rogers, 2005). Around this time research suggested childhood histories of abuse were important for the development of BPD, and concern was also raised with regard to the number of women diagnosed (Gunderson, 2009). Consequently, Vaillant (1992) suggested with a journal title that *The beginning of wisdom is never calling a patient borderline*. There was also a move towards considering the 'disorder' as incurable, requiring the adjustment of therapeutic goals. As a result Oldham suggests that individuals with the 'symptoms' of BPD became known within clinical contexts as "dreaded pariahs" (2009, p.509). In the 1990's, Gunderson (2009) identified that questions were raised about the persistence of the diagnosis following alleviation of 'symptoms'. This question remains unresolved partly due to the dubious validity of the diagnosis to begin with. It was also during this decade that it became apparent that childhood experience of abuse was not sufficient to identify aetiology. Progress was also made in treatment approaches with Linehan's development of DBT arriving in 1993.

B.2.6.1 The dominance of the biomedical model within psychiatry

A full exploration of the historical development of psychiatry diagnosis and the associated political, social and historical events influencing this is beyond the scope of this review. However, it is important to acknowledge that the development of the BPD construct since the early 20th Century occurred against a backdrop of political and social change, as well as paradigmatic shifts within psychiatry and psychology. These included the impact of war, a call for more scientific rigour within diagnostics, a rise of the pharmaceutical industry, the demands of insurance companies, and psychiatry's desire to establish its disciplinary imperialism within the mental health field. These changes are important for understanding the potential reasons for the dominance of biomedical model identified within B.2.4.3 and B.2.5, and in contextualising the assumptions underlying traditional psychiatric discourse.

While mainstream or traditional psychiatry in the UK today continues to rely upon a biomedical model this does not mean that all psychiatrists are proponents of the model. Within medicine there are different models and theories of psychopathology, as there are in

psychology. That is, because an individual is a psychiatry professional does not automatically identify their theoretical orientation or beliefs about the development of mental health problems or indeed the solutions underlying them, outlined in B.2.5. However, psychiatry has become synonymous with the biomedical model, and is referred to generally in abbreviated form as the *medical model*. The Shorter Oxford English Dictionary (2007) defines medicine as (italics in the original): ‘the science or practice of the diagnosis and treatment of illness and injury and the preservation of health; *spec.* the science or practice of restoring and preserving health by drugs and the regulation of diet, habits, etc., rather than by surgical methods’ (p.1740). This definition does not suggest that biology is the only model within which medicine operates.

Nonetheless, the biomedical model dominates within psychiatry as in medicine more widely, with all psychiatrists erroneously but equally positioned by users of services and others, including other psychiatrists, with this model. Smail (1996) identifies that despite widespread and enduring criticism from both within and outside the profession, little has occurred to thwart the continued dominance of the biomedical model of psychopathology within western society. In order to understand this dominance and the reliance upon the location of an internal physical cause of mental health problems, we must consider the impact of such a paradigm upon society and the structures within it. The reasons for the continued dominance of this model may be attributed to a number of influencing factors: historical influences from the asylum era, the positivist scientific paradigm, social order, the legal system, and political and economical interests.

Proponents of reform of the ‘lunatic’ asylum in the 1800’s put forth the opinion that public asylums should provide a homely and family atmosphere (Crossley, 2006). This had been found by The York Retreat, founded by William Tuke in 1796, to be most effective. However, as a result of economics this did not happen and the immense size of the population of the public asylums prevented this from being a reality. Crossley (2006) and McLaren (2011) identify that the poor were overrepresented within the asylums, and economics of the time meant that those who were unable to work became a financial burden to their families. Consequently, it was argued that the treatment of insanity required medical intervention, and thereby, became the remit of physicians who were medically trained (Crossley, 2006). Despite unease about this amongst the profession, due to the lack of success in applying medicine to those with such problems, the biomedical model became entrenched in the absence of an adequate and simple alternative, and thus the assumption of physical causality remained operationally unquestioned. In 1943, the Minister of Health, declared that mental health should be treated the same as physical health thereby bringing it under the auspices of the newly formed

National Health Service when it came into being in 1948. The mechanistic view of the body underlying this decision was permitted many centuries previously through religion, in particular Christianity, that allowed bodies to be dissected as a result of the mind-body dualism that prevailed at the time (Engel, 1977).

Shorter (1997) outlines that in the 1940's and 1950's there were distinct differences in the rates of psychiatric diagnosing in the US as compared to the UK. This presented a dilemma which suggested the process was unscientific and therefore lacked rigour and validity. It was not until 1952 that DSM came into being as a classification system standardising the names of disorders and diseases, which previously were unnamed. At this time the influence from psychoanalysis remained heavy, with half the committee developing the system being identified as psychoanalysts. Therefore the classification system was heavily influenced by analytic ideas. In 1959, Erwin Stengel published a critique of the diagnostic practice and this was influential in the 1960's towards medicalisation and scientific methods, and a focus upon locating accurate diagnoses that would identify cause and course of disorders, moving from clinical evidence to empirical research (Gunderson, 2008). This was essential in order for psychiatry to establish its presence in a positivistic, technological society. During the 1970's, there was a tendency to psychologise or socialise distress, rather than medicalise it, threatening psychiatry's position to deal with mental health issues (Shorter, 1997). Furthermore, as other psychiatric treatments had been unable to produce consistent improvements in 'patients', the profession returned to reliance upon biological models for explaining causation. This despite lack of physical evidence and previous methods of medical treatment within asylums, including pouring buckets of icy water over an individuals head, making cuts in the skin, whipping, applying red hot pokers and drilling holes in the scalp (Johnstone, 2000), proving unsuccessful.

The biomedical model in contemporary psychiatry enabled social control to continue to be enacted through the drug revolution of the 1950's and 60's that preceded the closure of asylums and brought about 'care in the community' (Busfield, 2000). It enabled 'patients' to be treated as passive objects by experts with medicines and medical technologies. This was due to the assumptions underlying the biomedical model, as identified by Busfield (1989): that a malfunction has occurred within the physicality of the individual, that this malfunction is a reducible and determinable entity, which can be specifically located, identified and treated, particularly with chemical interventions. Further, due to the accepted dominance of drug therapy within western psychiatry, non-adherence to medicine regimes are located as patient non-compliance, as such the individual is seen as not complying with the authority of the expert (the Medical Doctor). In many cases this is defined as part of the mental health problem

enabling many to have medication enforced by mental health law. Biological explanations immediately remove the problem of mental ill-health from the social environment and necessitate an individual's dependence upon psychiatric treatment. Furthermore, because it removes the need to understand or determine cause outside of physicality, replacing it with a need to know what medicine to prescribe to ameliorate the symptoms or control 'the problem', it removes responsibility from policy makers, society and politics for addressing social problems (Ingleby, 1981; Navarro, 1976).

The model protects social institutions and both maintains and enables the attainment of capitalist goals (Gaines, 1992). Actuarial systems of insurance companies require the application of logical diagnostics that enable decisions to be made about financing for psychological problems. Simple systems of physical causality are welcomed by such systems for this purpose. Pharmaceutical companies have responded to the proposition of physical causality by providing simple solutions, by way of drug therapy. Both insurance and pharmaceutical industries are driven by capitalism, profit-making and cost cutting. Without biological explanations: drug therapies would be called into question and this lucrative industry would experience a decline in trade, as the assumption, both explicit and implicit, of a biological cause leading to a chemical intervention would be redundant; and insurance companies would be forced to rely less on actuarial systems of decision-making, thereby increasing complexity and subjectivity of these systems and consequently costs. The impact upon the economy of the losses experienced by these industries, while uncalculated, has the potential to be immense.

Furthermore, the legal system relies upon psychiatry to define mental illness; to identify behaviour that is the result of a medical condition and, therefore, removes responsibility from the individual and places them under the control of the legal or medical systems (Davies & Bhugra, 2004). In addition, when psychiatry is unable to define such conditions, the legal framework reverts to the lay model of psychopathology, referring to the 'man-must-be-mad' test (Hoggett, 1990), further evidence of individualism. In legal terms biological causes offer improved credence, certainty of outcome and are considered less contestable than other potentially more complex explanations.

The biological model of psychiatry negates the need to challenge prevailing ideologies and bring about social change to address environmental and socioeconomic factors contributing or directly causing mental ill-health (McLaren, 2011). In short where there are no alternative methods of 'effective' treatment, the biomedical model offers policy-makers means of social control that is quick to administer and the costs of drugs are subsumed within health budgets.

In summary, the biomedical model enables hegemony to prevail: Medication regimes treating symptoms enable individuals to return to the workplace, as opposed to being supported by a welfare system while they address underlying issues causing the symptoms through longer term psychotherapeutic treatments. Social control of individuals behaving outside of social norms is possible. The ideology upon which policy-makers base their decisions remains unchallenged on account of the problems being internally located, even in the absence of evidence of physicality.

B.2.7 Transferability, Impact and Importance

Borderline Personality Disorder only exists because the mental health community, say it does. We have chosen to gather together a group of personal attributes, behaviours, and experiences and identify them as 'symptoms'. We then suggest they are permanent and unchanging, through choice of the term 'personality' and the creation of a category label suggestive of a fundamental dysfunction. In another culture, another language, another society or another era this same list of attributes, behaviours, and experiences may be recognised differently, or not at all. They may be, perhaps, considered a mood disorder, or disorder of social functioning which is not, necessarily, permanent and unchanging. However, these three words with their historical and potentially outdated sociocultural origins continue to be applied to individuals whose sense of self and identity is already uncertain, at best.

As such the medical model of illness and disease dominates the field of mental health, along with social structures such as the welfare benefits system. Without a diagnosis an application for benefits is unlikely to succeed and, in many cases, a claim cannot be made. Additionally, a diagnosis of PD carries with it a greater stigma than other psychiatric diagnoses. A number of academics, researchers and clinicians (Johnstone, 2010; May, 2007; Moncrieff, 2007) have proposed a move away from diagnosis in the treatment of mental health problems. Hodges (2003) supports a move towards shifting focus from the individual and consequential blaming that occurs, to societal power and influence upon the individual. My research will provide an investigation into this area, by examining the construction of self through the diagnosis of BPD. The research outcomes will provide information on the influence of medical diagnosis on the ways that individuals construct their experience and identity, and its consequence for the way that they experience the world and their behaviour within it (Becker, 2000). I will use CDA to explore client experience of the diagnosis of BPD, and how their internalisation of this is constructed through language. This is an attempt, to bridge the gap of BPD research both in relation to the client experience and to Discourse Analysis as there appears to have been little attempt to examine clients use of language within BPD research.

Nehls (1999) identifies that without understanding the meaning of living with BPD we cannot begin to improve practice, training or treatment. Counselling psychology uses process as the primary means for understanding and affecting therapeutic change. It is concerned with the individual, their development of self and their interactions with others (BPS, 2007) and it is concerned with wellbeing rather than 'illness' (Orlans, 2009). This can be more effective if we understand the discourse presented in this relationship and how those with interpersonal difficulties construct their experience, position themselves and are positioned, as it provides most efficient access to the effect of sociocultural variables on experience. Whether the diagnosis remains as a credible DSM classification or not, gaining increased understanding of what is constructed in discourse as a result of social, cultural, historical and economical influences, can only advance the field towards what is required for 'effective treatment' and the appropriateness of the construct. The humanistic values underpinning counselling psychology provide the opportunity to bring new perspectives to the field of BPD research and to provide critical reflection on 'why treatments do not work'.

B.3 Chapter 3: Methodology

B.3.1 Introduction to chapter and reflexivity

This chapter describes the research methodology. It identifies how the research was carried out, the reasons for my choice of analysis and the procedure. I also consider the issue of quality with this type of research. Throughout the chapter I interlace reflexivity in keeping with the qualitative approach, considering the impact of my personal context, identified in B.2.2, upon the research process. It would not be credible to rely upon an approach that is based in critical social theory without acknowledging and positioning myself within that in relation to my world view and theory of knowledge, truth and reality. For example my positioning with regard to my research aims is based on my construction of reality as a result of my access to different discourse communities, which has developed as a result of my personal and professional cultural history; this includes employment within the NHS, Criminal Justice, National and Local Charities, Private Organisations, as well as my educational, social and familial background. In addition, as this is empirical research and with an academic goal to further the knowledge of the field and present recommendations for the future of the BPD diagnosis; my language is constructed for the academic discourse community, situating it as a power discourse.

B.3.2 Rationale for qualitative approach

My preliminary literature search led me to determine that the vast majority of BPD research has been about prevalence and treatment. There has been little focus on experience of providers and even less of clients, as demonstrated by Nehls (1994). Aviram, Brodsky and Stanley (2006) suggest that this has meant the investigation of stigma around BPD has been limited, as compared to other mental health problems such as Schizophrenia and Depression, and, therefore, little known of its effects on treatment course. In addition there is only limited research on the impact of the diagnosis itself upon individual's constructions of reality. Ultimately, this means that service users have had little opportunity to participate in the debate on BPD, their experience remains largely undiscovered (May, 2007).

My epistemological and ontological position, as identified in B.2.3, and my research aim led me to qualitative research. This was something I was unfamiliar with. I was confident with quantitative research; I knew the methods, designs, analyses and most importantly the language. The decision to use qualitative research was going to be a new experience and involve learning a new language. However, it was something that I believed fitted with my

research aim, as stated in B.2.3.1. Discovering how individuals constructed their reality following a diagnosis of BPD; the way they constructed their experience of being diagnosed and any treatment received, as well as the way their construction of the diagnosis, this would be virtually impossible through quantitative methodology, as it would be in opposition to my epistemological position.

However, I was aware that by selecting to undertake qualitative research I was moving away from the Gold Standard Randomised Control Trial (RCT), influential within the medical model. Nonetheless, as a Scientist-Practitioner I considered that this 'gold standard' due to reliability and validity, had not yet provided answers, solutions or ways of understanding for every individual. Therefore, perhaps there was another way to understand individual experience in order to develop or adapt effective treatments for those whom the treatment protocols, developed through RCTs', did not reach. For example, Horn et al. (2007) found that individuals tended to internalise unhelpful views of themselves that were presented by others in response to diagnostic labelling. They suggest that individual formulations would be an important alternative and would include individuals in the process thus reducing dehumanisation which occurs as a result of diagnostic labelling. Alwin et al. (2006) support this individual formulation approach in relation to all personality disorder diagnoses, and Johnstone (2005; 2010) proposes this approach as an alternative to psychiatric diagnoses more generally. These are examples of how qualitative research can be used to propose alternative treatment options. As a counselling psychologist and a researcher I have the opportunity to bring about change using alternative or additional methods to those situated within the positivist paradigms of medicine and psychiatry. However, I also recognise the importance of maintaining rigour within research and later in this chapter (see B.3.7) I address this in relation to quality.

B.3.3 Discourse and why it is important

There are many different definitions of discourse dependent, principally, on the research tradition being employed (Mills, 2001). The study of discourse has been influenced by social constructionism, pragmatism, post-structuralism, postmodernism, linguistics, critical psychology, deconstructionism, and phenomenology, as identified by Rapley (2007). Bloor and Bloor (2007) provide a broad definition of discourse stating that it pertains to all human communication and interactions involving language, whether spoken, written or visual representation. They identify that it will likely encompass contextual information, historical information and shared knowledge between communicators. Furthermore, discourse takes place within a socially recognised context (domain) within which social practices and genres are familiar. Language enables meaning to be created by way of discourse and, therefore,

constructs reality, rather than language being the tool for referring to objects. Within this research I use the term discourse to define the particular meaning created by language when it is used in a particular way, which is formed by historical, social and cultural influences and occurs within a particular group of people, a discourse community. This discourse community is held together by shared social practices, genres and social events. The language used will be characterised by similar vocabulary, grammatical expressions and implies shared beliefs, ideas and experiences. The term discursive construction is defined as the way in which something is presented through the use of a particular discourse, or way of communicating.

Parker, Georgaca, Harper, McLaughlin and Stowell-Smith (1995) further reinforce that language and society have been neglected in the treatment of mental distress, with focus being, primarily, on the individual's diagnosis throughout the mental health system. They state that understanding language is an essential ingredient for the effective examination of this system. They call attention to the fact that who makes it through the gate-keeping system into mental health services also appears to be language dependant; the right language sets in motion the wheels to access the mental health system. They propose that 'facts' about an individual's mental health are not really facts but rhetorical constructions created from contextual answers to particular questions. As such, these 'facts' could change according to an individuals context.

In 1971, Michel Foucault first described the emergence of the discourse pertaining to the medical category of 'madness'. Later, Parker et al. (1995) further contended that the diagnosis of madness was a method of exerting control resulting from a human desire to be socially acceptable or 'normal'. They highlight that this is an advantageous position within a democracy. By locating the problems within individuals we do not have to acknowledge the problems and traumas that individuals have been subjected to in their lives. They suggest that when mental health professionals place individuals into clinical categories with the problem being located within them, societal responsibility is removed. Meanwhile, a position of normality is secured for those who carry out the categorisation, with this categorisation paying little attention to content of distress only to form. While the language of 'madness' has changed over history, and will continue to change, because language is tied up in clinical institutions it continues to hold power. Psychiatric institutions are powerful as a result of powerful historical regimes, and, therefore, power exists irrespective of the individual attitudes of those in powerful positions. It is only by uncovering discourses and exposing this power that the system can be enabled to take action accordingly.

Further, Parker et al. (1995) also argue that culture is important in understanding and deconstructing the language of 'madness'. If we do not have the language (words) to categorise then we cannot categorise, with language being influenced by culture. Categorising and identifying 'madness' is, therefore, dependant upon language. Cultural representations of 'madness' are apparent throughout the media and they highlight that popular culture can influence professional culture.

B.3.4 Discourse Analysis

Discourse analysis (DA) draws on the disciplines of anthropology, philosophy, sociology and linguistics (Cameron, 2001); Carla Willig (2001; 2008) describes how language became a focus for many of these disciplines during the 1950's. The theorists began to explore social reality as being constructed by language in order to advance social objectives. In the 1970's, during this 'turn to language' amongst the different disciplines, social psychologists started to challenge cognitivism. This challenge was based on the premise that a number of assumptions of cognitivism were spurious. The belief was growing that psychological concepts were the result of discourse: they were constructed by talk rather than accessed by talk; social and interpersonal goals were pursued through discursive resources, and they were used in different contexts to achieve different outcomes; this belief was considered to be the basis of concepts rather than being a result of enduring cognitive structures which individuals *had*.

From a social constructionist position, Rapley (2007) reports that DA involves asking questions about everything we take for granted in social life, because our understanding of concepts such as 'madness' is a product of human interaction, history, society and culture. This offers an opportunity for research to be directed towards how things are produced by social processes and in what ways our 'knowledge' of the world has historical and cultural specificity. The thesis purports that language is constructive, when you communicate you produce a world. DA involves focusing on what version of the world is being created by expressing something in a particular way; what identity or meaning is produced. This involves considering what is made available to the listener or reader, and what is excluded from them by expressing it in this particular way; which identity, membership category or subject position is constructed, what impact this has and how it connects to context and culture are all examined. The language is treated as opaque, never considered to be neutral (Rapley, 2007).

B.3.4.1 The different traditions of discourse analysis within psychology

Willig (2001) identifies two main research traditions within psychology which have been borne out of discourse analysis: Discursive Psychology and Foucauldian Discourse Analysis. These

developed in the 1980's following psychology's 'turn to language'. While the two traditions share a common concern they seek to answer different research questions and are based on different philosophies.

Discursive Psychology (DP) was brought into British Social Psychology by the publication of *Discourse and Social Psychology: Beyond Attitudes and Behaviour* by Potter and Wetherell (1987), although the name was coined later. It was identified as a psychology due to its exploration of psychological concepts including identity and attributions (Willig, 2001). This version of DA drew its underpinnings from ethnomethodology and conversation analysis, asking questions about what and how language is used to construct social interactions (Willig, 2001; 2008). It is based on the idea that people do not have prejudices, memories or identity, instead it is something that they do; they are constructed through discourse (Willig, 2008).

Foucauldian Discourse Analysis (FDA) was introduced after a number of psychologists, who were influenced by the work of Michel Foucault and other post-structuralists, sought to investigate the link between language and subjectivity, and how this link may influence research in psychology (Willig, 2008). FDA focuses on what discourses are available within a culture to construct objects and subject positions, the constructions create social reality and social order which effect experience, how people think and feel and what they do (Willig, 2008). FDA explores historical changes in discourse over time and how social processes of power relations are legitimised and embedded within institutional practices. In contrast to DP, FDA considers discourse to construct subjects, make meaning available and position speakers; DP considers discourse to be a tool that speakers use. FDA asks questions about experience resulting from the objects and subjects constructed by discourse, and what implications this has for ways of being (Willig, 2001).

B.3.4.2 Critical Discourse Analysis (CDA)

CDA takes a constructionist position; a 'text', which maybe written, spoken or visual demonstrates the social and cultural effects on the way individuals, construct their experience, others and their actions (Crowe, 2005). CDA asserts that hegemony is constructed through language. Hegemony occurs via the accepted wisdom of the most dominant group, so that this way of thinking is considered to be common sense and fated. This is what Fairclough (1992) terms 'naturalisation'. Language is not 'transparent or value free' (Cheek, 2004, p.1144), people construct particular texts, consciously or unconsciously, with particular audiences for a desired result (Locke 2004). The CDA framework enables us to examine these discursive constructions for dominance (van Dijk, 1993). The definition of dominance is: social inequality

brought about by hierarchical structures and powerful groups (van Dijk, 1993). Consequently, CDA has focused particularly on topics involving political issues.

According to Cameron (2001) CDA is concerned with the 'hidden agenda of discourse'. She states that the analytic purpose is to identify how the language used functions as a social practice that constructs the objects, rather than simply describing them, with the choice of the language being ideologically significant. CDA looks for these hidden ideological positions contained within discourse, they are not always consciously known by social group members (Bloor & Bloor, 2007).

CDA draws its framework and methodology from structural linguistics and critical theory (Cameron, 2001), in particular the neo-marxism of the Frankfurt School, Foucaultian archaeology, post-structuralist deconstruction and post modernism (Locke, 2004). Critical theory involves taking a critical view of traditional ideas about reality, subjectivity and knowledge, viewing concepts as constructed and not natural (Cameron, 2001). In identifying some of the underlying commonalities among critical theorists, Kincheloe and McLaren (1994) highlight that within any society some social groups will be more privileged than others for a wide variety of reasons, oppression occurs where the social status of the less privileged groups is accepted as inevitable or necessary. One of the main aims of CDA, as identified by Bloor and Bloor (2007), is to examine how oppression and discrimination are supported by discourse, and how language maintains inequality. They also highlight that the most dominant group are best served if the acted upon group accept their positioning as ideologically required. Certain social classification systems thereby impose identities on people which may be unwelcome if the underlying ideology was known. An example of this would be the attention drawn by feminist psychologists to the oppression of women identified in the application of particular diagnostic categories, and hence the association of particular difficulties with women (Shaw & Proctor, 2005). The analysis requires that a text must be considered both in terms of what it does and does not include; what are the alternative constructions that could have been chosen (Locke 2004). The analyst considers what the alternatives would suggest for the representation and understanding of the world, and what social actions would be brought about. This goes further than simply reading ideologies from a particular stance onto a text (Locke, 2004).

When considered alongside DP and FDA, CDA incorporates Foucault's work but involves a more ground-level approach to language providing more concrete examples of how texts demonstrate social inequities and concentrate on the mechanics of discourse. For example identifying grammatical choices and use of vocabulary in contrast to what alternatives could

have been used; the choice of pronouns to construct an experience such as 'I', 'we', 'you' or 'they' will provide an indication of how the individual wishes to position themselves in relation to what they are discussing. If this is perhaps an attribute which is considered undesirable as a result of ideologies relating to 'normality' they may choose to use 'they' rather than 'I'. If a particular position or collective identity is undesirable on account of social inequity individuals may wish to distance themselves from the collective through the use of 'they' rather than 'we'. While this is similar to DP the framework is different, it is drawn mainly from linguistics but incorporates cultural theory, rather than ethnomethodology and conversation analysis. This provides a more complex model of discourse practices and their impact on participants (Mills, 2001). As a result of the overlapping of ideology and language, careful systematic analysis of the language of the text is thought to uncover some of the workings, thereby, exposing the ways in which people are oppressed (Mills, 2001). It moves from description of the linguistic properties of the text, to consider critically what has been constructed through the language choices and their significance culturally, socially and politically in a continual process. This is a reinterpretation of Foucault's ideas, applying them such that the analysis is both replicable and verifiable, as dictated by the discipline of Linguistics (Mills, 2001).

In summary, CDA focuses on how reality is constructed through discourse and why it is constructed in this way; this is achieved by paying attention to both content and form in order to identify ideological significance and patterns of choices made by communicators. The focus is on what language is selected as well as what is not (Cameron, 2001).

B.3.4.3 Fairclough's model of Critical Discourse Analysis

I have selected Fairclough's (2001a; 2003; 2009) model of CDA because his epistemological and ontological positioning is most similar to my own. His approach draws on the work of Foucault (FDA); Gramsci (Hegemony) and Habermas (need for transformation through increased understanding). His approach is based on the foundation that language constructs social identities, social relationships and knowledge and belief systems. In addition he proposes particular focus on the analysis of the dialectical relationships within social practices (Fairclough, 2001b). Dialectics is a classical philosophical base which has also been used in the development of effective treatment for women with the collection of symptoms associated with BPD, credited to Marsha Linehan (1993), as described in B.2.5

According to Blackburn (2008) dialectical theory operates on several levels, as a world view it places the truth as the whole picture. It is the process, whether natural, historical, or intellectual involving constant change, transformation and development. According to the

philosopher Hegel (as cited in Blackburn, 2008) this occurs via thesis, antithesis and synthesis. A view is in place which then generates a directly opposite view which then generates a compromise between the two. This compromise then forms the basis of the new thesis. Fairclough's CDA also employs dialectical logic, as described by Chouliaraki and Fairclough (1999), whereby 'truth' is considered to be somewhere in between thesis and antithesis. The idea is that power issues can be identified where one view is stronger or expressed by individuals in authority and this prevents the compromise (or truth) from being identified. The thesis and antithesis is known as a dialectical pair, and the phrase is used to express the idea that there is a tension between conflicting ideas.

This methodology is an attempt to bring to the field of BPD research, both in relation to the client experience, and in relation to discourse analysis, an alternative thesis. Within research on BPD there has been little attempt to examine clients use of language. This information is particularly important to counselling psychology because of its implications for treatment, and the internalisation of views of self. Counselling psychology is concerned with individuals and the way that they function in the world, and how that is constructed. Counselling psychology professionals focus on the development of self and growth beyond symptom correction (BPS, 2007). This is particularly pertinent for the individuals with 'personality' and interactional difficulties. Research concerning the way that individuals construct themselves in language will inform the therapeutic process and assist professionals in this field to understand this construction more clearly enabling them to be more effective in therapeutic endeavours. I now move to identify my research design before finishing this chapter with the analytic procedure.

B.3.5 Research design

In the following Section I will begin by describing the sampling strategy and participant recruitment procedures, including the problems that occurred; following this I will move on to identify the procedure that I undertook once participants had been recruited; the next part of this section is devoted to the ethical considerations of this research. I have provided cross referencing where processes and considerations overlapped. The final part of this section details the transcription that was used.

B.3.5.1 Sampling and participants

The sample was self-selecting to enable individuals to make a clear personal choice about participation, without influence from others. However, I was aware that this could make recruitment difficult. Also it could mean that individuals who were nervous about meeting new people, or wanted to forget about their diagnosis would be unlikely to participate.

The criteria I used for participation were: adults over 18 years of age, for ethical reasons and because a diagnosis of BPD in adolescents is ill-advised (APA, 2000); male or female; from any sociocultural background, although they needed to be English speaking, due to the additional difficulties in using translators when conducting qualitative research based on language; they also needed to have been formally diagnosed with BPD by a psychiatrist based in the UK, this was to rule out any variables relating to non-UK diagnosing practices. I decided not to limit the time frame for diagnosis, therefore, no matter when the individual was diagnosed they could be considered if they met all other criteria. All were formally diagnosed post-1994, when DSM-IV was published and an additional criterion added. After further consideration and reflection with my supervisor and colleagues I added a further exclusion criterion that participants were not to be receiving therapy or counselling at the time of the interview. This was to ensure that the therapeutic process was not affected by participation in the research.

In addition, I identified that individuals should not be suffering from any untreated Axis I disorders in addition to the problems experienced as part of BPD. In order to identify this, prior to interview the potential participant was asked directly about any problems which were not, either directly related to their diagnosis of BPD or currently stable. It was explained to the participant that the reason for this was to ensure that the interview process was as safe as possible for them. The problems they were asked about included: substance-related disorders, psychosis or schizophrenia, depression or bipolar, anxiety disorders such as PTSD, OCD or generalised anxiety or panic, dissociative disorders, or eating disorders. Several of the participants did have secondary diagnoses, and I discussed this with them and established that this was something that was suitably stable to manage safely within the research interview. Stability was assessed by enquiring about severity, level of distress and protective factors. The interview questions specifically directed participants to consider their BPD diagnosis, and individuals with a secondary diagnosis tended to stipulate which diagnosis they were referring to.

Initially, I decided to offer the opportunity to participate in the research to individuals living within London and the South-East meeting the inclusion and exclusion criteria identified above. The reason for selecting this area was related to my initial preference for location to conduct the research interviews. Conducting the interviews within the University Clinic Room would mean that individuals would need to be able to travel with relative ease to the location (see section B.3.5.3 for consideration of interview location).

My initial targeting for displaying adverts (Appendix 1) included community centres, libraries, non-NHS support groups, charities and I also approached several of the main BPD internet support organisations in the UK. The adverts that I used were designed to encourage people to consider participating in the research as a way of having a voice and for this to be the first thing that drew people's attention to the advert. Research suggests that people remember most clearly the first piece of information that they access or is available to them (Woods, 2006). I wanted individuals to have the opportunity to get something out of the research and ultimately this was the way that I considered people would be most likely to do this. However, I received only 3 responses from this strategy and they did not become participants by choice. I have no way of knowing why they chose to decline to participate other than my own assumptions. In addition several internet organisations declined to advertise the research stating that they had a policy preventing them from doing this. I understood that there may be many reasons for these policies, however, it was frustrating. I believed that there must be individuals who wanted to have the opportunity to voice their experience.

I considered possible reasons for lack of responses: stigma attached to the diagnosis preventing people from wanting to talk about it; not meeting the research criteria; willingness of service providers to promote research for their own reasons or policies; and the lack of ease of taking down the details of the research from the research poster when displayed within a public place. After discussing this with my research supervisor I contacted various criminal justice agencies and asked them to display my advert and also found a self-help support group who agreed to circulate it. This second strategy led to involvement of one participant. However, I knew that if I was going to gain enough participants to make the research credible then I was going to have to widen my sampling strategy.

I thought about the most discrete ways that I could perhaps reach people. I considered approaching a mental health trust or organisation and decided that this would not meet my research aims. If I went to a trust, time restraints would limit me to one trust and, therefore, a particular discourse, potentially unique to that trust involving power dynamics unique to that trust also. I was also concerned about ethical considerations, I did not want to negatively impact upon the treatment that individuals may be receiving.

I considered how I might come to be involved in research and how I had done in the past, my attention turned to the worldwide web. As organisations were reluctant to advertise my research I decided that I would set up my own website. This would enable individuals to consider the research in the privacy of their own homes without being seen reading an advert

relating to BPD. It would also enable them to contact me with ease, through a link on the website. Fortuitously, I was able to secure the domain name www.borderlinepersonalitydisorder.co.uk (see Appendix 1 for webpage content); I decided that I would have three pages on the site which covered the same information as my adverts and also hosted a photograph; I thought this might be a way to give the research a 'face'. I then placed a 'google ad' so that whenever anybody entered the search terms 'borderline personality disorder', 'bpd', 'personality disorder', 'borderline', or 'borderline personality' they would be presented with a link to my website (see Appendix 9 for costs). The search terms that I selected ensured that my advert targeted those individuals who were actively looking for information on BPD. This was the strategy that proved successful. Over the course of 6 weeks I had 437 visits to the website, my ad was shown over 10,000 times, and I was contacted by 30 people, of these I went on to interview 7, a further participant contacted me as a result of a friend seeing the link. While the advert was available to a large number of people, I only received communications from 30, this may indicate something about either the diagnosis itself or the identities of the individuals with the diagnosis; conversely, this could simply indicate a general reluctance to participate in research. Of the 30, 4 were in treatment and 3 were not diagnosed by a Psychiatrist in the UK; 10 I received no further communications from and 6 presented ethical concerns and as such these 23 were excluded from the research and signposted as appropriate (B.3.5.3).

It is difficult to determine with qualitative research, how many participants provides the 'right' number or a good sample size. I had anticipated that I would like to interview between 8-15 participants. However, because of the methodology I knew that it was also important to ensure that the data that was produced was manageable. The difficulties that I had with recruitment meant that I was able to obtain appropriate interview texts from 8 participants. I was aware that if any of these individuals changed their mind about the research I would be risking losing credibility of my research. However, the individuals who were interviewed were very engaged with the process and keen to share as much of their experiences as they could.

Upon reflection I would definitely use the website strategy again, but beginning this earlier would yield more potential participants. It is a strategy which gives people the opportunity to participate easily and make contact without the undue stress of remembering, noting down or taking contact details from an advert placed within a public domain. I would use this in combination with some of the other sampling strategies to ensure that individuals without access to the internet had the opportunity to take part also.

B.3.5.2 Procedure

All respondents, except one, contacted me by email initially. This seems to be a non-threatening and indirect way of requesting more information before feeling like you have to make a commitment. I responded to all contact within a short space of time, to preserve the moment. Each individual was sent a participation information sheet and a copy of the informed consent form; they were all thanked for their interest. I identified the need to consider the enclosed information before making a decision and asking me any clarification questions before they agreed to participate. Some respondents got as far as arranging an interview and then changed their minds and discontinued contact. I followed these up with an informal email stating that if they did want to participate to simply get back in touch with me and we could arrange it. However, if not I wished them all the best on their journeys and thanked them again for their interest. A couple of my participants did come back following this email and I was able to interview them.

After the responders received further information about the interview I asked them to contact me again to let me know if they wanted to participate in the research. At this point I also answered any further questions that they had. Only 3 participants requested more information and this was with regard to reassurance about confidentiality (see also section B.3.5.3 for ethical considerations) and also clarification about what questions they might be asked. At this point I decided that I would inform all my future participants that the interview would be about their experience of the diagnosis and would not ask questions about their life history leading up to the diagnosis. On reflection I could have expected that this might be a concern and it may have been another reason why I had low numbers of respondents, because of the sensitive and/or traumatic nature of past life experiences. However, I made it clear upon initial contact that they would be able to decide what and how much they wanted to share.

I advised those individuals who indicated their wish to proceed with the research that the interview would take approximately 1 hour, that I would audio record the interview and that I would later transcribe this into text, and I also asked them to check and sign the informed consent form (see section B.3.5.3). I explained that following the interview there would be an opportunity for debriefing (see section B.3.5.3) where they could talk about the experience of the interview process and ask any further questions that they may have. I used a standard checklist of questions to ensure that all points had been covered and important information obtained (Appendix 7).

The interviews took place using a guide sheet of semi-structured interview questions (Appendix 4). This was a minimum set of questions which I identified as useful questions for encouraging the participant to start talking (Willig, 2001); while keeping the interview away from sensitive topics and also giving individuals the opportunity to share their experiences. The order of the questions was based on a natural progression from setting the scene to talking about perceptions, to talking about treatment, and making any final comments, this is an approach highlighted by Willig (2001) as a useful way of conducting interviews and establishing rapport. Testimony to the planned order of the questions was that these did indeed follow a natural progression in the interview, and often the story would unfold in this way without me needing to ask many questions. However, Potter and Wetherell (1987) do suggest that with interviews for the purpose of discourse analysis it is useful to ask follow-up questions or further questions in different ways about topics, this was my interview approach.

This was my first experience of conducting semi-structured interviews for a major piece of research. As this was also my first Discourse Analysis I was not entirely sure what information would be the most useful, so I considered that actually hearing the story would demonstrate the way in which individuals constructed themselves and would make sense to the client. I kept my interjections minimal throughout the interviews as I did not want to shape their answers or stories with my perceptions. After the interviews I made some written notes relating to the process of the interview and to identify any non-verbal semiotics pertinent to the process. As I undertook the first few interviews I incorporated a few more questions which had come out of these interviews, including: Do you think it is possible to recover from BPD? Is there anything that could have been done differently? How do you feel about others knowing about your diagnosis?

I reminded participants before they left that they could contact me or my research supervisor after the interview for further clarification or to ask any questions they had not thought of. I wanted to ensure that each individual had a good experience of participating in research but also that I did not replicate any negative experiences that they may have experienced previously. I attempted to convey this through rapport building with all the individuals who contacted me and genuine interest in their stories.

B.3.5.3 Ethical Considerations

I was aware from the outset that this research could raise anxieties about ethics. Primarily because of the nature of the symptoms that lead to a diagnosis of BPD. There was no way of knowing who would respond to my adverts and in what psychological state of mind they

would be in. However, with careful consideration I received ethical approval from City University (Appendix 8). In many ways the preparation I undertook was planned to manage worst case scenarios. It was not until I began to receive contact from potential participants, that the importance of being a practitioner and a researcher became apparent. The skills that I use as a practitioner in risk assessment came into play immediately and this skill I had initially underestimated in planning my ethics. However, it proved to be effective, as no participants who were actually interviewed required further therapeutic support, or became emotionally unstable within the interview, and all reflected on it being a positive experience. I think this is testimony to the importance of using counselling skills within the whole research process with human participants.

Due to the nature of this diagnosis and the purpose of the research, there was a possibility that participants would raise questions with regard to their diagnosis. The resource pack (Appendix 5) that I prepared enabled me to utilise appropriate signposting when I was unable to answer their questions. I was also able to follow up with 2 participants after the interviews with information about services specific to their geographical locations. I was very clear with all my respondents that the purpose of the research was not to question their diagnosis rather to determine how it affected the way they talked about and understood themselves.

As response to my website grew it became clear that some individuals were contacting me because they were reaching out in distress or because they wanted information about the diagnosis rather than wanting to participate in the research. In these three instances, I provided information and signposting to crisis services and support agencies. On reflection my professional and ethical responsibilities as a practitioner took priority over my needs as a researcher, even though I was aware that this could have ultimately impacted upon the research.

There were 13 participants who on the basis of my inclusion and exclusion criteria were excluded from participating in the research. I was also aware in my contact with them that the research was something that may not be beneficial. I was able to consider their well-being and determine their reasons for becoming involved in the research, whether related to their desire for support or their wish to use the research as a vehicle to express their anger. I think without my knowledge and experience as a practitioner I may have dismissed the meaning in their text (emails) as rich material for the research. It was my concern to put their well-being at the forefront of my considerations.

I received several emails which were incredibly personal and contained disclosures about traumatic childhood experiences. Upon receiving these emails, I contacted the individual with suggestions of signposting for organisations who may be able to hear their story in a more supportive way than a research interview. I took care to ensure that I offered the same sentiment about their contact as with other respondents, but was clear that perhaps this was not the best forum for them. This was a considered risk because I knew that in many ways this could be seen as rejection and I wanted to limit this as much as possible. My perception was that for most people it provided the opportunity to write down their story and deliver it to somebody who appeared to care and then be able to walk away from it. I used my skills; my knowledge and experience in this particular area enabling me to manage this process sensitively and effectively, again highlighting the advantage of being scientist-practitioner. My natural instinct was not excitement at the prospect of a participant, but concern to ensure that in reaching out for support these individuals were indeed pointed in the direction of individuals or organisations who could provide that support.

As this research involved human participants (BPS, 2008) they were asked to sign an informed consent form to agree that they: were participating voluntarily; understood what the research involved; were aware of the possible risks, although these were not outside of the normal risk of harm that they may be exposed to while going about their everyday activities; had a right to withdraw at anytime; agreed to the recording of their research interview; understood confidentiality and that their information would be protected under the data protection act and through anonymity; and that I had answered any questions they had about the research satisfactorily. Participants were given copies of the consent form, this detailed contact information for my research supervisor and myself (Appendix 3 for Informed consent form). Prior to signing the informed consent form participants were provided with a Participant Information sheet detailing the research (Appendix 2). They were given the opportunity to see this information prior to the research interview, so that they could discuss their involvement with an advisor and could choose not to be involved without feeling under duress.

Within any context when you ask somebody to reveal personal aspects about their lives and their lived experience, confidentiality is imperative not only ethically, but also to enable the individual to feel safe to share real experience. Informed consent forms that I asked people to sign addressed this, but I also repeated this verbally at the beginning of the interviews and at the end, explaining that all identifying details would be removed and no information regarding geographical locations or treatment services would be included. This was particularly important in two cases where participants were mental health professionals. I spent time

providing assurance on this matter. As a result I decided that within the research I would not mention any demographic information other than gender and occupation. This meant that all participants would be subject to the same high level of confidentiality. The concerns about confidentiality were firmly attached to the stigma and altered perceptions that people believed they may encounter if work colleagues, employers or clients were to know about the diagnosis. This provided important contextual information for the analysis.

When individuals decided that they wanted to participate I arranged a semi-structured interview. First I had to agree a location for the interview. A number of issues had to be considered, including the participants and my safety, particularly given the potential for affect dysregulation of the participants, for example inability to control impulses, anger, self-harm, or other extreme emotions. The location needed to offer confidentiality and be a safe environment. In most instances this meant not conducting the interview in the participant's home, as I could not determine the suitability of the home environment for this purpose. My first choice was to use the Counselling Clinic Room at City University as the safety and confidentiality of the environment could be controlled. With the room on the ground floor next to security, and a telephone in the room, there was immediate assistance available from security or staff, if the participant became very distressed or threatening. I asked a colleague to be available in the event of an emergency. Thereby, the clinic room provided a safe environment for the both the participant and myself.

There were several occasions when, due to expansion of the geographical catchment, using the clinic room was not feasible. I considered not interviewing people on this basis; however, I was aware that this would seriously limit my potential sample, due to the other factors that I was taking into consideration. Of the 8 interviews I refer to in my analysis 7 were in employment, this already indicated to me that there was a level of affect stability that enabled the individuals to cope in a work environment, and on this basis I decided that I would offer the opportunity to see people in alternative locations. Had the individuals not been in employment I would have considered other indicators of stability, as a means of determining a suitable location. This, in the majority of cases meant arranging a meeting room at a conference facility, again where they were assured confidentiality, and there were staff on hand if there was a problem (see Appendix 9 for costs). I offered the opportunity to those participants living out of London and south-east to suggest suitable venues where they felt they would be most comfortable. I then made arrangements based on preferences and safety considerations. The participants were provided with venue details and asked to contact me if there were any problems on the day.

In addition I introduced other safety precautions: rooms were set up to ensure that I could easily access the telephone and leave the room quickly if necessary, as a last resort. The participants were also advised to inform somebody where they were going, at what time, with whom and what time they expected to be back and to give this person my contact number; I did the same. I explained at the beginning of the interview to all participants that if at any point they felt they wanted to stop or needed a break in the interview they could do this. I also explained again that the aim of the interview was to get them to share as much of their experience as they felt comfortable doing. I was also aware that I may need to manage disclosure; to check out whether they wanted to be sharing such personal information within this context, a skill that King (1996) emphasises as being essential to the role of the psychology researcher.

In addition I was aware of the contingencies that I would be using to manage distress within the interview (Appendix 6). The potential for negative affect was discussed and I explained that I did not intend to bring about intense or negative emotions, such as anger, distress, impulsiveness or dissociation. However, if this occurred I explained that following employment of a range of interventions an emergency contact would be used if required. If they disclosed anything which suggested that they or anybody was at risk I would have a duty to break confidentiality. None of the participants required any intervention outside of core counselling skills. I think that this was for two reasons; one was because I was there to listen to them no matter what they said or whether it made any sense; and because I was empathic, non-threatening, friendly and relaxed, providing the opportunity for validation. Although this is my perception of how I came across, there was some agreement in this as participants appeared at ease and commented that it was a much more relaxed and less threatening interview than those experienced within the mental health system. King (1996) draws comparisons between the research and the counselling interview and the importance of using counselling skills.

I provided a debriefing at the end of the research interview; the participant was asked about their participation and whether they had experienced any negative effects. It was my aim to ensure that the participants did not leave the research environment in a negative state, and were in at least a good a state as when they arrived. The feedback that I received reflected this, with all participants reflecting that they left the research environment feeling more positive than when they entered. In preparation for this I compiled a resource pack (Appendix 5) outlining details of appropriate support, including signposting and details of suggested reading, I also had information leaflets available about BPD, coping with crisis, dealing with loneliness, types of treatment found to be effective and dissociative symptoms (Appendix 10).

All the participants commented that this pack was helpful and were pleased to be receiving additional information.

While it was not anticipated that the research was putting human participants in danger, contact details of therapists with experience in BPD, who agreed to provide therapy within 72 hours, were available and participants were informed of this at first contact. This was to ensure that any issues raised could be explored further if necessary with a qualified professional, thereby providing support following any negative impact brought about by their involvement in the research. I had arranged to pay for a one-off session with either one of these identified professionals if it was required and agreed that any further sessions would need to be agreed separately between the therapist and participant. When I expanded my geographical catchment area, I made it clear to individuals that I would put them in touch with a suitably qualified professional living locally to them, if required. None of the research participants used this resource. I did receive both written and oral follow-up feedback after the interview that the research had been a good experience, with several participants commenting positively on having somebody to listen to their experiences (see Appendix 10 for participant feedback examples).

B.3.5.4 Transcription

I used two Olympus Digital Audio Recorders for the interviews; one was placed close to the participant and one close to me. This was to ensure that I had back up recordings; and to counteract the low volume at which some participants might speak. I was then able to refer to both recordings during the transcription process.

There are many schools of thought regarding the transcription of interview data depending on its intended purpose. I used principles of the Jefferson system, as described by Potter and Wetherell (1987). This system includes fine details such as lengths of pauses, intonation, overlapping and extension of vowels. I did not include all the fine details as the purpose was to conduct a descriptive analysis which informs interpretation and social analysis, and not solely a linguistic or conversation analysis, this is supported by Parker (2005) who identifies that it is important to consider the purpose of the transcription. I did transcribe without punctuation other than a full stop to indicate a pause of less than 0.2 seconds, longer hesitations were indicated in brackets and timed in seconds. The purpose of not using punctuation was so as not to alter the text through my interpretation of the placement of the punctuation. This is a lengthy process, and it can sometimes render the transcript difficult to read. I have identified the length of time taken to transcribe each interview in Appendix 12. Within the analysis

chapter I have simplified the extracts by presenting the basic transcription, with contextual information, non-linguistic communication included as appropriate. I have collapsed the dialogue where I have simply used active listening skills to enable the text to be more easily comprehended.

B.3.6 Analytic Procedure

Through the use of CDA I wanted to explore individual experiences of the diagnosis of BPD, and how their internalisation of this was constructed through language. There is not one method of doing CDA and the process I used is just one approach, in fact, Fairclough (2001c) guards against allowing the process to become prescriptive, instead advising that the method be in the approach and not dictated by it. The analysis evolved over months of reading and re-reading the transcripts. There is no 'recipe book' for CDA and the approach requires a good enough knowledge of linguistics to enable the analysis to be performed. This was the first time that I had attempted to employ this methodology, and it is not one that has been widely applied within psychology research, this required me to engage in an extensive period of time gaining understanding of the terminology, process and broad methods, effectively learning a new language. I had to become familiar with the discourse of CDA. My aim in this description of my analytic procedure is to demonstrate the process that I undertook, explain important aspects of the approach and provide explanations of the terminology. I hope to do this in a way which makes CDA accessible to all readers.

The analytical process was undertaken as a modified version of the analytical framework used by Fairclough (2001a, 2003, 2009) and considered the ideas of Bhaskar (1993) and Sims-Schouten, Riley and Willig (2007). The framework for analysis according to Fairclough's (2009) dialectical-relational approach to CDA is a four stage process, followed by critical reflection upon the process of analysis, however, he identifies this is not a prescriptive process and does not dictate the order in which presentation of the analysis should occur. Table 3-1 identifies this framework and how I modified it to my research.

Fairclough's Stage Number	Fairclough's description of stage	Chapter in which each stage is considered within this research
1	Identify a social problem	Chapter 1 - Introduction
2	Identify obstacles to the problem being tackled	Chapter 4 – Analysis
3	Consider whether the social order needs the problem	Chapter 5 - Discussion
4	Identify whether there are any ways past the obstacles	Chapter 5 - Discussion

Table B.3-1: Fairclough's (2009) CDA Analytical Framework

Relating Table B.3-1 to my own framework, Stage 1 relates directly to my Introduction in Chapter 2, positioning the problem of BPD diagnosis and treatment in relation to its psychological, legal, psychiatric, political, anthropological and sociological contexts. Stage 2, which I shall describe in more detail in B.3.6.1, relates directly to analysis of my interview transcripts in Chapter 4. This stage involves conducting a linguistic analysis of the text⁵ (description); the text in relation to other associated communicative events and chain of other social events (intertextuality); the discourses drawn upon within the text and how they are (interdiscursivity); the content, constructions and positioning appearing in the text (interpretation); consideration of the constructions in terms of ideologies through social analysis of the topic (explanation); consideration of the extra-discursive features as described by Sims-Schouten et al. (2007). Stages 3 and 4 then relates to my discussion, in Chapter 5, what the analysis suggests about the BPD diagnosis, treatment, the ideologies and institutions that are involved in it, and how this impacts upon individuals. I also consider potential ways in which counselling psychology can assist with regard to the navigation of individual, organisational and system obstacles both in professional practice and through academia and research.

In order to conduct the analysis I initially identified the questions that I wanted to consider in relation to the texts. The purpose of identifying these questions was to guide my analysis and keep it focused, such that I could return to the questions to consider what each part of the process was telling me in relation to them. The questions I used are in Table B.3–2.

⁵ 'Text' is used to refer to the interview transcripts. Within DA the term 'texts' is used to refer to any communicative event which can be examined by means of discourse analysis as a 'speech' event that is meaningful and as such may include but it not limited to written text, conversations, speeches, music, art.

How do participants construct their experience of BPD as a phenomenon?
How do participants construct their experience of the diagnosis?
How do participants construct their experience of treatment?
How do participants position themselves through their constructions?
Considering the Genre chain what are the participants trying to do by making those constructions?
What do these constructions suggest about the ideology of the social practices which are represented in their talk?
What are the dominant discourses apparent within their talk and through their constructions?

Table B.3-2: Questions guiding process of analysis

The process of analysis involved continuous repeated reading of the transcripts (texts), for a number of reasons. Firstly, as there are a large number of textual features to consider throughout the process and it would not be possible to identify them all on a first reading. Secondly, this prevented me from conducting an analysis based on my initial thoughts, opinions, ideas, which could have been influenced by my context at the time of reading, by returning to the texts I was able to determine whether they had changed at different points in time. Finally, the interviews were rich in content and in order to be able to consider the texts in relation to each other I needed to ensure I was constantly refreshed of the individual and collective content. I also listened to the audio recordings of the interviews regularly as this enabled me to focus on the texts from an audio rather than visual perspective, which assisted with the analysis in relation to changes in tone, volume, tempo, and audibility. It was also useful to return to the notes that I made about non-spoken features of the text, which I made following the interviews, in relation to the audio. This enabled me to identify the visual picture that was constructed for me by each participant in the way that they presented themselves visually and audibly.

As identified at the beginning of B.3.6, the approach taken was founded in the dialectical-relational approach of Fairclough (2009). This means that all aspects of the analysis are considered to be linked and related to each other. Hence the process of describing the steps of analysis is complex. The procedure for carrying out the analysis involved moving in and out of each type of analysis throughout. Thereby, while conducting the descriptive stage of the procedure, or linguistic analysis, I was also considering how this related to other

communicative events that the individual may have been involved in and how these may have influenced or been integrated into the constructions within the interview transcripts, defined by CDA as intertextuality. In addition to this I considered what other discourses an individual may have had access to and how these influenced when they were integrated into the discourses apparent in the transcripts, defined by CDA as interdiscursivity.

When an individual takes an aspect of a discourse and integrates it within their own discourse, for example 'depression' comes from a psychiatric discourse and an individual may use it within their own talk about how they feel on a general basis, this is known within CDA as contextualisation. When the integration into a new discourse changes the meaning of the original term this is described as recontextualisation. Further while conducting the linguistic analysis stage of the overall process, I considered what the structure and content was indicating about the underlying ideologies through a process of social analysis. In its most basic form social analysis involves considering how different aspects of society, history, culture and politics may have influenced both the individual's constructions of events, experiences and people, as well as the creation of the ideologies. Diagram B.3-3 identifies this process visually, as identified by Fairclough (2001a). In essence this presents description, interpretation and explanation as occurring as an integrated process rather than an isolated sequential one.

In this analysis I define ideology further, as identified with Marxists, as the world-view of the dominant group in society. This is something which is maintained by, or created by, the most influential people in society. This ideology may be influenced by political positioning, hierarchical status within a community, socioeconomic experience, education and other social factors as well as cultural. These ideologies can become problematic when they disadvantage those who do not belong within the most dominant groups within society, or when their purpose is for social control of others which is not explicit or transparent; and those who are placed in a lesser position as a result of the ideology believe that their position is necessary and required. **Hegemony** is the term used to describe how this dominant group maintains its dominant position through non-coercive means by convincing individuals, groups, communities, nations that this position is the right one, or required, or necessary for social order and represents the 'truth' (Gramsci, 1971).

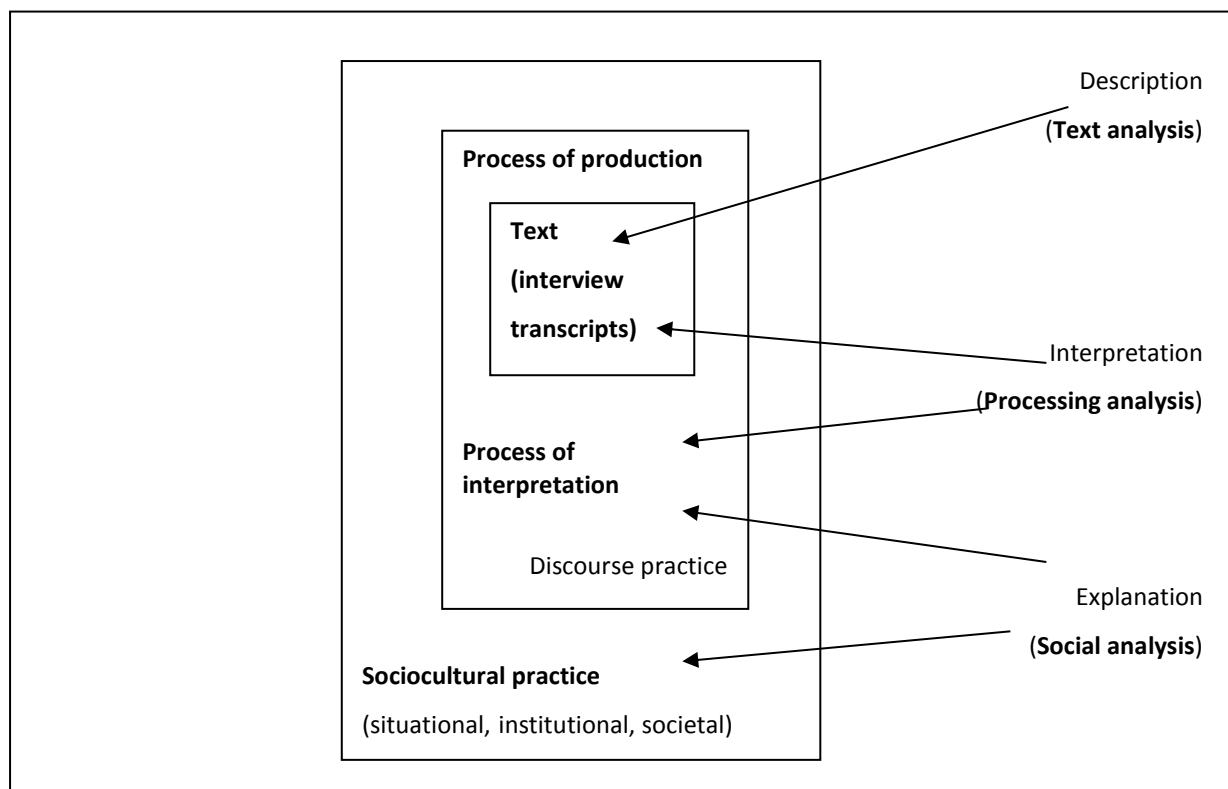


Diagram B.3-3 Graphical representation of the process of analysis as described by Fairclough (2001a)

B.3.6.1 Analytical procedural steps

After transcribing each interview (time scales for this transcription are identified within Appendix 12) I undertook the following procedural steps, with regard to these steps I was continually considering the grammar, vocabulary, intertextuality, interdiscursivity and social factors involved throughout the process. I spent time returning to theory and research to consider my thoughts around the analysis. Therefore, they should not be considered to be a fine detail recording of my steps as this is not possible due to the nature of the methodology. The intention of these steps was to enable me to obtain information which would answer the questions identified in Table B.3-2.

Initially I considered the choice of vocabulary, with regards to content, knowledge, beliefs, expressive value and metaphors; and grammatical choices with regard to their experiential, relational and expressive values (Fairclough, 2001a). I also considered what these suggested about the individuals interpretation of the context in which the research interview (social event) occurred; where they positioned themselves and others, and what roles they placed themselves in. I used the questions identified in Table B.3-4 as a guide when going through each transcript. I then produced a summary of the answers to these questions for each participant for ease of reference.

<u>Difference</u>	Which (combination) of the following scenarios characterize the orientation to difference in the text? an openness to, acceptance of, recognition of difference; an exploration of difference, as in 'dialogue' in the richest sense of the term an accentuation of difference, conflict, polemic, a struggle over meaning, norms, power an attempt to resolve or overcome difference a bracketing of difference, a focus on commonality, solidarity consensus, a normalization and acceptance of differences of power which brackets or suppresses differences of meaning and over norms
<u>Intertextuality – Between the network of texts</u>	Of relevant other texts/voices, which are included and which are significantly excluded ?
	In relation to the speaker and to other voices how are these voices reported? (active/passive; negative/positive)
	Are attributed voices quoted (directly reported) or indirectly reported ?
	Are other voices attributed specifically or non-specifically
<u>Assumptions</u>	What assumptions are made? Existential – about what exists ; Value – about what is good or desirable ; Propositional – about what is or can be or will be the case
	Are any of these potentially ideological? (supporting the view of a dominant institution)
<u>Semantic/ grammatical relations between sentences and clauses</u>	Predominant semantic relations between sentences and clauses? Causal (reason - because, consequence - so, purpose – in order to) Elaboration; Contrastative – but; Conditional – if; Temporal – when; Additive – and;
	Higher-Level Semantic Relations? – e.g. Problem-solution
	Are grammatical relations predominantly: Hypotactic - one clause is subordinated by the other (but, because, when) paratactic – clauses are grammatically equal or coordinate (and) or embedded – once clause functions as an element of another clause or as an element of a phrase (where I would put commas or brackets round)
	Are particularly significant relations of equivalence and difference set up in the text? hedging expressions - instead of, rather than; kind of; sort of
<u>Exchanges, speech junctions and grammatical mood</u>	Activity exchange or knowledge exchange?
	Speech function: Statement, question, demand, offer – (as it appears)
	What types of statement are there: Statements of fact - about what is, was, has been the case Evaluation - (about people, things etc) Hypothetical – (I might – statement given certain conditions) Prediction – (I will – future statement)
	Are there metaphorical relations between exchanges, speech functions or types of statement: Demands which appear as statements Evaluations which appear as factual statements – treated as 'what is known'
	What is the predominant grammatical mood: declarative, interrogative, imperative?
<u>Representation of social events</u>	What are the predominant process types? Material - 'doing' something (a material action) Mental - phenomena such as state of mind or psychological event (think, know, feel, smell, hear, see, want, like, hate, please, disgust, admire, enjoy, fear, frighten) Verbal – speech realised by verbs such as 'said' 'say' Relational - realised by the verb or other copular verb ie seem, become, appear, have, own, possess Existential – about what exists only
	Are there instances of grammatical metaphor in the representation of processes? Verbs becoming nouns - nominalisation
	How are social actors represented activated/passivated – Is the social actor the Actor in processes (loosely, the one who does things and makes things happen) or the Affected or Beneficiary (loosely, the one affected by processes)

	<p>personal/impersonal - social actors can be represented impersonally such as referring to the police as 'the filth'</p> <p>named/classified – represented by name or category (Fred Smith or the Doctor)</p> <p>specific/generic- where social actors are classified is it a specific group within the classification or more general</p>
<u>Identities – (Styles)</u>	What are the features that characterise the styles that are drawn upon body language, pronunciation and other phonological features, vocabulary, metaphor, modality or evaluation?
	What styles are drawn upon in the text?
<u>Modality – modality choices can be seen to texture how people self-identity</u>	What do interviewees commit themselves to in terms of truth?
	To what extent are modalities categorical (assertion, denial, etc)? Knowledge exchange: Statements: authors commitment to truth: Assert: The window is open Modalise: The window may be open Deny: The window is not open Questions: author elicits other's commitment to truth Non-modalised positive: It the window open? Modalised: Could the window be open? Non-modalised negative: Isn't the window open?
	What do interviewees commit themselves to in terms of obligation? Activity exchange: Demand: authors commitment to obligation/necessity Prescribe : Open the window Modalise: You should open the window Proscribe: Don't open the window Offer – author's commitment to act Undertaking: I'll open the window Modalised: I may open the window Refusal: I wont open the window
	To what extent are they modalised (with explicit markers of modality)? (modal verbs: can, will, may, must, would, should etc)
	What levels of commitment are there where they are modalised? modal adverbials: truth: high –certainly, must have; median – probably, will have; low – possibly, may have; obligation: high – required, must; median – supposed, should; low – allowed, can Other markers include: in fact, obviously, evidently, usually, often, always – Hallidays modality of usuality; Sort of, kind of; speakers intonation also indicates level of commitment
<u>Evaluation</u>	To what values (in terms of what is desirable or undesirable) do authors commit themselves?
	How are values realised – as: evaluative statements – statements about desirability or undesirability (what is good or bad)? statements with obligation/necessity – use of modal adverbials etc statements with affective mental processes – subjectively marked evaluations ie I like this or assumed values – less apparent according to markers for example 'helps to....' Assumptions of shared familiarity, belief in shared values
<u>Legitimation – Is there any evidence of this?</u>	Authorisation – legitimation by reference to the authority or tradition, custom, law and or persons in whom some kind of institutional authority is vested
	Rationalisation – legitimisation by reference to the utility of institutionalized action, and to the knowledges society has constructed to endow them with cognitive validity
	Moral evaluation – legitimation by reference to value systems
	Mythopoesis – Legitimation through narrative
<u>Ideational</u>	How is the thought of the author transformed into the message?
	What can we infer about what author trying to do?

Table B.3-4 Fairclough (2003) Textual Analysis Checklist (adapted) (p.191-194)

Following this I returned to the transcripts and identified the different constructions and discourses that appeared within them. The discourses were identified by considering the items in Table B.3-5. This resulted in the identification of 54 possible discourses. I was then able to identify those which were repeated, occurred frequently, or could be considered as part of a larger discourse framework identifying 9 discourses.

I then returned to the texts and collated all the samples of text from each of the transcripts under each discourse. This then enabled me to identify what the text was trying to do or construct in relation to that discourse. Once I had done this I was able to identify the constructions present within each discourse. Of the 9 discourses it was then apparent that 6 could be considered within the other 3 according to what was being constructed by the participants. This provided me with the 3 dominant discourses: blame, stigma and recovery.

Following this I revisited the texts again with regard to each dominant discourse and considered further the social determinants, ideologies and effects of these discourses. Throughout this process I considered intertextuality, recontextualisation, interdiscursivity. With regard to intertextual analysis I considered that for each individual their interviews drew upon other conversations relating to BPD involving professionals/friends; other research interviews; interviewees own 'research' relating to BPD. The interview also took place in a chain of other social events related to this one: responding to advert, emailing, making arrangements, meeting participant, contact following interviews, receiving feedback upon completed research. As a specific genre of social practice I considered the semi-structured psychology research interview to be placed amongst other social practices which these participants may have experienced including: psychiatric appointments; appointments with mental health professionals; receiving treatment; work place behaviour. When considering the individuals reasons for participation and, consequently the purpose for which they constructed their talk it was important to consider the genre chain, and this I determined to be: the research interview; then the transfer of my findings to thesis; the transfer of thesis to scientific journal; and finally the potential for the research findings to influence possible social change.

Next I had to determine which sections of text I would use within the analysis section to present what I had discovered. This was a matter of identifying those which provided the strongest examples of the discourse while also being rich with information regarding discursive constructions, subject positioning, use of vocabulary and grammar.

What I have presented in the analysis section are the dominant discourses as I identified them. With regard to the main constructions within those dominant discourses, another researcher may have chosen to label these differently or to identify other constructions, as the interview texts were rich with these, however, as a result of the scope of this research I had to determine those which occurred mostly frequently or represented deviation, not agreeing with other discursive constructions. The result of this is presented within the next chapter

Discourse identification
Think of discourse as: (a) representing some part of the world and b) representing it from a particular perspective
So in text analysis:
Identify the main parts of the world (including areas of social life) which are represented – the main 'themes'
Identify the particular perspective or angle or point of view from which they are represented
What are the features that characterise the discourses (semantic relations between words, collocations, metaphors, assumptions, grammatical features)?
Identify the relevant classification systems (what words are used that belong to that classification system and enable us to understand what is being talked about without being explicit) – synonym, hyponym, antonym
Identify what vocabulary is used but also how it is used

Table B.3-5 Fairclough (2003) Discourse identification checklist (adapted) (p.193)

B.3.7 Credibility of the research and dependability of the data

Qualitative research data is by definition naturalistic (Willig, 2001), therefore, it has been argued that the same positivist paradigm of quantitative research cannot be appropriately applied. Instead Merrick (1999) describes the qualitative equivalents to validity and reliability within quantitative research as credibility (validity) and dependability (reliability).

Within my interviews one of the credibility controls involved summarising and paraphrasing regularly what I thought the participant was saying, and at the end of the interview I summarised the main points that I thought the participant had said, this is a method highlighted by a number of researchers including Potter (1996) and Willig (2001). A major part of the quality measure within my research involves reflexivity, relevant not only because of the qualitative methodology but also because of my social constructionist position. I have reflected upon my position within, and impact upon, the process throughout the research. This highlights where my perceptions and discourses influence the text and my analysis of it (Willig, 2001). While qualitative research is less concerned with 'reliability', there is a difference in opinion between researchers about its importance. However, because of the transparency of the analysis and reflexivity it should be possible for another researcher to examine my data

and identify how I reached my conclusions (Silverman, 2005) referred to by Potter (1996) as readers evaluation.

The sample I used was self-selecting, while participation was determined by the individual, the sampling strategy enabled over 10,000 people (statistics provided by Google ad account) who were searching for information on the internet to access the research if they wished. The Google Ad was shown 10,000 times when certain keywords were keyed in; this provided a link to the website. Therefore, with regard to representativeness it is possible to assume universality within groups of individuals with the BPD diagnosis who have similar discourses, as suggested by Willig (2001). In addition, this analysis can build upon the small body of work conducted in the field already on the experiences of individuals with the diagnosis of BPD, identifying coherence in the data (Potter, 1996). In addition, coherence highlights any deviance in patterns and whether there are any special features of the deviant-cases which provide explanation, if not then this can be determined to be a pattern which is 'unreliable' (Potter & Wetherell, 1987).

B.4 Chapter 4: Analysis

B.4.1 Setting the scene - Introduction to the Chapter

In this chapter I present the results of the Critical Discourse Analysis (CDA) which I conducted on the interview transcripts using the analytic procedure outlined in C3.6. I begin by briefly introducing my participants, setting the context for the analysis. Following this I will present the discourse framework, identifying the dominant discourses I determined through my analysis and present the evidence for these. After drawing this chapter together in a summary, I will then present my reflections on the process of analysis, in conjunction with the considerations and difficulties I was presented with through the analysis.

Where I provide quotes⁶ I have differentiated between texts with fictitious names, as identified in B.4.2. Individual identities have been protected, and where names of people and places occur in the quotes the specifics have been removed and replaced with general categories or the fictitious names identified by italics. In order to aid understanding of the linguistic analysis some words in quotes have been placed in bold to identify those to which I am referring.

B.4.2 Introducing my research participants

Each one of the individuals who responded to my research advert is unique. Their life experiences, educational, economic, cultural and social backgrounds, as well as biology, result in this uniqueness; they are heterogeneous. Despite their heterogeneity, just three words bring them together with a single diagnostic category used to describe their collective experience, BPD. It is apparent from my interviews with them that after this categorisation all individuals, no matter how variant their experience, are considered only in relation to these three words. Perhaps unsurprisingly individual meaning is lost; cause is glanced over, and prospect of recovery unconsidered in relation to the individual. Nonetheless, each in their own individual way seeks resolution of these issues, and the diagnostic category appears to fail to provide these answers either directly or by indirect consequence.

Appendix B13 provides a brief description of each participant. It presents the participants in a way which enables the readers to have a greater understanding for their discursive positioning and use of discursive constructions. These are real people and each has come to participate in

⁶ There are many quotes which have not been included as examples for this section, this is due to the need to manage the qualitative data effectively so as not to include superficial data which dilutes the presentation of the results, and also due to limitations on space. However, I consider the implications of this and my position as transcript editor within my reflections as this presented a significant challenge.

this research for their own reasons, and thus their language can be viewed to be constructed accordingly. I believe that as a scientist-practitioner I have a duty not only to further the knowledge of the field of counselling psychology for the benefit of future generations, but also to do justice to the voices of those in the present. I hope that I have accomplished this within my analysis.

In keeping with the qualitative methodology, I have selected fictitious names for each interviewee, these names were the most popular in England during the 17th Century, pre the diagnostic classification systems that we know today, and pre-borderline concept. The names were chosen from the Top 50 names, as identified by Smith-Bannister (1997), selected in alphabetical order. From hereon the participants will be identified as Anne, Beatrice, Clemence, Dorothy, Ellen, Francis, Grace and Helen.

Some of the experiences of these individuals are similar: each has experienced varying types and degrees of childhood trauma; each has received additional diagnoses over the years; each is looking for an explanation, a meaning, an answer to the enigma of an experience labelled BPD, and seeks to resolve the dilemma of permanence that the diagnosis clearly brings with it. Stigma, blame and recovery all fall within the overall enigma of the disorder and are the dominant discourses apparent within the transcripts.

B.4.3 Discourse Framework

One of the most striking features of the interviews was the presentation of BPD as an enigma. Across the 8 interviews it became clear that while the use of a label had brought with it, initially, a sense of identity, of belonging, of relief even for many. The term itself and the method by which it was presented to the individual resulted in more questions than answers; a loss of meaning and increased lack of understanding between and within people. The impact of this apparent void, this unexplained phenomenon being dependant upon the individual and the coping resources they employed, along with the availability of certain types of treatment. The dominant discourses apparent throughout all the interviews adding to the construction of this enigma were those of blame, stigma and recovery. Figure B.4-1 identifies the discourse framework visually as I perceive it to have unfolded across the interviews.

The Venn diagram, in Figure B.4-1, represents the overlapping dominant discourses and the point at which they each overlap identifies the enigma construction. While each discourse contributes to this phenomenon, they cannot be seen to be distinct from each other, they are dialectically related. Each can be said to be separate from one another and Enigma as well as

being part of it. The external circles represent the main discursive constructions of the dominant discourse; that is the ways in which the participants chose to construct or represent the diagnosis of BPD, which were identified as contributors to the dominant discourse. That is not to say they were the only constructions, however, these are the most frequently occurring ones that I have chosen to discuss within this Chapter.

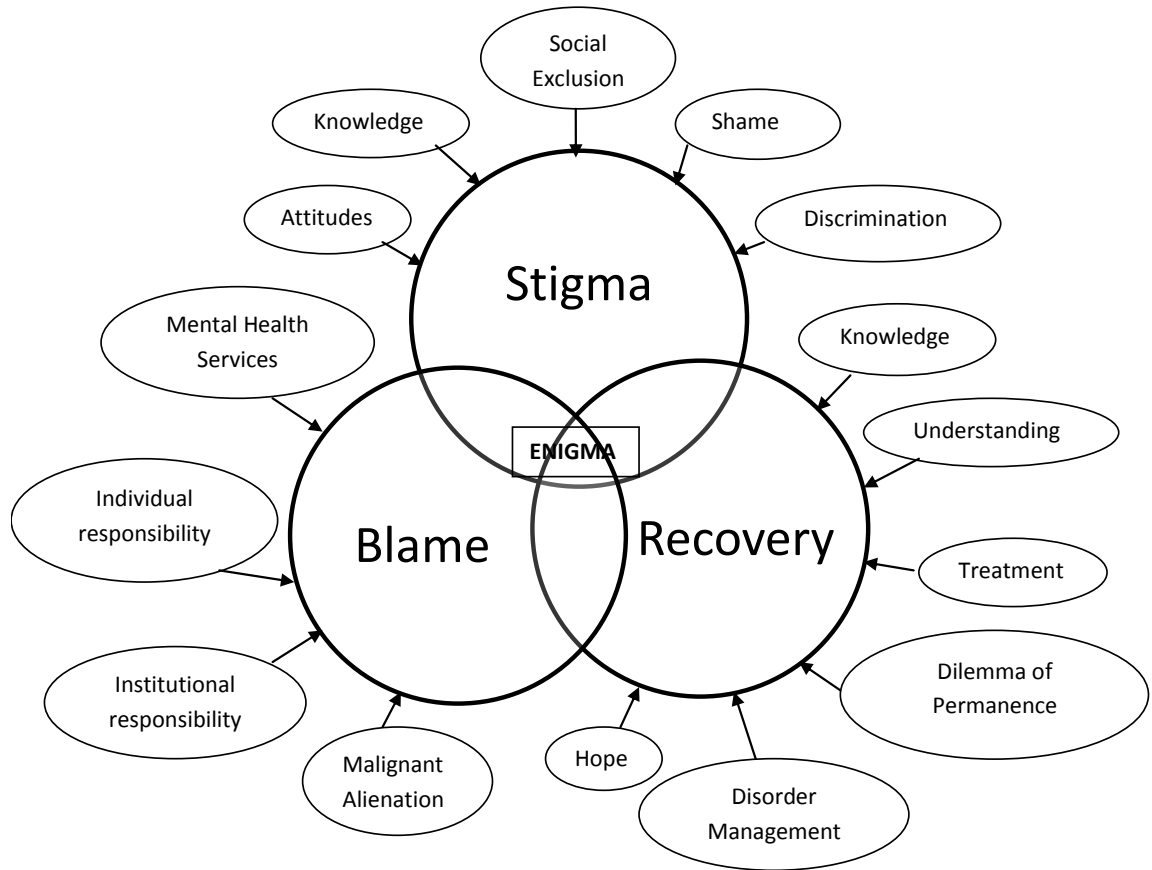


Figure B.4-1: Discourse Framework

B.4.3.1 Enigma

Upon being asked how they would describe BPD to somebody who had no knowledge of the diagnosis most of the participants struggled to define it. Extract 1, from Anne's interview, highlights how difficult she found it to describe. Her dialogue was stilted and her statements were spoken with uncertainty, there are significant pauses in the text, which are not apparent in the rest of the interview which was free-flowing and spoken with assertion and certainty. As identified in B.4.2, those who are diagnosed with BPD are a heterogeneous group; Anne's struggle to define the diagnosis appeared to result from this heterogeneity. Also Anne appears to have become so familiar with referring to her collection of symptoms as BPD that she is no longer able to describe what the term means to her.

Anne: I think I would say it's (3) the main symptoms for me are that you're that you (3) it's very difficult this question isn't it that it's about mood swings you might meet people that have go sort of from one extreme to the next within minutes. Erm that people that just seem not friendly a bit sort of withdrawn erm they are sometimes incredibly eccentric sort of odd ((laughs)) erm that (3) I don't I think I'd probably I'd have to maybe I'll just think about it hold on a minute I'll write it down for you and I'll give you a book on it ((laughs)) I think I think it's really difficult I think there's so many things about it that actually it would take you hours and hours to talk about it because we are all different.

Extract 1: Anne

This extract from Anne's interview also demonstrates a switching between talking about collective symptoms and her own experience. While her tendency to talk generally about a collective experience may be related to her positioning and role within her social context as campaigner; it also highlights that for each person the experience is unique and without reference to this individualism the diagnosis cannot be accurately defined. Overall, this appears to construct BPD as an enigma, something which is difficult to define, a mystery, with no clear or simple answers.

Similarly to Anne, Francis had difficulty defining the problem without reference to the diagnostic label. He speaks less fluently in Extract 2, compared to the rest of his interview. He resorts to defining it in terms of being different to 'normal' personalities. However, this presents a further difficulty in determining what 'normal' personality represents. He directly references how hard it is to define something without referring to the diagnosis. When Francis received his diagnosis (Extract 47) he did not ask any questions about it or receive any information about what it meant in his past, present or future, he simply accepted the

diagnosis as a simple answer to the problems he had been experiencing. The diagnosis itself appears to have removed meaning for him, in the same way that Anne has spent so long referring to the diagnosis, so has Francis. Again, similarly to Anne, Francis attempts to answer the question by referring to the collective experience of those diagnosed with BPD. For both Francis and Anne there is an apparent reliance upon psychiatric discourse. When they are unable to use this to define their experience they struggle with identifying an alternative discourse to use. This presents an enigma, something which appears not to exist in the world outside of psychiatry, indescribable outside of the psychiatric discourse community.

Francis: What would I tell them erm ((laughingly)) what would I tell them erm (5) that's a tough one yeah ermerm well I mean at first you know would I go about it erm because I mean you've got your sort of normal your normal personalities as it were erm what's seen as normal personality and they'd see themselves as different wouldn't they so it would be like erm (4) oh I don't know ((laughs)) how would I go about that. I never I honest I never thought of that erm (4) no naming system it's really hard ((laughs)) can you give me an easier one....Erm

Extract 2: Francis

For others they found that defining BPD involved discussion of an inability to control emotions or as disorder of the emotions. They appeared to find it slightly easier than Anne and Francis to think about and describe. This was true for Beatrice, Dorothy, Ellen and Grace. Interestingly, what appears to be the same for all is that in order to define it, there is reliance upon individual experience despite the diagnostic label itself implying homogeneity.

Beatrice: Well I would say the first thing that it's a it's a disorder of the emotions and it's basically like having the mind of a child (I:Okay.) trapped in an adult's body and that when distressed they regress to a childlike state. The worst thing someone can do is kind of pull yourself together or raise your voice or insult someone this will escalate the anxiety and the attack.

Extract 3: Beatrice

Beatrice, in Extract 3, likens her experience to that of a child's emotions, however, she generalises this through the use of evaluative statements, which appear as facts, and through the imperative mood; she relies upon metaphor and psychological discourse to illustrate her description. By presenting her response in this way Beatrice seeks to construct a sympathetic position with her difficulties and a reduction in expectations of personal responsibility. Children are not generally held responsible for their emotions and behaviours in the same way as adults. Beatrice's description of BPD uses a collective pronoun (they), however, it is apparent that this is a construction of the way she experiences BPD and what she believes

would be helpful to her. The contextual information required to determine this relates to her having had very minimal contact with anybody else who has the disorder. Her information is also assembled from the many books she has read on the topic, she brings this into her own discourse and makes use of phrases such as 'regress to a childlike state'; 'escalate the anxiety'; and 'disorder of the emotions'.

Dorothy:	Erm (6) I would say that it's basically where you can't control your emotions in the way that normal people do and you can't deal with things like stress as well as ordinary people do or the majority of people do. Erm and (4) you can't erm what is it ((laughingly)) I don't know
I:	It's okay it's not it's not a test you're all right it's it's just really kind of erm how do you assist them to understand the problems that you experience
Dorothy:	Erm (3) like when like the majority of the time I'm pretty okay I'm pretty well it's like I just fly off like I I don't I think I just say to them that I can't deal with stress or like and I can't deal with emotions like if I get angry I can't cope with it I don't know how to cope with it I don't know how to like process it properly so I just fly off the handle or overreact a lot all the time I over react. My mum would say I'd a drama queen or whatever. Yeah and people do often say you're so you're so fucking dramatic <i>Dorothy</i> you're such a drama queen and ((laughingly)) this that and the other. So erm I think I just say look it's my it's to do with my emotions that I can't deal with them and stress I can't cope with a lot of stress.

Extract 4: Dorothy

Dorothy and Ellen also construct the diagnosis as emotional disorder. There is a focus within both their interviews upon dislocating blame by identifying that the problem lies outside of their control. Dorothy, in Extract 4, refers to 'normal people' and 'ordinary people' and then falters struggling to find a way to describe it further. After a further prompt on how to think about the question she provides examples of being unable to control her emotions. Her description contains an element of simplicity, purporting that it is too difficult to explain 'So erm I think I just say look it's my it's to do with my emotions that I can't deal with them and stress I can't cope with a lot of stress'. This statement is an attempt to construct the experience in terms which appear in most everyday language, the concept of stress. Within this there is the value assumption that 'normal people' can and should be able to cope with stress.

Ellen draws on medical and biological discourse in her interview, identifying the cause of the problem as the 'amygdala', again dislocating blame by placing her problems outside of her control. Both Dorothy and Ellen, similarly to Francis, present their description as one of

difference, being different to most people. This relies upon an assumption that there is a commonly held agreement about the way human beings should manage their emotions. However, this is something which is determined according to the current social order, historical and cultural factors. Therefore, this is an assumption which is socially constructed. If we examine emotions through the ages and across different cultures, there are different views and perceptions of 'acceptable' emotional expression. Therefore, on its own their description of the problems experienced does not provide enough information to clearly define the diagnosis, once again suggesting somewhat of an enigma. There is a reliance upon psychological discourse which is unlikely to have been available to them had they not been brought into contact with the mental health system, for example terms such as: 'stress'; 'process it properly'; 'I can't always regulate them'; these identify the psychological discourse available to them.

Grace:	I would tell them (8) that it you can be very much controlled by your emotions. That those emotions can fluctuate within hours so you can go from feeling intensely happy and euphoric to suddenly feeling very low erm (5) that (5) you're constantly doubting people that it's impossible to form any kind of half decent relationship with anybody because you're constantly ((sighs)) (3) looking further into them looking at what their real erm (3) what their intentions are between about being friends with you. Erm you become very paranoid and see things that are not there erm you read people (3) from not just what they're saying to you but the way they're looking at you erm the way they're smiling at you. (8) One minute you hate them for the stupidest of things and the next you're completely idolising them. Erm you go from wanting to push them away and never have anything to do with them again to ten minutes later being completely scared that they're going to leave you. (I:Hm.) Erm (10) and when you've got those feelings they come from so deep inside (4) the anxiety you literally feel just ill with it (5) and you just cannot control it at all until you literally just burst with it all and then you either end up hurting yourself or you you hurt other people because of it
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Extract 5: Grace

Grace provides perhaps the most distinguishing description of the diagnosis in Extract 5. She provides examples of how the criterion of the diagnosis applies, stating relationship problems and mood regulation difficulties. She also attempts to convey the intensity of the experience 'those feelings come from **so** deep inside (4) the anxiety you **literally** feel ill with it (5) and you **just** cannot control it at all until you **literally just** burst with it'. The placement of the adverbs, represented in bold type, emphasise extremes of the actions that follow them. This presents the experience somatically, an attempt to construct an empathic position within me as the

listener and others who may come across her text. Grace retains her position as mental health professional by using collective pronouns, she does not use 'I'. This may be an attempt to distance herself from the experience and retain her role as a professional. However, her pauses are significant and require her to call upon constructions of her own experience to describe the features of the diagnosis. Grace uses extremes to describe the experience: 'euphoric', 'constantly', 'impossible', 'completely'.

Grace's construction of the diagnosis provides the reader with a sense of what the diagnosis means by way of its symptoms. Upon considering how Grace has been able to do this, I referred to the discourses available to her. As a mental health professional working in secondary care mental health services she is familiar with the diagnostic criteria, this provides her with an awareness of the features of the diagnosis in psychiatric discourse. Her personal experience of those features enables her to relate the parts which are relevant to the diagnostic criteria. Also, a good friend of Grace's went through each criterion in detail and applied them to her behaviours, this appears to have brought meaning to the diagnosis which the other participants did not have available to them.

Clemence: Borderline personality even to this day I still don't understand it I just don't what borderline to what. (I: Hm). I mean I understand the historical thing I think of borderline between psychosis and neurosis erm I think that's where it comes from I'm not entirely sure on that. Erm and I can und-- I understand where it come from but it seems so out of date it doesn't actually say anything you know what does it mean I can't get it you know.

Extract 6: Clemence

Helen: Er I think the shortest answer to that would again be erm like a professional term that border line between psychosis and neurosis

Extract 7: Helen

Clemence (Extract 6) and Helen's (Extract 7) answers further present evidence of BPD constructed as an enigma. They provided similar responses by reference to historical psychiatric terminology 'borderline between psychosis and neurosis'. However, this defines the diagnosis by reference to other diagnoses. Clemence clearly identifies her struggle with constructing the meaning of the diagnosis and how this does not appear to provide any answers, merely a holding term perhaps, something to refer to an experience by when you are not really sure what it is. She also demonstrates her lack of understanding of the term, 'I can't get it'.

Helen: someone hands you a label and you're not really sure what it is that you're you know... it was like bestowed on you but I didn't have a clue about it. All I know was out of you know I displayed all these these behaviours I guess that's what it is isn't it it's all this erratic behaviour erm you know..

Extract 8: Helen

Helen's choice of vocabulary (Extract 8) indicates being given something important which is not understood or perhaps deserved, 'bestowed'. She provides reference in simplistic terms to behaviour which she was unable to understand either, 'erratic', as her only available understanding of where the diagnosis came from. Further on in the interview Helen states the vocabulary used in the diagnosis is actually advantageous as it presents 'an enigma it's like people don't actually know what it is which is great in fact'.

All the participants, with the exception of Grace, construct BPD as an enigma when asked to define the diagnosis. This is apparent through the inability to determine the meaning of the term. Grace, as a result of her working for the NHS within a secondary care mental health setting, has access to discourse which is not available to the other participants, consequently she presents what appears to be missing, that is understanding the diagnosis as it relates to them as individuals, how she has come to understand the enigma. In the next sections of this Chapter I will move on to consider the three dominant discourses which appear to further construct BPD as enigma.

B.4.3.2 Blame

Apparent in all the interview texts was the struggle with regard to blame and the question of responsibility. This was something that was debated throughout all the interviews, with each participant positioning themselves in relation to the discourse of blame. This discourse varied across the interviews with regard to overt constructions of blame, or responsibility, and those which appeared to be a response to an unspoken question with regard to implications of blame, either in relation to the symptoms of the disorder or the question of the effectiveness of treatment. The participants positioning appeared to be related to the extent to which the individual had resolved, what I would identify as the dialectic of responsibility.

Ellen: I think I think really that I think it would be so helpful if there was erm a a manual a book or something to help people when they're when they're actually ready to look at it to actually say look this is this is the situation it's not your fault it's happened probably because of this and these things might help you I would say. ((clears throat)) And and also that if if people like MIND or people are writing leaflets if they could get the reason the little sentence about why the mind doesn't regulate before the actual er description of symptoms because that's hideous ((laughs)) do you know what I mean and at at least you know because of (I: Hm.)...because of A B occurs where it seems to be at the minute on a lot of the articles and things that I see erm these are the symptoms but there's only you know it doesn't cover I think the causes should be put before the symptoms and then it's less of a blow ((laughs)).

Extract 9: Ellen

Within the interviews there was evidence of the assumption of blame for the 'disorder', with some of the participants explicitly identifying the need for mental health professionals to state that they were not to blame. For example in Extract 9, Ellen uses a verbal process to suggest they say 'its not your fault' when informing them of the diagnosis. When participants moved their grammatical mood from declarative to imperative they highlight the importance of allaying such assumptions. This was evident in all the interviews when the participants were asked whether anything needed to be added to treatment and diagnosis of BPD, the mood was imperative, this may have been as a consequence of my sentence construction or phraseology, or it could be as a means of expressing their opinion to the powerful object that is the mental health discourse community.

The use of evaluative statements involving mental processes identified by words such as 'think' 'feel' 'fear' 'see' suggest opinions and beliefs. Commitments to statements and the 'truth' tend to be expressed moderately through words such as 'could', 'might', 'probably', 'would' indicating an intention not to appear to directly challenge the way things are done but suggest an alternative. This avoidance of direct challenge positions the mental health professionals as powerful, unapproachable 'experts', holding the answers. This possibly a result of considering those with BPD to be 'blameworthy', and therefore, undeserving of help and support, implicitly the suggestion exemplified in Ellen's, Extract 9, that the interviewees feel judged by the mental health professionals presenting somewhat of a paradox.

Using Extract 9 as an example, a number of the participants presented BPD as an actual event, or something which actually exists, 'its happened'. The implication behind this legitimization of

the construct is that within medical discourse there is an assumption of cause-effect-solution 'knowledge'. Each participant indicates the importance of understanding the cause of BPD, of being able to attribute a precipitating factor, 'because of A B occurs', 'it doesn't cover the causes'. This would perhaps act to allay blame, if something occurred to cause the 'disorder', such as a neurological problem, it potentially places it outside of the individual's control and therefore within moral philosophy outside of the conditions for blame to occur. In addition, the 'symptoms' are the predominant focus, with few participants conveying their understanding of the meaning behind the symptoms. The use of the word 'blow' within Extract 9 by Ellen, suggests that there is something about the 'diagnosis' which is considered significantly shocking; undesirable; or a setback, Ellen is contending that the knowledge of cause makes the knowledge of this shocking.

Grace:	I think you know the other thing that's going through my head is that (3) however it may seem you know that people are doing these things they don't actually want to be they don't want to feel like they do inside because it's torture it (I: Yeah.) it's a horrible feeling when you get to the point that you just feel like you're going to explode and the build up to that it's it's an absolute living nightmare and people don't want to feel this way no matter what professionals may say you know that they're attention seeking and they want this attention because that's so far from the truth (I: Hm.) because I think at the end of the day you just want to be normal you want to be able to have friendships and relationships (4) without always being on the edge of a cliff.
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Extract 10: Grace

There is a commonality across all the interviews with all participants describing a collective experience evidenced by their use of pronouns, particularly when relating negative experiences for example, treatment by professionals or emotions, although primarily the pronouns used are 'you', 'they', and 'its', a few participants using 'we' but only occasionally. For example, Grace in Extract 10 positions herself by non-identification with the collective, '**they** don't want to feel like **they** do' rather than '**we** don't want to feel like **we** do'. This may relate to a dialectical relationship between blame and recovery discourses. While presenting a position aimed at promoting compassion within the reader, me as the researcher in the first instance, there is also a positioning of difference and constructing the assumption of recovery. Grace positions herself with regard to the blame discourse, by challenging the idea of choice 'however it may seem you know that people are doing these things, as a campaigner for inclusion, while trying to avoid including herself as belonging to the collective through the use of 'people'.

Clemence: It's it's seen as this kind of oh it's a shit thing and it's all very awful and everything. But not enough credit is given to people who have survived it. Isn't it incredible that they've bloody survived all this stuff when they were a kid and they haven't killed themselves you know. (l: Hm.) Really and I don't think there's enough credit given to that and it's not respected enough that people have survived what they've survived and and actually the very fact that they're in therapy (l: Hm.) means that actually they want to he-- they they don't want to die (l: Hm.)you know there's a bit of them that wants to survive and wants to get better even if that bit's you know outweighed by the other shit at times you know. But I don't think there's enough credit given and I don't think people respect what you're having to struggle with. And just what a bloody nightmare it is. (l: Hm.) It's it's absolutely a living nightmare (l: Hm-mm.) you know it's every day is a living nightmare you know and it's-- I mean I sort of when I think about it now I just think Christ you know but it is it's there is this permanent deafening deafening noise in your head that is a disturbance in the whole of your body (l: Hm-mm.) and it's it's it makes you ill. You know and this disturbance this noise is trauma which you can't process you can't make sense of. Nobody else can make sense of because they're speaking russian and and it's it is an absolute nightmare it really is. And I hope to god I never ((laughingly)) have to go through it ever again.

Extract 11: Clemence

The use of the words 'torture', 'absolute living nightmare', 'explode', 'a disturbance in your whole body', as evidenced in Extracts 10 and 11, present a metaphor of agony and persecution, this implores the reader to feel compassion as opposed potentially to the value assumption of negative moral judgement. In Extract 11, 'a permanent deafening noise in your head' draws comparison to something uncontrollable, as such seeking to dislocate the blame discourse. The use of the repeated phrase 'don't want' suggests an assumption that if they did 'want' it would be a choice and therefore be worthy of blame. Grace commits herself strongly to the statement again demonstrating her position in opposition to that of the general mental health community, as campaigner for justice, 'people don't want to feel this way no matter what professionals may say'. Grace does switch between her use of the pronouns 'they' and 'you' suggesting movement in the text between her professional and personal positions, this appears to add power to her statements 'you just feel like you're going to explode', 'you just want to be normal'. The pronoun 'you' enables an author to express something as applicable to the self as well as others. This makes statements less isolating and reduces the risk of vulnerability that is inherent in revealing a personal experience.

The use of the word 'explode' depicts the metaphor of a powerful event that you have no control over and, therefore, cannot be blamed for. 'People don't want to feel this way no matter what professionals say you know that they're attention seeking and they want this attention' these statements present mental health professionals as negatively attributing behaviour of those with this particular collection of symptoms, and suggests that this is the prevailing opinion, despite, as suggested by Grace, that this is incorrect from the position of the individual. This is a proposition that the reality of the individual is quite different to that conceived by professionals.

There is reference to a desired position of 'normal' within all the interviews, for example Extract 10. The assumption behind this position being that this is a shared social value, and assumes that mental health professionals possess this value. This is hegemonic; the belief that professionals are normal protects the dominant view in society of hierarchical superiority according to status. Anybody that is not therefore considered normal cannot be worthy of consideration with regard to experience or reality. Grace in this transcript states 'attention-seeking' with an assumed value of it being undesirable and negative. The supposition is that she has experienced the pejorative use of this vocabulary as part of a discourse that is available to her through her cultural and social experience; whichever discourse this experience draws on constructs the experience as being 'blameworthy'. Thus the actual meaning of the word appears to have been lost; for example an infant who cries to attract the mother's attention, is literally 'attention-seeking' behaviour, however, the connotations are different to that of an adult who is in distress and cries out to attract care-giving, even though the desired outcome might be the same. This presents a moral value, whereby there are right and wrong ways of behaving, and an individual must request attention in ways which are deemed to be socially acceptable. To err from this implies blame for moral value violation.

Further the view of 'normality' being shared by mental health professionals presents a potential dilemma of positioning between personal and professional identities, which may identify the imperative to identify with a 'normal' subject position. Both Grace and Clemence are mental health professionals, and their transcripts clearly demonstrate the use of powerful metaphors, an attempt to convey an alternative experience to that perceived by outsiders. It suggests that it is essential to construct their experience to evoke empathy and compassion, to prevent judgement by the desirably positioned mental health professionals on account of their diagnosis, and thus resisting a subject position of 'abnormal'. Their transcripts both suggest the extreme importance of challenging the commonly held view or 'truth' about those with the diagnosis. It would seem that the price one would have to pay as a mental health professional,

if others did blame and judge you based on diagnosis would be too high and challenge professional identities. This unveils the power of the ideology underpinning the mental health communities. Further evidence of this discourse can be seen in Extract 11.

Clemence in her interview describes BPD as a reaction to trauma and in Extract 11 the subject under discussion is taken to mean the cause of the diagnosis. Clemence uses powerful metaphors and emotive language to construct the experience of trauma, to enable understanding of her position, and relocate blame attributions. The use of pronouns 'I' and 'that people' and 'they' rather than 'I' or 'we' enables a collective experience to be described while being distanced from it. Further stating: 'I hope to God I never have to go through it again'; this identifies with an alternative subject position of 'normality'.

Evident within this discourse, and as I have already identified, there is a lack of understanding and acknowledgement of the experience by mental health professionals. Clemence draws a contrast with foreign languages by stating: 'nobody else can make sense of because they're speaking Russian'. This metaphor suggests not only a lack of understanding and communication with mental health professionals but also potentially hints at a different cultural experience and the problem inherent between discourse communities, that of mental health professionals and service users with the BPD diagnosis. When constructing this lack of acknowledgement in discourse participants tend to identify more clearly to their commitment to this position of being 'devalued'. For example Clemence in Extract 11 suggests 'its not respected enough that people have survived what they've survived', although at times she moderates this by identifying that she is expressing her opinion, 'I don't **think** there's enough credit given to that'. Clemence also makes reference to the assumption of recovery being desirable, 'there's a bit of them that wants to survive and wants to get better'.

B.4.3.2.2 Blame constructed as Individual Responsibility

Francis:	what what you do you've got to do for yourself you can't rely on anyone else to do stuff for you you've got to want it and you've got to do it there's no other way otherwise you're just stuck you stay where you are. So ((laughs)) (I: Yeah wow.) Yeah I mean I've I've I've been beaten and starved and nearly drowned and I've seen people die and so just I've I've been told I've got erm erm post traumatic stress
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Extract 12: Francis

Each of the participants refers to their position with regards to a construction of internally located 'blame'. This is constructed in different ways with most participants implicitly

identifying a struggle with regards to being to blame for their problems. Use of phrases such as 'it's not my fault', 'uncontrollable force', 'it happens' suggest a desire to expressly deny blame or to identify that they are not 'blameworthy' on account of it being uncontrollable. However, a deviant case example is that of Francis who represents this internal location differently and positions himself as 'controller'. There is evidence within his transcript of the acceptance of the internal location of the problem and that if he does not seek to manage this he will be 'blameworthy'. Therefore, while there appears to be a general tendency to resist blame attributions there is also evidence of acceptance of them which has assisted in moving to a positive subject position within this attribution. However, by examining Francis' extracts in more detail there is also evidence of a rejection of elements of the discourse.

Francis positions himself as a 'survivor'; while evident within other participant's transcripts he infers reference to blame vocabulary rather than using it to construct the position. In Extract 12 he refers to extremely adverse life events 'beaten', 'starved', 'drowned' and 'seen people die'. He appears to similarly deny blame through cause in a similar way to the other participants, suggesting these are events which are outside the realms of normal human experiencing; his unspoken statements could be inferred to be 'its not my fault, I've done all I can, despite my experiences'. However, he also accepts blame with statements such as 'you've got to do it', 'there's no other way', 'you stay where you are'. This appears to link with the 'self-help' era of mental health services, as considered by Nehls (1999), such that if you do not 'help yourself' then you cannot be helped and the reason for that is internally located and thereby implies internal location of blame. With regard to this he uses the imperative mood and represents evaluative statements as facts. This demonstrates his construction of reality; his perception of the opportunities for change; and his subject positioning.

This 'self-help' construction within the discourse of blame identifies the ideology, the values and beliefs of current mental health services; and one which Francis has integrated into his own discourse. However, Francis' transcript may also provide information on the impact of this type of construction. The reason this particular discourse and positioning was open to Francis is likely to be as a result of the alternative discourse being unavailable to him, possibly as a result of his life experiences. He had to depend on himself, as do many individuals who have experienced severe and prolonged abuse in childhood with limited social support or validation. For some individuals and Francis in particular, participating in this research may have been an attempt to see whether an alternative experience would present itself to him, an opportunity to be 'helped' from his position as 'survivor'.

Francis: Erm I can be erm a little bit prone to mishap and sometimes can't do right for doing wrong you know that sort of thing. So to say to them look you know my personality thing it's it just it explains everything about me now so they can sort of understand and give me that little bit of freedom to make my mistakes because sometimes you know erm even the simplest little things sometimes can be so stressful trying to get it right that I get it wrong you know. There's still that part of me that's still goes back to the way (I: Hm-mm.) I used to be (I: Hm-mm.) you know so have to let people know. Erm it generally it generally does it becomes positive because they can sort of give me that little bit of freedom to to do what I'm doing and take the pressure off me so yeah.

Extract 13: Francis

The internal location of blame also appears to provide the opportunity for a protective or permissive positioning; one which enables mistakes to be reasoned and behaviour to be seen as a 'symptom' of the disorder. This was evident in the discursive constructions of both Francis and Anne. Both relate to the buffer this provides for them to behave in certain ways and not be held to account for this. For example Francis, Extract 13, suggests 'give me a little bit of freedom to make my mistakes', and Anne positions herself as 'never hav[ing] to grow up'. It would appear that the blame discourse can be used to rationalise some events and actions.

As described in B.4.3.1 the meaning of the diagnosis appears to have been lost for most of the participants, and this appears in part to be related to a lack of knowledge about the diagnosis, either due to information being unavailable, withheld or controlled. As such Francis, evident in Extract 13, refers to his 'personality thing'. In the absence of any clear answers Francis has constructed his understanding of the diagnosis and represented it as a 'personality thing'. The issue with regard to disclosure, non-disclosure, and limited disclosures will be explored further in Chapter 5. However, it would seem that there is an overall reluctance to inform individuals of the diagnosis which appears dialectically related to all discourse within the framework.

Using Extract 13 as an example, a number of the participants refer to different identifications of self, before and after a period of change following receiving the diagnosis. They present a past and present self, with the receiving of the diagnosis appearing to be a pivotal point, 'the way I used to be'. Francis states that 'it becomes positive', this places the diagnosis ('it') as the subject and that 'it' changes ('becomes') to something different ('positive'). In contrast to the initial appearance of the text content this is based on an assumption that the diagnosis is negative. He makes use of the hedging expression 'sort of'. This suggests a need to lessen the impact of the statement for some reason, potentially related to social impressions, perhaps that considering the diagnosis as positive is socially undesirable.

B.4.3.2.3 Blame constructed as Institutional Responsibility

There is significant reference within the transcripts to institutional responsibility for the social welfare of individuals who present a risk of harm to themselves, however, there is some variance in where individuals position themselves in relation to this. This may be related to context and extra-discursive elements, such as the treatment that people have received and where they position themselves in relation to recovery. For example, Clemence, Dorothy, and Grace hold similar positions in relation to institutional responsibility in regard to risk management. While Beatrice and Anne hold similar positions in relation to non-recovery.

Clemence: Erm and I think that because I was self harming so badly erm that I that in itself makes people feel anxious clinicians feel anxious because there's always that anxiety amongst clinicians that you're going to kill yourself. Or you're going to self harm on their watch type of thing. And they're going to be sort of you know held responsible.

Extract 14: Clemence

Dorothy: (3) Erm I can kind of see where they're coming from because I know that when I'm in that state when I've gone into psychosis I am just completely argumentative will not-- I think that I know what is best I will not agree with anybody I will put myself in dangerous situations lie to get out of things and stuff. So I can kind of see why they think oh god we can't deal with this just medicate her up and put her in the locked ward for a month that'll ((laughingly)) sort her out. Because I can see that maybe that's the only way that they know how to kind of deal with someone like that especially when it's someone's so unpredictable that they-- it's like I suppose it's their job if I were to like they were to let me go or believe what I said and then I went and killed myself they'd probably lose their job or have to go through a whole procedure of like being questioned and why did you do this and why did you do that and (I: Hm-mm.) you know she was suicidal in the first place. So I can kind of understand it in some ways but I also just think that they could be more tolerant and understanding and maybe try and talk to people a bit more and explain to them what's going on and why they're doing the things they're doing rather than just say right that's it.

Extract 15: Dorothy

In Extracts 14 and 15, Clemence and Dorothy both construct their understanding of the need for mental health services to manage the risk that they present to themselves to prevent the professional being held accountable should an individual harm themselves. This suggests an underlying ideology related to social responsibility, a culture of blame and punishment. Professionals find themselves in a caring role and are concerned about being punished for not taking enough care. This highlights that contrary to naïve dialecticism, which requires a search

for a compromise, in Western culture, the resolution occurs through identifying who was in the wrong.

Both Clemence and Dorothy identify their own actions through ownership of their statements by using the pronoun 'I', and the impact their actions have on other people. They describe their actions through the use of the phrases 'so badly' and 'so unpredictable' implying through the use of the adverb 'so' an extreme of the adjective, the outcome of which resulting in the ultimate risk of death. This further indicates an acknowledgement that while an individual's behaviour is perceived by the Western society to place an individual at risk, and an acknowledgement of this perception. There is also an implied assumption by both participants that from the individual's position this is not intended, although it presents a risk.

Dorothy highlights a direct statement in regard to being better understood by professionals, and there being space for more compassion and less punitive approaches, 'I also just think that they could be more tolerant and understanding'. Dorothy's statement here refers to the mental health professionals collectively through the use of the pronoun 'they', rather than one individual, suggesting that within this discourse community all professionals construct the act in the same way when they believe an individual presents a risk of harm to themselves. Also Dorothy, in Extract 15, states 'I think I know best', the unspoken opposite of this would be to assume somebody else, in this instance mental health professionals, know best. This again suggests an ideology related to the hierarchical and hegemonic nature of mental health services, and the assumption that the opinion of mental health professionals is the correct one. Further in relation to this, the meaning behind the perceived risk of harm appears to be lost. The extracts of Clemence and Dorothy tell me as immediate recipient of them, that their actions are constructed as aspects of risk and not as constructions of meaning, or indicators of an attempt to communicate an experience of inner turmoil.

In contrast to Extracts 14 and 15, Extracts 16 and 17 demonstrate Beatrice and Anne's positions, which involve them having passive roles in the situations they describe, unlike Clemence and Dorothy who identify themselves having an active role in events. The subject of both Beatrice and Anne's extracts are psychiatrists, although for Beatrice her statements relate to psychiatrists generally rather than a specific individual as in Anne's extract.

Beatrice: and that is the the rage it's like being abused a second time because a lot of people with BPD have had abusive childhoods and go into the mental health system as it is today I feel is another form of abuse it's another dysfunctional family with someone who is just some pompous psychiatrist pumps you full of drugs couldn't care less whether you live or die throw you to the wolves with a mishmash of dysfunctional people and if you don't get on with them it's your fault. Okay. So I'm very angry about it...

Extract 16: Beatrice

In Extract 16, Beatrice uses the word 'abuse' and relates her experience of psychiatrists as a metaphor to 'another dysfunctional family', this presents her position as one of blame against the profession and of her being passive in the event, identified by the placement of the subject of the sentence after the action; 'some pompous psychiatrist **pumps you** full of drugs', '**throws you** to the wolves'. Her choices of metaphors act to convey an extremely traumatic and harrowing experience. Her construction of how, in her reality, psychiatrists have acted to ignore her individuality and, thereby, devalued her personal experience and removed meaning, 'with a mishmash of dysfunctional people and if you don't get on with them it's your fault'. This is a powerful image of being cast aside with others who are classified by psychiatric diagnoses. In comparison to Clemence and Dorothy, Beatrice relates risk in terms of psychiatrists being unconcerned, and not fearful for their accountability 'couldn't care less whether you live or die'. This statement is created by Beatrice as a fact, rather than an evaluation, although earlier in the clause she highlights this as being the way she feels. It acts in conjunction with the rest of the extract to further demonstrate there is a risk, which is the responsibility of mental health but that they have ignored the meaning of her behaviours and as a result re-enacted painful childhood experiences for her. This construction indicates the power that psychiatrists hold over their patients when they are able to invoke this type of reaction. Helen expressed a similar experience in her interview, extract 17. This indirectly identifies an assumption of risk requiring physical restraint, despite a perceived belief that an individual is not worth saving.

Helen: I think they assume that you're mad and that you're really not well and there's no point saving you. But then all these people came from nowhere and they used a a sort of unnecessary amount of force that was very frightening'.

Extract 17: Helen

Anne: And then he kept phoning me at home because he wanted to see me a moment of guilt or is that guilt mm and I waited and then I called in Dr Death because I'd I'd since found out that actually on my care plan it states do not give *Anne* any medication because she will take it impulsively and I have tried them and they don't work on me they make you go for poohs I put weight on they do all sorts of nasty things erm and I take herbal tablets because I believe that they're healthier for you than taking mainstream medication. So that's when we called him we call him Dr Death because he could have killed me because when I got home I was so suicidal if it wasn't for my son sleeping next to me that night I would have gone because you feel like there's no hope what's the point what's the point of wasting my time and energy and having a consultation with somebody that doesn't even understand the diagnosis.

Extract 18: Anne

In Extract 18, Anne goes slightly further than Beatrice by identifying a particular psychiatrist in her experience whom she came to call 'Dr Death'. The implications of her statements are the same as Beatrice, a suggestion of serious incompetence on the part of a psychiatrist which could have resulted in fatality. However, by personalising the experience and specifying a particular psychiatrist and an event, which identifies directly a 'near-miss', her statements act to convey blame and accountability to the psychiatrist and positions herself as a passive actor. Similarly, to Extracts 14, 15 and 16, the text constructs institutional responsibility which removes meaning 'having a consultation with somebody that doesn't even understand the diagnosis'. While this could be determined to refer to the risk associated with the behaviours characteristic of the diagnosis, it would seem that her reference is to the fact that there is a lack of understanding about her individually 'on **my** care plan it states do not give *Anne* any medication because she will take it impulsively'. Anne's extract serves to dislocate responsibility for her own life to that of mental health professionals who create a care plan for her.

Anne's expressions of cynicism about the psychiatrist's intentions, 'he wanted to see me a moment of guilt or is that guilt mm', seem to indicate that she is positioning him as being concerned for his own self-preservation, his job, similarly to Dorothy. The extract is powerful in its suggestion of incompetence, and acts to give Anne justification for impulsive behaviour. Mental health services and psychiatry through their hegemony create a context in which they remove responsibility from individuals for their own life preservation, by failing to account for meaning, and place the responsibility in their own hands; apparent through the passive role identified by both Beatrice and Anne. This as I mentioned earlier, however, may be further mediated through the experience of recovering personal meaning in a later stage of recovery.

Anne: I think sometimes yeah you can be reactive with somebody on the other line I do do that and I apologise when I'm doing that but there are some times it comes from the other other person it's because they're not being supervised properly you've got to have proper supervision if you're working with somebody like me otherwise you get this this malignant alienation I love that term which means really fuck off and die ((laughs)) in my you know. (I: Absolutely.) and I think if they don't get it that's what happens so I always say sup get supervision if you're going to work with me sign a piece of paper telling me you're going to be supervised by a proper person who knows what they're talking about not any old supervision you have to have really good quality otherwise it won't work.

Extract 19: Anne

A discursive construction which appears to be described by several of the interviewees is that of 'Malignant Alienation', with Anne using this phrase specifically. This classification describes a process by which relationships between patients and psychiatric healthcare professionals have broken down to such an extent that a casual attitude and casting aside of any hope for a patient occurs. This is as a result of staff perceptions that a patient's behaviour is provocative and unreasonable (Potter, 2009), whereby death is considered inevitable, with the whole process having been found to end in a fatal outcome (Watts & Morgan, 1994). This is not a well-known term outside of the psychiatric community and is not something which has been taken up in the training of mental health professionals; however, the vocabulary has been used by Anne, as identified within Extract 19.

Anne uses the phrase 'malignant alienation' to construct what happens when a mental health professional is 'not being supervised properly' when working with individuals with the borderline personality diagnosis. Anne uses the term to lay blame with the institution, if the health professional is not provided with 'good quality' supervision. She repeats the word supervision many times throughout this extract, repetition when used in this way may suggest the level of importance with which the concept is regarded. This may indicate that an expression of complexity and challenge, setting up a defensive position. Anne acknowledges an element of her behaviour within the response she describes receiving, however, this is mediated by statements suggesting that it is the responsibility of the mental health professional to manage her appropriately at all times, 'sometimes it comes from the other other person it's because they're not being supervised properly'.

Social practices can identify discourses, for example Anne refers to the signing of a document inferring its binding nature. The assumption behind this being blame is attributable if it does not happen. This indicates a legal discourse of blame attribution. The implication being that without appropriate hierarchical, traditional lines of responsibility in place, they would be to blame for her actions. Her use of the term 'Malignant Alienation' also demonstrates that this particular discourse has been made available to her, and she has brought it into her own discourse community and provided her own interpretation of its meaning in her own life 'fuck off and die'. This is the way that discourses become translated and transferred into new discourses and reflect ideologies. Anne has used this phrase to provide reason for the difficult relationships she has had with many mental health professionals and identifies the extent to which the institution of psychiatry has taken over individuals' responsibility for change.

Grace:	Erm (9) she came in on my discharge meeting she came in to hospital and kind of stormed into the room and you know flew her arms up in the air how did you end up here you know I was absolutely gobsmacked that you're here what are you doing here erm (3) I I don't understand at all why you're feeling like this erm because I think from the outside (3) it probably appeared that I was quite a fortunate person.
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Extract 20: Grace

Extracts 20-24, demonstrate what could be described as 'Malignant Alienation', without explicit reference to it, as this is not a discursive term which is available to the other participants. Instead they draw on alternative resources to construct the same idea. Grace uses metaphorical language in Extract 20, providing a visual representation of an event, reproducing the verbal transaction that occurred. This refers to an exchange following a hospital admission with her allocated mental health professional. Grace justifies the individual's actions by suggesting she believed the individual thought she was 'quite a fortunate person', this in itself suggests that 'fortunate people' should not have problems which lead them into the mental health system. This extract acts to suggest to the reader that Grace believes she was considered to blame for her problems. At the same time she is protecting her new professional identity by supporting the mental health professional with a justification for their response. This identifies the impact the mental health institution can have upon an individual.

I: How have staff within the mental health system responded to you

Helen: ((laughs)) Erm with varying deg-- sort of degrees of disregard erm sort of indifference erm sort of treating you like a erm I don't know sort of feeling quite dehumanised by it as well as having psychiatrists and counsellors who did care. Erm but my early experience of it was there was no cont-- continuity you were sort of passed from counsellor to-- pillar to post that was upsetting initially. Erm (3) feeling like a I remember at *hospital* in erm erm *city* when I before I'd moved back to *the county* and stuff just being in absolute you know I was very I was quite suicidal because the the pills had taken me made me worse and I remember going in for these reviews and like having a whole panel of people I remember once there were like there was the lead consultant psy-- psychiatrist and then all these other people and I was just in bits and just feeling so I don't know like a like a you know like a an experiment I suppose (I: Hm.) like a guinea pig in the whole thing. And and I did feel like a guinea pig because they were trying various meds erm so you did you know I cer-- I did feel like that and it w-- you know and then you're left to your-- you're sort of at the mercy of these things that they don't actually know how it worked ((laughs)) you know.

Extract 21: Helen

In Extract 21, Helen describes her experience of mental health professionals with the adjectives: 'dehumanised', 'disregarded', 'indifference', 'guinea pig' and having been 'passed from counsellor to – pillar to post' and feeling 'like a an experiment', the choice of each of these words suggest a experience of being invalid, part of a system, a lower ranking part of a social system. 'Having a whole panel of people' continues a metaphor of an experiment or project, with nobody knowing the answers but professing to be the experts, 'you're sort of at the mercy of these things that they don't actually know how it worked', further purports being controlled by medication, the subject referred to by 'it' and 'these things', and those who prescribe it. Fundamentally this positions responsibility with the institution of mental health and psychiatry, highlighting how, through a process of being objectified and a problem to be solved removes the responsibility from the individual, and also meaning of their experiences by attributing current state of mind to the right level of psychiatric medication 'the pills had made me worse', 'they were trying various meds', a medical model of mental health positioning the staff as 'experts'. There could be said to be a hidden ideology that the panel of people that Helen refers to are trying to 'correct' her and make her more like them. In another part of her interview Helen states 'I think they assume that you're mad and that you're really not well and there's no point saving you.' This further provides evidence of the construct of 'Malignant Alienation', where individuals with BPD are positioned as not worth saving. Additionally, this extract exemplifies the positioning of mental health workers as 'experts', and

consequently, the 'patients' as 'non-experts'. The assumption being 'experts' hold the 'knowledge'; if this 'knowledge' is not forthcoming then they are potentially 'blameworthy'. Alternatively, by being positioned as 'experts' they are, by assumption, qualified to adjudicate blame.

I:	How did you find that people responded to you either professionals or kind of people outside of the mental health world
Dorothy:	Erm (7) I think ((clears throat)) (4) professionals like I suppose like erm like psychiatrists and stuff they just like look at me ((tuts)) oh god she's back again they kind of get fed up with me (I: Okay.) and they're a bit oh no what do we do with her now and what are we going to do with her and stuff. Like my family I think well my brothers and my sister I think they're just like-- and I don't think people don't know how to deal with it really they're just like oh no she's gone off on one again erm yeah they don't people I don't people really don't know how to deal with deal with it or what to think about it really.

Extract 22: Dorothy

Dorothy, in Extract 22, describes believing that 'psychiatrists and stuff' 'kind of get fed up with me'. While she hedges her statement with 'kind of' to soften the statement and appearing to commit to it less, still it presents the suggestion of causing annoyance, a value judgment of not being pleased with her. This can act to attribute blame for non-response to treatment methods but also potentially evidence for 'Malignant Alienation', where the client is not likeable and the behaviour is perceived to be within their control and manipulative. This is further demonstrated with 'oh god she's back again', and 'what do we do with her now'. Again, in similar ways to the previous aspects there is an assumption of social responsibility through the use of 'we', as though the individual is a problem to be solved, and when 'they' are not solved they become annoying. However, Dorothy seems to be conveying that there is no attempt to explore the meaning for the individual. Dorothy provides justification for the response she receives by saying 'I don't think people know how to deal with it', and repeating the words within this evaluative statement in the next clause. The diagnosis is constructed as an object in her statements and this extract suggests that there are no answers amongst the mental health professionals who, through implied assumption through all the interviews, are the ones that are expected to hold the answers. My question to Dorothy also asks about non-professionals and she refers to them not knowing how to respond to her 'they don't people I don't people don't really know how to deal with deal with it or what to think about it really'. This statement acts to objectify the diagnosis as a separate entity, this again isolates the behaviours, symptoms and label, without considering the reasons for them.

B.4.3.2.5 *Summary of Blame Discourse*

Through examining all the texts in relation to the discourse of blame a significant dialectical pair is present, there are contradictory positions of individual responsibility (blame) and social responsibility (blame). This presents a dilemma or ideological struggle, common in Western culture, of differentiating which position is correct. It would seem that Aristotle's Law of non-contradiction (Gottlieb, 2007) plays out in a number of the transcripts presenting an unresolved dilemma quite overtly for some. This is when the individual appears to struggle to decide whether the problems they experience are their fault or whether there is a reason out of their control which is to blame; the Law of non-contradiction states that two opposing positions cannot both be correct, and, thereby, the individual must decide between the two. This cultural polarisation has benefits for self-preservation, such that publicly an individual could save face by dislocating blame to another, while privately there is potentially a struggle over what it would mean if they were to blame for their problems. There is also evidence of the consideration of the part that the mental health community has in maintaining or helping their progress. Here individuals consider whether they themselves are to blame when treatments are unsuccessful or whether the professionals are to blame. This leads to discursive constructions of incompetence. Incompetence on the part of the professionals also presents the benefits of this polarisation, such that responsibility is removed from the individual and in addition a sympathetic position is potentially made available to the reader. Similarly, there is also the dilemma of whether the 'experts' should take responsibility for their care or whether the individual should take this responsibility.

B.4.3.3 *Stigma*

The second dominant discourse to be apparent through analysis is 'Stigma'. All the participants constructed their experience of the diagnosis through language which could most readily be attributed to stigma and its associated causes, influences and impacts. This discourse is one which has developed over recent years and is dialectically related to discrimination and prejudice. That is, while discrimination and prejudice can be studied individually, they are not distinct from stigma, the impact of discrimination or prejudicial attitudes or behaviour is likely to be the creation of stigma, and inversely stigma may be related to an actual experience of discrimination or prejudicial attitudes, although it may also be anticipated as a result of cultural background and knowledge misinformation (Thornicroft, Mehta, Brohan & Kassam, 2010). Thornicroft et al. (2010) identify that stigma can be identified as containing three main elements: knowledge problems or misinformation, attitude problems, and behaviour problems. Each of these along with the components already highlighted was apparent in the interview transcripts.

Clemence: if it did say chronic trauma this person has experienced you know major trauma blah de blah de blah and self harms because of it they would treat me a lot differently you know. I I feel they would. I feel that people would perceive me differently. (I: Hm-mm.) Even professionally they'd go oh you survived it and you're all right now well done ((laughingly)) do you know what I mean (I: Yeah absolutely.) It would like like well done for getting through all of that bloody hell you know. Do you know what I mean if somebody was it's you know it's like you know yourself if somebody has been in a major trauma you know like say you know that tsunami on boxing day the tsunami and that if somebody survived that it was traumatic or whatever like that or even 911 (I: Yeah.) Okay 911 right biggest bloody trauma ever right and somebody survived that they'd gone through the trauma they've had to have therapy blah de blah de blah and then they're holding down a decent job and got their life sorted out people are like bloody hell well done well done for getting through that. And they wouldn't actually think that person's still traumatised they'd actually go cor well done.

Extract 23: Clemence

Dorothy : Yeah because I have often thought I'd rather have ((laughingly)) PTSD than BPD and I kind of did I kind of am-- have been diagnosed with that as well so maybe I could just say I've got that one (I: Hm.) because that's like I know somebody that's got PTSD and it's like I don't know people seem more tolerant of his kind of behaviours and stuff because of it. Because like his event was it is so traumatic it's just like oh my god how can anyone live through that experience but it's like people actually just like kind of tend to support him more and stuff like that. And I don't know (I: Hm.) so I think yeah I think it would be better as a kind of trauma-- post traumatic thing

Extract 24: Dorothy

Attitudes of mental health professionals towards the diagnosis were identified within the stigma discourse of participants. In describing this participants drew on different discourses with Clemence, Dorothy and Francis drawing particularly on a trauma discourse, evidenced in Extracts 23, 24 and previously 12. They constructed mental health professionals as identifying negatively with the nosological term, BPD, such that there was a disregard for the meaning of the behaviours or for understanding the developmental precipitants, only a stereotypical positioning of them by those they encountered resulting in a lack of empathy for their contexts.

Both Clemence and Dorothy suggest that if the diagnosis contained reference to the trauma they had experienced they would be positioned differently by those they encountered. They do this by drawing on examples of attitudes of mental health professionals positioning of those who have experienced events which might result in a diagnosis of PTSD, 'they would treat me a lot differently' (Clemence), 'people seem more tolerant' (Dorothy). The trauma discourse is one which can most readily be empathised with by all readers particularly when raising large-scale traumatic events such as 9/11, and the Boxing Day Tsunami. These comparisons by Clemence enable her to position herself differently in relation to the stigma discourse as well as the blame and recovery discourses. Both Clemence and Dorothy make reference to survival of extreme events outside of one's control as typified by the discursive construction of trauma 'well done on getting through that' (Clemence), 'oh my god how can anyone live through that experience' (Dorothy).

Further without a direct reference to trauma within the discursive label there is an underlying assumption evident within a number of the participant's texts that they are 'defective', they are 'not normal'. For example Dorothy states 'if I have to have anything' and 'I'd rather have'. There is an implicit acceptance within this that her problems predicate an assumed reality that there is something wrong with her. This reflects further the power of a culture, which defines behaviours and experiences outside the range of those usually expressed by that community as not 'normal' and thereby, unacceptable; the instilling of these assumptions within members of that cultural group create an experience of being different. Another example appears in Extract 29, where Helen identifies that depression is a preferred diagnosis, as it positions you as different but not as different as having a PD.

In Extract 23, Clemence makes reference to the desirable capitalist attributes of 'normality' such as being employed, having a stable relationship and an organised life, suggesting the assumption that to have these indicates mental health and without these one is considered different. Where this can be directly explained as resulting from a traumatic event there is less stigma and more understanding. This further identifies the ideology underlying the construction of mental health services and society in general, the desirability perhaps of productivity and conformity to the societal rules and norms. These references to employment, secure housing, stable relationships are apparent throughout all the transcripts.

Clemence also raises an important issue with regard to medical notes. Research suggests that mental health professionals are reluctant to disclose diagnoses to the individual concerned but will document their diagnoses within written documentation (Allen, 2004). This is something

which was identified by Ellen, Dorothy, Beatrice, and Helen. This has been identified as occurring for a number of potential reasons with concern about stigma being one of them (Lequesne & Hersh, 2004). In effect this actually acts to increase stigma rather than protect the individual from it, as highlighted by Clemence in Extract 23.

Both Dorothy and Clemence use verbal processes within their dialogue to convey the perceptions of others, and the alternative perceptions. This identifies how powerful language can be in conveying attitudes, expressing opinions, and how dependant upon them we are as human beings for communicating. This use of a verbal process gives much information, such as how the person might say something, what they might say, as well as intimating meaning.

B.4.3.3.2 *Stigma constructed as 'Knowledge'*

Anne: 'I'm not a paedophile oh no I don't want to be even in that little box but no I think I think its scary for people or they think you're going to be mass murderers and you're going to stab people no its its not that its not as clear as clear cut as that'

Extract 25: Anne

Dorothy: Erm I think without it being explained properly I think it's quite scary it's like you just think that there's something wrong with you. I I thought for a long time that I had like multiple personalities and I was too scared to tell anyone because I just thought that I I had like all these different personalities and that people are just going to think I was a complete freak if I told anyone.

Extract 26: Dorothy

Another aspect of stigma discourse drawn on by Anne and Dorothy are the 'knowledge' problems that occur when people hear the term 'personality disorder' and how this creates perceptions of fear and danger. They both use extremes of vocabulary to construct this: 'paedophile', 'mass murderer', 'multiple personalities', 'complete freak'. Their statements in Extracts 25 and 26, set out undesirable attributes and experiences 'they think you're going to be mass murderers and you're going to stab people' (Anne), 'I just thought that I I had like all these different personalities and that people are just going to think I was a complete freak' (Dorothy). Both Anne and Dorothy identify through their choice of statements how terminology creates a position for them as dangerous which, they wished to reject. The fear for both being that they would be socially excluded as a result of misinformation by others: 'I don't want to be even in that little box but no I think I think its scary for people', in this

statement Anne is rejecting the identity which is assumed as a result of the diagnosis, a wish to be in a different category so as to be socially included; the underlying assumption being if something is scary it is undesirable and therefore avoided. Dorothy, similarly, by stating she did not want to be seen as 'a complete freak', suggests this is undesirable and may therefore be avoided. Her use of the word 'complete' suggests there is nothing else, there is a commitment to the noun 'freak', and this could assume that if this is the case people would discriminate due to there being no room for doubt as would be suggested by less commitment to the noun by: 'a **bit** of a freak'.

Ellen:	There was a lady that I saw erm for an assessment in January and she'd seen the letter from my doctor and I was going to be seeing her for CBT but she'd spoken she told me that she'd spoken to her supervisor and that they felt it appropriate to be referred on to somebody else and she looked terrified ((laughs)) she looked terrified she looked terrified do you know what I mean. And that felt hard she was she was perfectly pleasant but erm
I:	You felt that
Ellen:	She she I actually felt that she yeah she was terrified. It's a really it's always a relief when I can talk to somebody that that knows
I:	Yeah.
Ellen:	I'm not because you don't look scared ((laughingly)) you don't look do do you know what I mean

Extract 27: Ellen

Ellen also describes experiencing people as being frightened by her in Extract 27: 'she looked terrified'. This is something that she attributes in her discourse to misinformation: 'its always a relief when I can talk to somebody that that knows'. The underlying assumption behind this statement could be said to be that the individual who 'looked terrified' did not know what the diagnosis meant. This again positions the experience of Ellen as one of being stigmatised. In addition Ellen draws on how widespread this experience is by referring to 'they' when saying 'they felt it appropriate to be referred on to somebody else', this conveys a collective behaviour towards excluding her from their care, a potential experience constructed as discrimination. Ellen draws a distinction between her experience of what was said to her 'pleasant'-ly and the other non-verbal indicators which suggested extreme fear, 'terrified'. She goes on to suggest that I do not look scared and thus indicates her positioning of me as somebody 'that knows'.

Beatrice: There's also this feeling that I've never met anyone else with this illness even when I went to mental health drop-ins I was an outcast because I'd be babbling away and being inappropriate and yet this clique of nutters were able to get on all right. (I: Hm.) So imagine how I felt. (I: Yeah.) And then so it's this terrible feeling of isolation in the community everywhere in the outside world in the mental health community with so called well they're not peers but other people with difficulties.

Extract 28: Beatrice

Helen: Erm I do obviously I feel alone because I I feel I I can't go and chat to anyone about it and it would be great actually in like ten years or five years if someone ca-- perhaps I should start a group ((laughs)) but what would I call it you know ((laughs)). Erm BPD anonymous or something you know because as as well I think I I it will be hard to get people to actually come to to something like that because maybe there is a lot of not shame but just erm I don't know erm not embarrassment it it's sort of somewhere along those lines you know where people don't want to admit actually because it's like so you're really you know off the wall. I think all those eccentric people (I: Hm-mm.) you know those quirky peop-- and that's how I describe myself to cover all my mental ((laughingly)) health issues I think you know the way I come across. And often in the office I just go oh I'm having another neurotic day. I in that way I'm quite honest but I'm not going to go hey I have a personality disorder that's a step too far I think I don't think people are ready to hear any of that yet erm it's bad enough just saying you suffer from depression I think.

Extract 29: Helen

Francis: I keep I mean I do go through bouts of depression and and erm mood swings and one thing and another but I keep them to myself erm. My wife my wife knows she she can see it a mile off but no one else can tell if I can help it you know erm it's between me and her now any any physical any outside signs that I am suffering or whatever erm I try to keep it in because just to show it shows everyone that you're mad and it can alienate people that's that's the difference. (I: Okay.) So yeah I don't like people to see if I'm not well (I: Hm.) because that's that's that's how I see it. I don't see the personality disorder as an illness but various aspects of it the depression and so on can be an illness

Extract 30: Francis

A number of participants construct social exclusion through describing isolation occurring as a result of difference. Beatrice, Helen and Francis in Extracts 28, 29 and 30 exemplify this. While each positions themselves differently and draws on different discourses to construct that

which they are trying to convey, the effect is to portray the same context. Beatrice draws on stigma discourse and her own stereotypes of individuals with mental health problems 'clique of nutters', identifying the apparent stigma present within lay discourse; she positions herself outside of this as well as the group she wishes to identify with. Helen draws on what might be described as mystical discourse with reference to 'eccentric' and 'quirky' to position her difference and social isolation. Francis draws on psychiatric and lay discourse to construct alienation as a result of the stereotypes of 'madness'.

Each of these participants identifies less favourable treatment due to the diagnosis, as previously identified with B.4.3.3.2, by virtue of misinformation, discrimination and prejudice. They also raise the issue of how to define the problems they experience without reference to the disorder, something which is apparent in other participants interviews also for example 'do you describe it as some kind of defect' 'that you're not a whole you're not functioning as normal people should be' (Helen). This identifies that the diagnosis presents an undesirable position of being outside of the majority.

Identifying further the stereotypes with which the general public create stigma discourse, Francis draws on an example of being witnessed to 'be mad' (Extract 30), 'I don't like people to see I'm not well', this presents an underlying assumption that this is not desirable and undesirable behaviour results in social exclusion. It would appear that in order to exist within this discourse he has constructed BPD not to be an 'illness', but that other aspects of it can be. This presents an interesting perspective in essence he continues to identify with the label while not accepting the medical model inherent within it. This is in contrast to the other participants and might identify the usefulness of alternative models of understanding which do not rely on a 'disease' rationale. This demonstrates the way that an individual can perceive a diagnostic label and recontextualise it within their life to make sense for them. Francis appears to have taken the terminology and constructed it as a foundation for his experience and a fundamental part of him. This is something which other participants alternatively try to reject as it has implications for recovery.

I:	Hm okay. And are there any differences in erm your experience between then and now. Do you have any do you still have similar thoughts do you still feel relief do you feel anything else as well
Grace:	No very, very different now (I: Okay yeah) Erm I think over time I became more embarrassed and more ashamed of it I think at the time I told quite a lot of people erm but now I wouldn't tell a soul erm I don't know why I think I've become over time I've become more aware of the stigma attached to it erm and how people can with that diagnosis can just get put in one bracket and under one umbrella and and that's it erm (3) and I think after the diagnosis I would say things spiralled even more and I became more and more embarrassed and ashamed of what I was doing and who I was. Erm certainly now erm I don't know because my attitude towards people with borderline personality disorder is very much a sympathetic one because I know how it feels on the inside but and how you know (2) I don't know how awful those emotions are to deal with but (3) I know a lot of other people don't think that way I know people are just seen as a pain really claiming the services erm
I:	And is that what you get from you know the professionals around you the kind of (Grace: Yeah) Is it the things they say or just kind of a feeling that you get from them or both
Grace:	Both both but I've I've heard a lot of a lot of bad things said yeah

Extract 31: Grace

A common construction for the participants was an initial feeling of relief upon receiving a diagnosis followed by an increasing experience of shame and embarrassment. These experiences appear to be drawn out through the use of stigma discourse, for example Grace in Extract 31 states: 'now I wouldn't tell a soul erm I don't know why I think I've become over time I've become more aware of the stigma attached to it'; and Ellen also in her interview identifies 'incredible shame'; Clemence states 'I don't think its shame its more I would feel vulnerable'. Grace's statement that she would not 'tell a soul' suggests she is highlighting an intense desire to keep the diagnosis from anybody rejecting a subject position. Grace also highlights as others have in their interviews less directly, that 'people can with that diagnosis can just get put in one bracket and under one umbrella and and that's it'. This statement reflects the position that the diagnosis creates a lifetime identity for people at the hands of others perceptions; a collective identity which places a heterogeneous group of individuals as a homogeneous one with regards to others attitudes and behaviours. Grace also makes what appears to be a factual statement towards the end of the extract, on which I ask for

clarification: 'I know people are just seen as a pain really claiming the services'. This implies an actual experience of this attitude, which Grace goes on to confirm.

B.4.3.3.5 Stigma constructed as Discrimination

Francis: I didn't dare take benefits because I sort of saw myself as a fraud you know not working and not having any real physical reason not to be working.

Extract 32: Francis

Extracts 32-36, demonstrate how the stigma associated with mental health problems and BPD, are constructed by Francis, Anne, Clemence and Helen in relation to employment. In Extract 32, mental health problems are constructed by Francis' as being fraudulent and, therefore, not being justified in receiving benefits. In itself this construction highlights cultural attitudes to mental health which would be considered discriminatory but nevertheless exist within political ideologies.

Anne: People don't know about my diagnosis. They know about my OCD but not my BPD people close to me know about it but people who I work for they don't not unless its if they need to know then they'll know because there's a stigma behind it'

Extract 33: Anne

Anne, Extract 33, who campaigns for mental health service improvements, states 'people don't know about my diagnosis' including 'people who I work for', specifically attributing the reason for this to stigma, the intimation being that she would be treated less favourably if they knew.

Clemence: mental health services are the worst worst people for stigmatising mental health problems. You know if you've got a mental health service and you want to work in the NHS god help you...you know especially if you want to work in mental health.

Extract 34: Clemence

The assumption upon which Clemence bases her statement (Extract 34) is that mental health services in the NHS should be promoting social inclusion across society including modelling employment opportunities. However, the commitment with which she makes this statement as a fact constructs the opposite reality.

Clemence: I was terri-- absolutely terrified of them finding out (I: Yeah.) that I'd been in hospital and you know it makes me laugh you know all this business of the medical health service is saying you know oh yes we know we need to kind of promote this kind of what do they say they'd need to promote this ((clears throat)) trying to get away from the stigma of mental illness (I: Hm-mm.) I have to say that the mental health services are the worst worst people for stigmatising mental health problems. You know if you've got a mental health service and you want to work in the NHS god help you (I: Hm-mm.) you know especially if you want to work in mental health you know. And erm you know this idea that you can have a mental health problem and yes you can you if you have enough insight you can control it you can take care of yourself you can look after yourself you can look after you protect yourself and your patients and all that kind of stuff seems to bypass them you know. It's it's it's absolutely awful. I don't know maybe it's changed now and you don't have to do that but certainly when I was doing it you had to put everything (I: Hm.) And there was this thing if you did put everything they could sack you.

Extract 35: Clemence

Helen: I think they have a problem of mental health issues anyway erm you know and if you're seen as a depressive anyway you're you're seen as you know unemployable or you know there's a lot of stigma with that so erm it's it's probably worse to say you've got I'm certainly not going to be waving a placard saying I suffer from BPD. Erm and so so in that respect erm how do I feel about it now (2) I I don't really talk about it as such. Erm on a on employment forms and stuff I just say I suffered from depression and let that kind of be an umbrella for covering all that.

Extract 36: Helen

Clemence commences, in Extract 35, by highlighting that she was 'absolutely terrified of them finding out' when she worked for the NHS. This conveys to the reader an extremely frightening experience. While this was not an event that occurred for her the anticipation of the possible treatment she would have experienced if it had is verbalised as traumatic and harrowing. Clemence describes a lose-lose situation. Similarly, Helen (Extract 36) states how despite the stigma attached to depression, she would prefer to disclose her depression than BPD because that would be worse, and therefore, declares depression on applications for employment. In a social climate where depression is considered as one of the highest causes of sickness amongst employees, this positions BPD as more highly stigmatising as a result of high levels of misinformation, shame, embarrassment, discrimination and prejudice towards the diagnosis and the categorisation of those with the diagnosis.

B.4.3.3.6 Summary of Stigma Discourse

Noticeably, with regards to the stigma discourse all the extracts in B.4.3.3 highlight a tendency to verbalise events, experiences and thoughts with use of the pronoun 'I'. Conversely, the most used pronoun with regard to the blame discourse appears to be 'they', although, I have not validated this through content analysis. Qualitatively the significance of this would be that generally there is a move, with increasing publicity and education that 'stigma' in all its guises is immoral and personal identification with experience is considered acceptable. However, there is no such agreement, all be it in its infancy, with regard to the attribution of blame for mental health problems.

B.4.3.4 Recovery

The third dominant discourse within the transcripts was that of 'recovery'. This was presented in different ways and drew upon different constructs and concepts for each of the participants, however, participants demonstrated recovery as a dialectical dilemma of permanence, one which may fundamentally impact upon treatment outcomes; shaped by their discursive and extra-discursive constructions. Two of the participants used a drowning analogy to exemplify their experience of the diagnosis and their construction of recovery; I will discuss this towards the end of the section, as this presents a powerful presentation of the enigma of the diagnosis and suggests that the diagnosis itself as a construction is in fact dialectical in nature.

B.4.3.4.1 Recovery constructed as Treatment

I:	Erm what what treatment have you actually received
Anne:	I have a CBT that does not work with people with b-- personality disorder does not did not do anything to me did not help me in any way and don't know why but I've since spoken to somebody who knows their stuff and said well <i>Anne</i> actually it's a waste of time it will never work and it wasn't they didn't tell me why but the but the person's quite experienced she knows what she's talking about there must be a reason why she told me that she said don't worry <i>Anne</i> it doesn't work. And I had CAT therapy (I: Okay.) which was helpful but very unhelpful because I didn't tell them I'd had flashbacks (3) and you know it could be quite helpful for somebody to say well actually when you're having CAT therapy you do realise you know there is a small percentage a small chance that you might have flashbacks or nightmares I had flashbacks. And then I remembered some stuff that actually I wish I hadn't but I remember now but that's okay that's good and it makes me realise why I do certain things

Extract 37: Anne

Extracts 37, 38 and 39, find Anne, Beatrice and Grace respectively constructing treatment for BPD each from a different position. Anne in Extract 37, presents her discursive position of having received the 'wrong' treatment and infers this has prevented recovery; Beatrice's position is that the removal of the 'right' treatment has prevented her recovery; and Grace positions herself as having received treatment which helped her recovery but that others are prevented from recovering due to the withholding of effective treatment due to professional attitudes.

Evidence-based treatment dominates the field of mental health, it has its origins in the positivist paradigm and as such operates within essentialist ideas, that a treatment that is found to be helpful through empirical research can be applied universally relying on homogeneous groups of problems. The problem with regards to BPD is that effective evidence-based treatments have only recently been identified, as such they are not widely available, expensive and further they are being applied to a heterogenous group of individuals. The research evidence suggests that when an individual is offered treatment and it is not viewed to 'work', the reason for it not working is placed within the individual. This is evident within the discourse in Extract 37; Anne discusses two treatments that she has received, CBT and CAT, both of which have demonstrated variability in effectiveness for those with the BPD diagnosis. However, CBT in particular is widely thought of as 'the' evidence-based treatment. Anne's statements act to defend her against this individualism; she tries to dislocate the blame discourse for her non-recovery following the treatments she has received. She uses the imperative mood and strong commitment to statements of fact to achieve this and further backs her position with 'expert' opinion. Her statements also act to position her as a naïve recipient of this information, unclear why they would tell her this. Further there is evidence of her constructing errors in the way that treatment was delivered, the underlying premise being, if it had been delivered correctly it might have been more helpful. This further identifies the underlying ideology of the discourse within the BPD field, the tendency to consider individuals to hold responsibility for the effectiveness of treatment, that they make a choice about whether something 'works'. Anne draws on psychotherapeutic discourse, the acronyms 'CBT', 'CAT', 'flashbacks' and 'the recovery of memories', to indicate her positioning as a 'lay expert' who 'knows' the language of therapy.

Beatrice: I you know because I was making progress at the with the team at *the unit* in '96 because I had a team behind me I I got on with them and the I really felt that I wanted to to work hard because I felt they were you know valuating me (I: Hm-mm.) and and this psychiat-- psychiatric nurse said we're all very proud of you and this no one had ever said that to me. And I was just making progress but they never told me which was negligence. And I think so many people are committing suicide because of the incompetence of the mental health system in this country and it's absolutely criminal that I'm left to suffer. And I think the older you get the more they think well this person is not going to respond to treatment and I, I'm left with nothing so that's my spiel.

Extract 38: Beatrice

Connected with this view that the 'patient' is responsible for the outcome is the idea of the 'good patient'. There is an expectation within mental health services, and the medical model more generally, that an individual is required to occupy a 'sick role' and be a 'good patient'. This refers to the idea that an individual will be compliant, grateful and 'get better'. When an individual does not appear to conform to this role they are viewed as 'manipulative' and 'attention-seeking'. This was evident within the transcripts of most of the participants. Beatrice, in Extract 38, exemplifies this positioning herself as 'the good patient', complying with treatment and that this was because she believed that she was supported by a team of people and she wanted to show her appreciation, or gratitude. She constructs their compassion: the team 'said we're all very proud of you', this suggests the inherent power with which mental health professionals have to validate or invalidate an individual and invoke reciprocal behaviours. However, Beatrice then switches to present the team as 'negligent' for not advising her of the diagnosis. She sets up an alternative position of having tried to be a 'good patient' but that the changed behaviour of others towards her altered this, drawing on a legal discourse to iterate her point using 'criminal' and 'negligent'. This acts to punish those who she positions as rejecting her, although not specifically, enabling her to maintain her construction of their compassion. Beatrice attributes the problems further to a loss of hope for recovery with age, suggesting that her chances to recover are prevented by the withholding of treatment as a direct consequence 'they think well this person is not going to respond to treatment and I'm left with nothing'.

This extract demonstrates how a medical model of symptoms would interpret her text, as one of extremes between idealising and devaluing, and avoidance of abandonment. However, the discourse suggests reading this text from a different position that these positions are reflected

by mental health services themselves, responding to the 'good patient' as an ideal and devaluing the 'bad patient'.

Grace: I think the services should be there for these people because at the end of the day it helped me it helped me move on it helped me recover erm you know and I no longer need to see anybody in services from from wherever so at the end of the day I think (5) it's more cost effective if somebody's getting that the treatment that they need and that will ultimately stop them seeing people. Erm personally ((sighs)) (11) I don't know (6) because in a way I'm going to be quite harsh on myself (I: Yeah.) but (4) I think the things that I was doing (6) I'm quite ashamed of and I think I should have I think I could have been more in control of it. (7) So I don't know. I feel it's completely contrasting.

Extract 39: Grace

Implicit within the recovery idea is the assumed goal of successful outcome being no longer in need of services. When this is linked with the constructions of 'good patients' and 'evidence-based treatment' a further assumption can be identified, to achieve the goal in the shortest time possible with minimum costs. These assumptions are apparent within Grace's extract 39. She positions herself as recovered by reference to 'these people' and 'stop them', this acts to set up an alternative position for herself as no longer identifying with 'these people'. Grace draws on the assumption of recovery and mental health services aiding this. However, she identifies the politics of mental health in relation to cost saving, 'cost effective'. Her construction suggests that the goal of recovery cannot be achieved through the current methods being employed. That mental health services do not operate from a position of the individual, but from the capitalist demands of the service, identified by Flannagan, Miller and Davidson (2009).

Further evident in this extract is the impact that shame and blame appear to have on an individual positioning themselves as recovered. The difficulty that appears apparent in her discourse at reconciling her roles as professional and patient. Her statement 'I think I should have I think I could have been more in control of it', highlights her dilemma along with the length of her pauses, searching for the right discourse, and makes me question what she chose not to say. It is possible that the hidden ideology is that mental health professionals are expected to be 'higher beings', to be morally irreproachable and the shame she experiences is based on her insider 'knowledge' of mental health services as a professional, perhaps in the way individuals are discussed or the judgements that are passed about their behaviours. This is further evidenced in Extract 40.

I: Okay. Do you think that this is something that you can recover from people can recover from

Grace: That's an interesting question because to an extent yeah because I am miles away from where I was two years ago. (I: Hm.) (12) I'm trying to think how I can describe how how different I am (4) you know I think two years ago (10) I am ashamed of a lot of things I've done (13) I think if I told people now that only know me as a professional they wouldn't believe (I: Hm-mm.) a lot of the a lot of the things that I did and why I did it ((coughs)). Erm those emotions that I felt during that period were just always always up and down and then I would act on those emotions erm (4) and just so impulsive (7) and I think I have recovered to a certain extent erm both through counselling erm and through that friend I was telling you about (I: Hm.) (3) to a point where my (4) yes I do still get a lot of the feelings I'm still crap with relationships erm deep relationships on a superficial level I'm great erm (4) particularly when I'm stressed I will get very very paranoid erm (5) and when people touch a raw nerve as well I will still get very very anxious and believe that people's intentions are not what they say they are. And I don't see how that will ever change because I see this as my personality. (I: Okay right) The only thing I could change which I have changed is (3) my reactions to it how I cope with those feelings (I: Hm.) and that's why I probably (3) don't come across to people who only know me on either a professional or superficial level as having borderline personality disorder.

Extract 40: Grace

Clemence: You know and I hope that it is and when I say you can recover from it I say it but also with wishful thinking because I'm scared you can't because of the label. (I: Yeah.) Do you see what I mean (I: Yeah.) So I want to know I want to feel that it's that you can recover from it because if you can't I'm fucked really and I'm just on a higher level of functioning and then what happens if there's a crisis do I resort back to that I don't-- I hope not. You know do I resort back back to that because that's my personality (I: Hm.) if you like. And that's the problem with the diagnosis is that it condemns people to a lifetime of hell if you like (I: Hm.) because you're saying you're never going to get better. (I: Hm-mm.) Yeah it's not like post traumatic stress disorder you can recover from that. And depression yeah you can recover from that you take some tablets you know it's a lot of tablets don't seem to touch it sometimes either you know. Erm and so and so it's I want to be able to recover from it because if you if you can't recover from it (I: Hm-mm.) then I'm I'm bugged (I: Hm.) you know. So but it's it is a worry that you can't recover from it because if it's true and the psychiatrists are right and I am borderline personality disorder does that mean I'm always going to be it (I: Hm-mm.) you know. And I've always got a little bit of an eye on that you know I always kind of think is that a little bit. Perhaps you can talk yourself into it as well I think and that's what it's a little bit like and that's the other problem with it I'm not I'm going off on a tangent you probably want to stop now but but that's the other problem is that do you give people this label and if you give I've tried not to do this because I could see that and I well I wasn't really bothered what they put at the time but if you if you're sense of self is so weak and you're just relieved to have a label which means that you've got an identity then you could see how you can buy into that. It's a little bit like when you take medication and you get all the side effects if you read all the side effects sure as likely you're going to bloody get them. So ((laughingly)) don't read the side effects read the first three, if you ain't got the first three don't worry too much. (I: Hm.) But if you read all the way down to the bottom and this long line and you can then know because your sense of self is so fragile you could end up bloody developing it ((laughingly)) do you know what I mean I know that sounds funny but you could end up (I: Yeah.) buying into it. And reading DSM-IV or wherever it is and and the other book and thinking yeah that's me that's me that's not me yet but it might be soon ((laughingly)) do you know what I mean (I: Yeah.) you know. (I: Yeah.)

Extract 41: Clemence

I asked the participants whether they considered recovery possible. As such it could be said that I influenced talk within a recovery discourse, although this was a question that evolved after several interviews and was suggested by Clemence as an important consideration, consequently the question was generated through discourse. The responses that I received

indicated a dilemma, one relating to the concept of permanence. Each participant positioned themselves differently, those who considered BPD unrecoverable experienced a dilemma about what this meant for the future and tended to position themselves as having to manage their 'disorder', those who considered it recoverable positioned themselves as 'recovered', but experiencing a dilemma as to whether this was truly possible on account of 'personality' within the label suggesting their fundamental self was affected. Shame also appeared to influence the discourse, as identified in extracts from Grace, Helen's and Ellen's interviews. This appeared further influenced by professional identities, would Clemence and Grace be devalued in their professional roles on account of having had the 'disorder'? Extract 40 is punctuated by hesitation and contemplation, suggestive of role conflict; a need to demonstrate from the position of professional as no longer being identified with the collective identity of BPD, while fearful that the past prevented this from being the case.

Extracts 40 and 41 demonstrate the struggle to resolve the dialectical dilemma posed by the terminology. Is it possible to recover from something which by definition diagnoses your personality as disordered and is considered permanent and unchanging within the DSM. Furthermore if you cannot recover what does that mean for you as individual? The construction of my question to Grace reflects my recognition of her use of pronouns to distance herself from the collective identity of BPD, I rephrase my question from 'something that **you** can recover from' to '**people** can recover from', my intention to clarify my use of the word 'you', so that I did not suggest, by way of implication, anything about the status of her recovery. Her response, contrastingly, positions her from inside the cultural experience of the diagnosis rather than her professional position outside of that experience, by reference to her own journey. After distancing herself directly from the experience by referencing time and space, which are themselves social constructions as identified by Fairclough (2003), 'I am **miles** (*space*) away from where I was **two years** (*time*) ago', this acts to tell me and other readers that she is removed from the event she is describing, that she is now occupying a different position. After a significant pause, she attempts to emphasise this distancing by reflecting 'I'm trying to think how I can describe how how different I am'. After further pauses, reflecting her contemplation of her past experiences and the need to perhaps find the appropriate words to convey the message she wishes to impart to me, she repeats that she experiences shame about her past behaviours. This I would suggest as in my discussion of Extract 40 highlights that her feelings of shame influence her ability to construct her 'recovery' as her reality. Within their interviews both Clemence and Grace draw on the application of this dilemma to their professional roles, this is perhaps constructed as a particular issue because they both work in the mental health field and as such the issue of 'mental health' as a professional is

most pertinent. There is evidence of ambivalence within their discourse, 'I think I have recovered' (Grace), 'I hope that it is...I'm scared you cant because of the label' (Clemence). What comes through in the recovery discourse is the lack of consensus around what 'recovered' really means. Grace draws on disorder management, and Clemence draws on a 'higher level of functioning' as a way of equating with the idea that parts of the personality are perhaps unchangeable. They both appear to be responding to an unspoken assumption or judgment or question from the 'experts' that they have not been 'cured' only learned to manage their 'symptoms', this identifies an inherent problem with the medical model of mental health. By defining a social and cultural problem medically without biological markers, how does one then determine that the problem has been resolved without reference to biological markers. In whose opinion should we consider the problem to be 'recovered'? In essence it presents an unanswered philosophical question.

In Extract 40, Grace rephrases through an embedded clause ('which I have changed') to emphasise that she does things differently now, she has done all she can to 'recover' and hopes this will be considered enough perhaps. At the end of her extract she suggests that other professionals do not 'see' the diagnosis, because she has learned to 'control' the symptoms more effectively or differently. She also suggests that her colleagues have a superficial knowledge of her, not a 'real' knowledge, recognition that she has different roles and constructs different realities according to the roles she is positioned in. Does this 'not seeing' of a diagnosis mean that it is not there, or does it mean it is hidden?

Clemence in Extract 41 asks 'do I resort back to that because its my personality?' Clemence goes on to construct what she considers to be the problem with the diagnosis 'condemned to a life of hell...you're saying you're not going to get better'. What Clemence does not say, but is implied through her construction, is that the ideology is that all individuals seek to be normal and the branding of individuals as 'disordered' excludes them from this normality, 'personality disordered' makes this impossible to ever achieve, and therefore results in the individual being excluded permanently from the collective subject position of 'normal'. This identifies through the recovery discourse the wider problem of who determines that somebody is 'mentally ill', according to whose reality we determine that something exists. While Grace and Clemence demonstrate the wish to draw on their own reality, what is apparent is the consideration that it is perhaps the 'reality' as determined by an 'expert' that decides this. Clemence states 'if its true and the psychiatrists are right' she suggests that psychiatrists generally represented a belief in the existence of 'disorders'. This acts as an identity classification system then rather than simply a way of being able to talk about a group of symptoms or experiences by short

hand reference to one term, 'I am borderline personality disorder' rather than 'I have borderline personality disorder'. The classification of people rather than disorders. 'Does that mean I am always going to be it' is Clemence drawing attention to the discourse which suggests a lack of answers, the reductionist foundations of the medical model creates more questions which remain unanswered, and in so doing does not assist with the concept of recovery.

Similarly, Dorothy, Francis and Helen in constructing the management of 'disorder' each draws out different elements of their 'reality' to represent this dialectical dilemma, if a disorder suggests a fundamental problem with an aspect of yourself which is regarded as permanent, does that mean it can ever be eliminated or only managed? This raises a further question for me, is the 'disorder' something that requires 'recovery', or is it simply a discursive construction used to describe an experience outside of the social norms and rules, and as such is the quest for being 'normal' actually immoral, should we even be associating a discourse of recovery to an experience which according to the 'reality' construction of the majority or a group of 'experts' is considered abnormal? The answer to this question appears to lay in whether we determine BPD to be something that does in fact exist. However, it raises important questions about the way in which we as mental health professionals give messages about recovery and position individuals accordingly. These questions related to the dilemmas of permanence and relevance of the concept further demonstrating the enigma that is constructed by BPD as a diagnosis.

In social anthropological terms, all human beings require a 'group' to survive initially physically and ultimately psychologically. By creating desirable groups and undesirable groups the psychiatric system inherently sets up a powerful management of social groupings. By creating a benchmark of 'normality' as the desirable group to be in, all individuals who do not fall into this group are faced with different levels of undesirability. This is so powerful that the words that Clemence chooses to describe this undesirability are 'fucked' and 'buggered'. 'Swear' words which are used to convey extreme emotion and suggest offence, while part of our modern culture, they appear to be used by Clemence to suggest that there are no other words with which to describe her sentiment and perhaps to shock me with her unexpected use of them. A further example of this fear of being unable to attain 'normality' is expressed by Beatrice in her interview; she says 'the whole worry that I'll never be able to lead a normal life'.

Another consideration within the dilemma of permanence and the idea of classifying people rather than disorders is related to labelling theory. Evident within a number of the interviews was the 'knowledge' of the diagnostic criteria list for BPD resulted in individuals recognising aspects of their behaviour attributable to the diagnostic criteria, much like a pseudoscience such as Astrological charts. Clemence, with a psychology discourse available to her acknowledges the possibility of labelling theory in Extract 41, her discourse demonstrates a reflection on the idea and her choice of metaphor highlights that, people are able to find examples where the criteria apply to them without 'real' evidence for this existence. She is highlighting how powerful an effect a diagnosis can have and how it can result in the creation of an identity, despite this dilemma of 'truth' about the existence of diagnostic criteria.

B.4.3.4.3 Recovery constructed as 'Disorder' Management

Extract 42: Dorothy	
I:	Do you think that there is something that you can recover from
Dorothy:	Erm no I don't think I can fully recover from it. I think it really scared me it it does scare me but erm like looking back in hindsight I can see the build up to that breakdown that I had four years like two years ago I can see the build up ((clears throat)) in hindsight and everywhere I went wrong that kind of would possibly not have helped that kind of escalated into that great big kind of erm breakdown. But what scares me is that I didn't see it coming at the time and I didn't know it was coming at the time. Erm and it's like I was quite stable for quite a long period of time and then it just come back and hit me and I'm scared that that's going to happen again in the future. It's like how do I how do I kind of stop that from happening again if I didn't even know it was coming in the first place because erm-- and I also I just think like erm (3) it's like every time I have a ma-- massive breakdown like that well I've only had two ((laughingly)) when I was 14 and like when I was 25 but every time I have a massive breakdown like that my whole life starts again because I lose everything erm like this time I've lost my job my child my erm driving licence erm I don't know how I managed to keep hold of my flat that was only because my psychiatrist spoke to my landlord ((laughingly)) I think he said please don't chuck her out. Erm but basically I go back to starting complete so I come almost starting completely afresh and (I: Hm.) completely again.

In Extracts 42 and 43, Dorothy and Francis position themselves similarly with their respective statements: 'I don't think I can fully recover from it' (Dorothy), 'I personally don't think you can recover from it it stays with you' (Francis). While they express their reasoning slightly differently they both make statements about their symptoms being part of their identity which they cannot change. Dorothy describes the uncertainty and unpredictability of the 'disorder' through her statements which result in her having to rebuild her life completely each time she experiences a 'breakdown'. Francis describes directly 'aspects of me that will never change'.

This suggests that they have also taken the biological understanding of personality, as being permanent and unchanging, and applied it within their own discourse to construct full recovery as not possible due to the underlying assumption of the medical model being ‘cure’. However, in extracts from their transcripts which I have placed later in this section, their ambivalence about this construction is apparent. Dorothy in Extract 42, describes her fear of having another ‘breakdown’ and not being able to ‘see it coming’. ‘I’m scared that that’s going to happen again in the future’ this statement supports the view of the dominant. If there is a possibility, or lack of certainty about what might happen then we can not determine that recovery is possible in case we are wrong. Through her discourse Dorothy is telling me that to assume that recovery is not possible, she can expect the worse and lessen the impact when ‘it happens again’. Her expression is one of inevitability which appears to match her experience of mental health professionals as viewing her as a revolving door client ‘she’s back again’ (Extract 22).

Francis:	because I'm not cured I don't think there is a cure as such but (I: okay.) you can modify your behaviour you can sort of change the way you are to sort of compensate (I: Hm.) you know
I:	Okay. So ((clears throat)) I guess the the erm there's another kind of question that can come off that and and say do you think it's recoverable do you think you can recover from this
Francis:	I I I personally don't think you can recover from it it it stays with you I mean I've been I've been like it since since my teens because that's when it develops really erm and there's still aspects of me that will never change you know like like I say the the nervousness of simple tasks being afraid to get them wrong. Erm the obsessive compulsive thing it's like erm the fear that something really really bad is going to happen (I: Yeah.) It's really weird to explain erm (4) the fear you know that'll never go away that's the thing just the fear of a mistake (I: Hm.) know.
I:	(3) Did the mental health services give you any impression about whether this was something that was recov—recoverable
Francis:	Erm no to be honest with you as soon as pretty much as soon as I found out then I didn't really follow it up that much I think I stayed with the I worked with the psychiatric nurse for a bit longer erm I can't even remember his name now and I should erm I I stayed with him for a little while and then after a period of time he just said right we'll keep your file open and you're free to come back if you need us erm and that was about it. I don't think I was ever told it would be it's like a you know a disease or something you can cure I mean I don't see it as an illness (I: Hm-mm.) as such because it's it's the way you are your personality is you so to have a different personality doesn't necessarily make you ill I mean your behaviour as a result of that could be seen as ill you know but to give to call it personality I mean I I would go with that to be honest personality disorder (I: Hm-mm.) borderline personality disorder but you know it it does need thinking about.

Extract 43: Francis

In Extract 43, I ask Francis what impression he was given about recoverability by the mental health professionals; an attempt for me to understand the context for his exposure to this discourse. His response indicates that he does not recall any direct discourse around the concept of recovery, however, he states that his psychiatric nurse said 'right we'll keep your file open and you're free to come back if you need us erm and that was about it'. This recall of the events surrounding his final contact with mental health services implies an existential assumption that his requirement for services would continue to exist although he may not 'need' them at the moment; by suggesting that his file would remain open implies that an expectation he will need them in the future but that at the current time there was no more that they could offer him. This suggests further the view of the dominant that BPD is an ongoing problem and therefore not recoverable.

Francis adds that they had not led him to believe that BPD was a 'disease or something you could cure I mean I don't see it as an illness'. He is relating to me a mental process of understanding the construct of BPD as something you have to live with because 'it's the way you are your personality is', the 'diagnosis' makes a statement in effect about who you are and what group of people you belong to. However, he then goes on to express what appears to be an element of doubt about what he was saying. He appears to have an unspoken series of thoughts about the appropriateness of the term 'personality disorder'. This can be identified by incomplete expression of his sentences and the use of 'but' and 'I mean'. This may connect with his opening statement of Extract 49, 'I'm a completely different person'. If he believes this then is he questioning the use of the terminology 'personality disorder' because for him this means permanent and unchanging, and yet he describes how he has changed. This is further evidenced by his statement which appears to question whether BPD as a construct actually exists in 'reality', he says 'borderline personality disorder but you know it it does need thinking about'. In this final statement of the extract my question appears to have triggered a discursive event challenging his belief about the diagnosis and the possibility of recovery, drawing attention to what could be conceived as a dilemma of permanence.

Overall his response to my question acts to tell me that his experience of the mental health system has resulted in his construction of a discourse which places a distinction between disease and disorder and, therefore, its implicit conveyance of the assumptions of recovery dependant upon a diagnoses placement within the disease and disorder category. Ultimately both act to maintain the dominant view that if people do not fit within the undiagnosable category of normal they are either positioned within a category which suggests 'curable' or

'non-curable', with 'cure' relating to the ability to become, or gain an identity which is, 'normal' according to the view of the dominant, the psychiatric system.

I:	Okay. Do you think that ((clears throat)) this is this borderline personality disorder is something you can recover from
Helen:	Recover from erm yeah I thought I thought I could erm erm because I thought I was okay but again as I said now that I'm in a relationship I know it's something I have to live with. And where I think there's quite erm there's a certain amount of comfort in that actually erm that I don't have to feel that erm I'll be cured of it erm you know I suppose it's like er an addict really isn't it it you know they can manage their addiction at times and at times they won't be able to they'll have relapses and and that's how I look at it now. (I: Hm-mm.) That it's erm something I have to live with because maybe it was sort of erm conceived through my early life experience yeah undoubtedly erm and erm it's sort of inherently a part of me. Erm and it's interesting I like that word personality because for me it's not when you add disorder on the end it seems like a negative but really it's also responsible for my great personality ((laughingly)) as I I feel in those eccentric quirky moments. (I: Hm.) So it does define me what I don't really want it to do is ruin (3) my life really in the way that it had or has done. I want to be able to manage it a bit like that addic-- you know an addiction. Erm and that's the tricky part

Extract 44: Helen

Helen begins, in Extract 44, by expressing her lack of certainty, immediately making me aware of her change of opinion based on her interpretation of her contextual experience. She expresses this as a fact, in comparison to her initial opinion. Helen goes on to suggest that knowing this helps her, it prevents her from seeking 'a cure' and feeling the pressure to be 'cured'. This is a powerful demonstration of submission to the authority of mental health/psychiatry. She draws on a metaphor of addiction to illustrate her point and that her 'disorder' requires constant management because it is unpredictable. She has the same view of the construct of personality as the other participants and believes it to be 'inherently a part of me'. However, she goes on to explain that for her this is positive, demonstrating a similar position to Francis, because it is 'responsible for my great personality ((laughingly))' she describes herself as 'quirky' and 'eccentric', rejecting the 'sick role' position. She identifies that when you add 'disorder' after 'personality' it becomes negative, suggesting a cultural tendency to see 'disorder' as undesirable.

By contrast, in another part of her interview Helen refers to how she decided that she 'wanted to heal' and 'wanted to recover' and 'didn't want to be in that system for the rest of my life' and how 'I've done that successfully now touch wood ((laughs))'. This contradicts her

statements in Extract 44, suggesting that she is constructing the dilemma of permanence. While she considers her personality as something you cannot recover from, she wants to recover by changing the way she manages her experiences. What this suggests is that there are different constructions of recovery, with different people believing recovery to be something different, but believing that the dominant view held by mental health services is that recovery is defined by 'normality' and require cure for which they use their own yardstick. Mental health services could be described as being unable to tolerate contradiction, you are either cured and, therefore, normal or you are not; there is no middle ground. What this assumption does is act to separate mental health professionals who create this distinction from the people that they treat, such that the people they treat can never become like them, and as far as possible they can never become one of the people they treat. Helen constructs the middle ground as requiring 'tools' to keep you there and that this 'is the tricky part'. This would suggest that these are not constructed as readily available from those who could impart them, that is mental health services, again this could be interpreted to suggest the powerful repression of those considered 'disordered' by those who consider themselves to be 'normal'. The ultimate power is to have knowledge of the 'tools' required but not imparting them to those who require them.

B.4.3.4.4 Recovery constructed by Hope

Clemence, Dorothy and Anne draw upon the concept of hope in relation to the discourse of recovery in Extracts 45, 46 and 47. This develops further Beatrice's suggestion in Extract 38 that professionals give up hope for your recovery with increasing age. Clemence and Dorothy instead of increasing age, construct that the diagnosis immediately results in professionals giving up hope of recovery. Anne appears to have recontextualised this idea within her discourse to suggest that she is unhelpable and in fact predicts her own mortality.

Clemence, in Extract 45, identifies a powerful construction of doom associated with the disorder by mental health professionals. Clemence makes a global statement of fact, suggesting an overriding discourse of non-recovery inherent within the mental health system, she rewords this further demonstrating a dialectical struggle. Clemence states that despite her 'knowledge' gained through her professional role and own treatment she is unable to lose the powerful discourse of non-recovery associated with the suggestion of having a disordered personality, it appears to overwhelm her and leaves room for an element of doubt about what exists and is 'real'.

Clemence: What they don't do with borderline personality disorder is think you're going to get through it nobody expects you to get through it you know including the people who have diagnosed it you know. (I: Yeah) So you're really basically setting setting that person up not to actually recover because of the diagnosis itself suggests you won't recover you know. And even with all the insight and awareness that I've gained and my professional life there's still this horrible horrible little word inside me that but maybe you don't recover from this because it is a personality disorder you know. And and you set yourself-- set people up for it (I: Hm.) you know. And then when they don't recover they go ah see they don't recover nothing works for them you know they reject all the therapy you offer you try and try and try but they won't be helped. And I ((laughingly)) I hear it all the time I hear it a lot

Extract 45: Clemence

Furthermore, Clemence points to an ideological assumption by the mental health system which enables professionals to justify their position, she states 'when they don't recover they go ah see they don't recover nothing works for them you know they reject all the therapy you offer'. This is dialectically related to the discourses of blame and stigma already discussed. The blame discourse is identified by 'you try and try and try but they won't be helped' enabling a professional position of 'it is not our fault'. The stigma discourse is apparent in 'ah see they don't recover nothing works'; this acts to suggest confirmatory evidence for negative attitudes towards those with the diagnosis of BPD. Clemence adds further credence to her statements by finishing the extract with 'And I ((laughingly)) I hear it all the time I hear it a lot'. This statement acts to tell me that this is not something she has imagined but something which she has witnessed, has heard, rather than interpreted.

Dorothy: I think the other negative thing about it is it's just like erm it's like a lot of people when like even psychiatrists and stuff they like once you've got a ((laughingly)) borderline personality disorder it's like they know that nothing's going to work for you (I: Right) immediately they know that whatever they say do nothing's going to work for you so they don't really take you seriously ...

Extract 46: Dorothy

Dorothy chooses similar language to convey her experience of the mental health systems non-recovery discourse in Extract 46. Interestingly in constructing these statements both Clemence and Dorothy speak through amusement, potentially identifying they're nervousness around the idea, making light of something which has far-reaching implications and suggesting a meaning for the diagnosis which is difficult to acknowledge. Both Dorothy and Clemence also refer to professionals directly as holding a view of non-recovery but express this in a way

which suggests that the common assumption is that mental health professionals should believe in the possibility of recovery. Dorothy does this through the use of the word 'even' in the following statement: 'it's like a lot of people when like **even** psychiatrists and stuff'; and Clemence does this with the word 'including' in the following statement: '**including** the people who have diagnosed it'. Dorothy goes on to suggest that the implications of this discourse are that 'they don't really take you seriously', what we can imply from this statement is that with a diagnosis of BPD you are regarded as less important or deserving than other people, both service users within the mental health system and the professionals who are dominant within it.

Anne:	I know I haven't got a long life you know some professionals say don't be silly <i>Anne</i> I know my life isn't going to be as long as everybody else's life because I know that one day my impulses are going to get me into trouble and I am going to die that's fact and I have to accept that but what I can do is make sure my kids are okay well adjusted and make sure that they know it's not their fault. And that's about writing down things and making sure that they don't feel punished they don't have to punish themselves or blame themselves. But that it's fact and I suppose you talk to a lot of people that probably say the same thing it's fact you have to accept it if I live until I'm 50 that's great but I don't know (3) it's great that I've got this far but without any help and support I've done well to get where I am
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Extract 47: Anne

Anne expresses her experience of reality as the inevitability of mortality associated with the 'disorder' in Extract 47. This extract exemplifies Anne's attempt to present the 'truth' about the disorder, the seriousness of the 'disorder'; in part this appears to function as a dislocation of blame to an external force outside of her control, by saying 'without any help and support I've done well to get this far'. This is a statement also made by Beatrice, its intention to present an image to the reader of an ongoing battle being fought alone and suggests that with help things would be different. While Anne acknowledges it will happen as a result of her own behaviour 'one day my impulses are going to get me into trouble', it positions the event, impulses leading to death, as having a foreseeable outcome which is not being prevented. Also the extract demonstrates the recontextualisation of the non-recovery discourse suggested by other participants to be conveyed through mental health services and psychiatry. 'Inevitability' suggests a certainty and while death itself is an existential event, a predicted early death is not and, therefore, must have arisen from a discursive construction. If mental health services use a discourse of non-recovery then this can be recontextualised within an individuals own life, dialectically, to mean that the self-harm risks that in part define BPD as a diagnosis, if not changeable will eventually end in mortality.

In essence Anne's extract acts to invoke compassion by her apparent resignation, expressed through her choice of language, to an early death; her statement of concern for her children; and the presentation of this event as outside of her control. She identifies how it is dismissed by professionals, 'some professionals say don't be **silly Anne**', almost as if to counter any denial of her existential statement that I may be considering. She states that she will 'make sure my kids are well adjusted and make sure that they know it's not their fault', drawing on a discourse of blame and indicating her preparation for the event. This is a powerful extract which demonstrates the impact of the underlying ideology of mental health services upon Anne and her construction of the reality of her life course.

B.4.3.4.5 Recovery constructed by 'Knowledge'

A further aspect of the recovery discourse which is drawn upon by Ellen and Francis is that of the importance of knowledge in constructing their experiences as recoverable. They refer to the diagnosis as providing them with 'knowledge' which enabled them to gain a position in relation to the potential for them to overcome their problems. This 'knowledge' is considered by them to give them a better chance of gaining control, 'disorder management'. They both construct the receiving of a diagnosis, a name for the problems they were experiencing, as beneficial to their long-term prognosis. However, they go on to identify how this 'knowledge' brings with it a need to accept that they will never 'be normal'. In effect it provides an alternative identity which excludes the desired state of 'normality'.

Ellen: I think I've got a better chance knowing I've got a better chance (4) but I think that where in the past I just wanted to be normal I don't ((clears throat)) I don't have that expectation and I don't have any distress relating to that I accept that that this is a condition that I've got where I can can manage it I'm not you know I am making the steps I'm making slow but you know what I mean they are sort of steps forward. Erm and I think that understanding the way that it's affecting me means that I can erm do things that are not going to cause the problems do you see what I mean. So the awareness I think is so important. But I think probably for people I could imagine somebody having this condition and not wanting to know and then I think perhaps well if they didn't want to know it would be damaging. But I think where you've got a a patient that that really does want to know and wants to try and take a proactive approach I think it's important.

Extract 48: Ellen

In Extract 48, Ellen states 'I've got a better chance **knowing** I've got a better chance', this draws on the assumption that something different from her current experience is desirable, that her previous reality was not desirable. This is itself a social construction of what is

desirable in relation to interpersonal experiencing and mood states. Ellen does not appear to experience the same dilemma of permanence as the other interviewees. She describes accepting that she cannot be 'normal', 'I accept that that this is a condition that I've got where I can manage it', this suggests a underlying assumption of the diagnosis that you cannot recover. This is treated by Ellen as a fact of her 'knowledge' that she has a 'personality disorder', Ellen states 'I think where in the past I just wanted to be normal I don't ((clears throat)) I don't have that expectation and I don't have any distress relating to that'. Her statement suggests an unquestioning acceptance of a mental health discourse of non-recovery. Ellen refers to the construct of BPD unquestioningly, despite her fears of stigma and blame, as being 'real' and factual, and how understanding this reality helps her to manage. Although the point at which she clears her throat may suggest this is something she does find difficulty to construct as her reality, or at least to voice.

As a whole this extract appears to demonstrate how the diagnosis has provided Ellen with an identity which she has perhaps accepted, despite her misgivings about its associations identified in previous extracts from her interview, and does not challenge its accuracy. This is demonstrated in her statement 'I think that understanding the way that **it's** affecting me means that I can erm do things that are not going to cause the problems', she objectifies the construct of BPD by her placement of 'its' as the subject in the statement. Ellen draws on the assumptions of medical discourse, identified by the use of 'condition' and 'patient' in this extract and 'illness' and 'amygdala' in other parts of her interview, that there is something 'wrong' with her, she is not 'normal'. In the final part of Extract 48 Ellen reiterates that the 'knowledge' of the diagnosis as being what's 'wrong' with you is important, this draws further on the existential assumption that the diagnosis represents 'the truth' as she constructs it. This demonstrates the power of the psychiatric diagnostic and classification system at creating a 'truth' about what exists for people, and what that system implies about recovery.

I:	Okay. What do you think the differences are in your experience between when you first diagnosed and now
Francis:	I'm a completely different person (I: Okay.) most definitely erm just realising that sitting at home feeling sorry for myself isn't going to work isn't going to change me. And to be honest with you I'd probably be dead now anyway you know I would have done something to myself simple as. So you know to change things you've got to know what the problem is to start with (I: Hm-mm.) so that's how that's what I did I sort of you know borderline personality disorder fair doos er what is it. And I never to be honest considered going into detail with the bloke who diagnosed me so I went out and looked checked it out for myself.
I:	Can I ask why you didn't consider going into detail with him
Francis:	Because I was relieved that there was actually an answer you know it wasn't just depression which is what I was told it was all the time.

Extract 49: Francis

The same unquestioning approach to the receipt of the diagnosis and its discursive implications was taken by Francis, apparent in Extract 49. This approach is identified by his statement: 'I was relieved that there was actually an answer'. Throughout his interview this 'knowledge', that the diagnosis provided him with, he constructs as the reason for him being able to change his experiences. He states that 'I'm a completely different person', this statement of 'fact' by Francis appears as an attempt to communicate to me that he no longer experiences the problems that he did before and indicates a new social position and identity. However, in Extract 43, he identifies that recovery is not possible. This again calls into question the definition of recovery within its common usage. Are there different levels of recovery; does the mental health discourse definition involve 'full recovery' meaning a return to 'normality'; and if so what defines a 'full recovery' and 'normality'?

Francis' construction, while potentially appearing to demonstrate an ideological conflict with regards to the limits of recovery, could indicate that his definition of recovery is based on that of mental health services and, therefore, considered unachievable, as he has been discharged from mental health services with an 'open case' and will never, therefore, have the diagnostic label removed. Francis identifies his experience of change in simplistic terms; he suggests that changing his discourse was enough to change his experience. He suggests implicitly in this extract that the 'knowledge' he gained by the receipt of the diagnosis saved his life, perhaps what Ellen referred to as 'damaging' within Extract 48, when the knowledge is not available. He makes an interesting statement about the 'knowledge' that he received when he stated: 'I never to be honest considered going into detail with the bloke who diagnosed me so I went

out and looked checked it out for myself'; this again in a similar way to Ellen draws on the assumption that the information he received was therefore not from a psychiatric or medical discourse community, beyond the name of the diagnosis itself. This changes the type of discourse available to the individual.

Ellen and Francis expressed similar attitudes to the diagnosis, in relation to their unquestioning approach, and an acceptance of the diagnosis at basic level. In fact Francis identifies his immediate acceptance of the diagnosis that was given to him. This on the basis that he received it from a psychiatrist who was considered 'an expert', as he details in another part of his interview, however he did not go on to ask him to explain further or validate his diagnosis. This further demonstrates the power with which psychiatrists hold bringing about unrelenting belief in what they communicate to their patients at face value.

B.4.3.4.6 Recovery constructed by Understanding

The final two extracts in this chapter demonstrate Clemence and Helen likening their experience to an analogy of drowning and being swept away by a river. However, they focus on the diagnosis in different ways within their constructions with different intent. This demonstrates how a metaphor can be used differently. It also constructs the heterogeneity of those 'diagnosed' with BPD, in both their interpretation and contextualisation of the diagnosis. It highlights how BPD can be constructed as an experience of 'drowning' and of saving from 'drowning' at the same time. For Helen the diagnosis itself is enough, while for Clemence it is what occurs after the diagnosis. This provides a further construction of enigma.

Clemence: So that's it isn't it it's kind of meeting you halfway and saying come over here and talk you know have a go at it (I: Yeah.) you know see what it feels like have a little paddle around. You know what I'll tell you what it's like right it's like and I always think CBT is like this to be full of you've got this diagnosis I'm supposed to have is it's a bit like some-- you're drowning (I: Hm-mm.) right you're drowning and CBT person's standing on the bank going right what you need to do it's russian language swim right and swim and start paddling and maybe stand up see if you're not drowning at all just swim now and I can't understand what they're saying right. But but when you're off-- when you what-- but if you've got somebody who's there and they say and they're offering you a real relationship they paddle out. (I: Yeah.) They don't don't do that thing where they're drowning themselves not if they know what's good for them (I: Hm-mm.) Hopefully they're in supervision enough so they don't do and they've got a bit more insight but they paddle out they get involved in the shit. (I: Hm.) And I think that's the problem is with borderline personality people don't want to paddle out and get involved in the shit because it's messy and it's smelly and it's horrible (I: Yeah.) and it's bloody in my case. (I: Hm.) But with people with if you have a therapist that is not scared of paddling out (I: Hm-mm.) and getting kneeling and in the shit and paddling out and knowing they're going to get shit and knowing they can have a shower later on and they can get rid of it and be okay with themselves and it will be all right for them. But they can paddle out they can hold a hand out and they can maybe pull you to the shallows a little bit so you can at least stand up. (I: Hm-mm.) And even if you don't understand what you're saying you can at least at least not drown and then you think oh okay you know and once you actually stop panicking maybe you can hear them a bit better.

Extract 50: Clemence

In Extract 50, Clemence is describing her experience of an effective therapeutic approach as saving you from drowning in 'BPD'. This powerful metaphor constructs helplessness, extreme fear, danger and threat to life. Clemence's use of language with terms such as 'in the shit', 'messy', 'smelly', 'horrible', 'bloody' constructs BPD as undesirable, something which has the power to repel people, and she commences this point by saying: 'the problem is with borderline personality disorder people don't want to paddle out and get involved in the shit'. She highlights how the therapist can 'have a shower later on and get rid of it' which leaves the powerful impression with me as recipient of her discourse that this is something that the individual cannot do. They cannot simply choose to 'get showered' and simply wash away their experiences, further demonstrated by 'it will be all right for them'

Clemence's analogy appears to be an attempt to accentuate the importance of compassion and collaboration in beginning to communicate with individuals diagnosed with BPD; rather

than being repelled by them and using a discourse which they have yet to understand. She suggests it is this which results in the assumption that somebody has not tried to save themselves, has not recovered, she says 'and even if they don't understand what you're saying you can at least not drown', 'once you stop panicking maybe you can hear them a bit better'. This links with my discussion of Clemence's previous Extract 46, where she identifies that mental health professionals displace blame for non-recovery by taking up a position that nothing will work and if it then doesn't they are able to say 'Ah you see', in effect 'I told you so'.

In essence Extract 50 sets up a blame position with the professionals for non-recovery. Clemence states: 'CBT person's standing on the bank going right what you need to do it's Russian language', this acts to position her against CBT for BPD and constructs this as the therapist standing on the bank shouting instructions for how not to drown but in a foreign language. Linehan (1993) proposes a similar metaphor to Clemence of the use of standard behaviour therapy treatments as shouting instructions to a drowning swimmer while sitting on a life raft, all be it in a soothing voice. This is a metaphor for trying to bring about change while simultaneously invalidating the experience. Clemence constructs this as the reason people do not recover, because professionals do not want to get involved themselves in case they 'drown'. Thereby, rather than attempting to communicate using a discourse which both therapist and client can understand, they avoid communication. Clemence highlights this when she says 'they paddle out they get involved in the shit' and 'they can paddle out they can hold a hand out and they can maybe pull you to the shallows a bit so you can at least stand up'.

Helen:	I suppose and all that baggage kind of popped out again. And then I thought-- and then it's almost like you feel you're being swept down a river and in a strange way it's like a like a like a branch or something to hold on to and you think oh I'm holding on to my illness diagnosis whatever you know oh and that's fine actually because it's I choose to embrace it then I don't feel like I'm going mad. Erm and so that's kind of weird I suppose that's like almost like a paradox in a way because you're handed this thing and-- but maybe it was supposed to define you and then yet it feels as well it feels like a some sort of a like a lifeline as well because you hm you can put it down to something. It's nice to sort of erm erm what's the word erm erm not allocate erm attribute it to something in a way.
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Extract 51: Helen

Helen positions her metaphor differently to Clemence, likening the diagnosis of BPD to a 'branch or something to hold on to'. She objectifies the diagnosis with this statement as something concrete when 'being swept down a river'. She uses this metaphor to describe the

experience of the 'disorder'. Helen identifies this as 'strange' this suggests she is aware of a value assumption, that this is an unusual way to perceive the diagnosis. She was, perhaps, trying to mediate my reaction to her metaphor based on the assumption that I would be surprised that she perceives it in this way. Helen goes on to provide a reason for this metaphor of the 'branch over the river' as one of 'knowledge' that you are not 'going mad'. She further suggests 'so that's kind of weird I suppose' again possibly expectant of my reaction, or the awareness of a discourse which suggests this to be the 'wrong' way to think of the diagnosis. Helen then presents the diagnosis as a paradox, explaining that in her construction of the purpose of the diagnosis it is to 'define you' but that it actually offers a 'lifeline as well because you hm you can put it down to something'. This is similar to Ellen and Francis who view this 'knowledge' as pinnacle in their attempts at change. In this way Helen constructs the diagnosis as if the underlying assumption within psychiatry is that a diagnosis of BPD places you outside of the 'normal' group; and yet for Helen it enables her to remain out of the 'mad' group, which she feared prior to diagnosis. This demonstrates her acknowledgement of the power that psychiatry can have to create an identity, but she communicates to me through this metaphor that it has not done that, appearing as a disconfirming statement to the discourse communities of mental health and psychiatry.

B.4.4 Summary of Analysis Chapter

This Chapter is not exhaustive and presents only the discourses which I consider to be dominant as a result of my analysis. The less dominant discourses and those which appear to be touched upon within the interviews have not been discussed in any detail. This is due to necessity, however, I acknowledge that there are many different ways in which this data could have been approached, which may have highlighted different aspects of experience. I have commented upon discourses which appear to have been recontextualised within the dominant discourses and how these influence the ideologies presented. Similarly as with all DA there are many ways in which the discourse itself could be labelled, I have constructed the discourse labels through my own discourse community of counselling psychology and the field of professional work with BPD. There will be alternatives to my choice of descriptors for the discourses, however, I decided upon the particular vocabulary according to that used by the research participants.

I have provided a number of examples of the dominant discourses I refer to and have relayed my interpretations of the discourse and begun to discuss the related ideology and consequential power relations. In summary, blame is presented within the interviews as an unresolved ideological conflict of responsibility for actions with individual or professional being

to blame variedly; stigma is identified as constructed by the diagnosis and presents a dilemma with regard to its accuracy; and recovery constructs the diagnosis as a dilemma of permanence and a concept which remains undefined leaving room for doubt and ideological struggle over whether it exists. In the following chapter I identify how I think these discourses demonstrate the internalisation of the views of the dominant and more powerful groups in society.

The three dominant discourses are dialectically related. It is not possible to determine a hierarchical or causal relationship between them, and they cannot be considered completely in isolation from each other as I have demonstrated through drawing on the other dominant discourses apparent within the discussion of each. Blame, stigma and recovery could be said to be attributed to each other, if an individual believes a condition is unrecoverable does this require blame to be present or does it create blame, if an individual feels to blame for their condition does this result from stigma or cause it? These discourses all act therefore to construct the concept of enigma in relation to the BPD diagnosis. They do this by suggesting there are no answers other than the existence of the label itself, where there is a possible thesis with regard to a dilemma of meaning there is an antithesis, and as a result of our Western reliance upon Aristotelian philosophy of the world we are unable to allow the two positions to exist, we strive to resolve which is right and wrong excluding the middle ground.

B.4.5 Reflections

Fairclough (2009) identifies the importance of considering yourself within your analysis in order to obtain quality standards of this type of research; and to identify one's own ideologies which need to be considered within the analysis. The most significant challenge in conducting my analysis was managing my position as 'editor'. Upon completion of the transcribing of my interviews I was faced with over 400 pages of text from 8 participants. While in itself I found the quantity overwhelming, further as I began the process of analysis I became acutely aware of the need to select from the 400 pages, which quotes and extracts would become part of this section. This was an uncomfortable process. The reason for my discomfort directly relates to the topic of my research, that is the social construction of reality. How then could I be true to my epistemological and ontological position and also decide what to include and exclude from the texts? I had to find a way to overcome this in order to complete this section. As a result I went over each transcript many times and took a significant amount of time to produce, edit and present what is now in this Chapter. This process of continual analysis, being part of DA approaches more generally, I found that each time I had to approach the text with a different question, or concern, and awareness of my expectations of what I was perhaps hoping to uncover.

As I identified in my introduction to the research, this subject is one which I have been interested in for a long time, and I have come from a position of providing interventions, from support work to long-term therapy, to individuals formally or informally diagnosed with BPD for over 10 years. I have worked for the NHS, Charities, Private Companies, Public Sector, Criminal Justice and have, therefore, come to regard the psychiatric institution from different perspectives; with different discourses; and different constructions of their power. Therefore, I commenced this research, from a sympathetic position considering that the diagnosis of BPD was unhelpful; a pejorative term used to describe individuals who proved most challenging to their psychiatrists, or whom staff did not like, or who would be well-known to all front-line services and would not conform to societal rules with regards to appropriate behaviour. My awareness of this position enabled me to question each stage of the research process and resulted in some enlightening new constructions. The difficulty was in ensuring I presented a balanced position in relation to my views. While the aim of CDA is to identify with the position of the oppressed in the investigation of a social problem, I was also aware of the imperative not to construct my participants' responses according to what I was expecting to find.

As a result of my approach to ensuring validity of my analysis I became aware of findings which I was not expecting. Firstly, the relief described by the participants when they first received the diagnosis, and for most they perceived this as occurring after a lengthy period of time that what was seen as 'information withholding'. For some this was understood as 'intentional', while those working in the mental health profession understood this from a position of 'withholding of labelling'. I was expecting to find that constructions of the diagnosis would identify pejorative application of the diagnosis and this was not the case. However, this could be as a result of my construction of the questions; although few respondents to my research advert identified such a construction.

The second surprising construction was that of the general perception of participants that for the lay person there was a relative non-reaction to the diagnosis compared to the reactions of mental health professionals. My assumption was that there would be negative responses from lay people, more in line with the academic literature and rising media campaigns on 'Stigma'. My overall impression from the interviews and analysis was that the whole process of being in the mental health system had been constructed as traumatic for reasons not simply related to negative constructions of the diagnosis itself. However, from a critical realist position, this could be as a result of all the participants having histories of childhood trauma and thereby, limiting the discourses and subsequent positions, available to them.

Finally, I was expecting participants to construct their experience of the mental health system negatively; partly as a motivation to participate in the research, and also as a result of my own experience of mental health attitudes towards individuals with the diagnosis of BPD. However, the majority of the participants constructed their experience both positively and negatively, although these positive attributions also identified potentially problematic ideologies. There was, however, the unexpected outcome for me with regards to recovery discourse and that was related to the construction of a dilemma of permanence. This was something that I had not previously considered.

Furthermore with regards to ensuring validity, I found that the continual re-analysis of texts; discussions with my research supervisor; regularly revisiting the literature available from different disciplines; and examining new service user research as it became available enabled me to remain true to the texts without becoming distracted by my own agenda. As well as giving me the opportunity to consider the transferability of the constructions I was uncovering and the ideologies that I considered these constructions to be identifying. However, in keeping with my social constructionist position, this is essentially my social construction of the discourses and ideologies that were present according to my 'reading' of the text. That is not to say that it is the 'correct' view as this would never be possible to obtain, but nonetheless it is a construction which is limited by my education, social and cultural experience.

B.5 Chapter 5: Discussion

B.5.1 Introduction to chapter

The aim of this research was to identify how individuals with a diagnosis of BPD constructed: their experience of the problems labelled as 'BPD'; their understanding of the diagnosis; positioned themselves and considered themselves positioned by the diagnosis of BPD. Through Critical Discourse Analysis the dominant discourses revealed were blame, stigma and recovery which drew upon a range of other discourses such as medical, mental health, lay, therapy and trauma amongst others. The dominant discourses dialectically constructed BPD as an enigma. In addition to the discursive constructions identified in Figure B.2-1, there were a number of subject positions which could be identified as: sick; victim; abnormal; survivor; mental health professional; lay expert. My examination of these discourses, constructions and subject positions considers the political, social, historical and cultural context alongside the ideologies identified and the potential for oppression as a result of this. I further consider the importance of these findings in relation to Counselling Psychology as well as the mental health field more generally. Finally, I move on to briefly discuss alternative approaches to the construct of BPD and to reflect upon the research, its limitations, future work and transferability of my findings.

B.5.2 Interpretation of analysis

BPD is constructed through the narratives of 8 individuals as an enigma. A diagnostic category that, more than any other, reduces a collection of symptoms to three value-laden words; while promising hope through identification and existential assumption, it removes meaning and decreases understanding of the difficulties individuals experience within their social and cultural contexts. The origins of the dominant discourses apparent within the construction of the enigma are in the prevailing ideology of mental health, psychiatry, psychology and society.

Currently, our UK political power system is organised according to Enterprise Capitalism, as identified by Heywood (2000). This economic model is built upon: self-interest and a drive towards increased productivity and wealth; minimal public ownership; emphasis upon market competition; a minimal 'safety-net' welfare-system; and trade unions with minimum influence. The economy is further driven through post-industrialisation and technological advancement; the foundations for continued and increasing wealth (Jones & Elcock, 2001). The ideology underlying the political, and consequently societal, system cannot be positioned within a 'true' ideology, with writers describing the major political parties as differing more in relation to policy than ideology. However, what can be drawn out upon closer analysis are the more general values of individualism, responsibility, tradition and anti-welfare (Heywood, 2000)

upon which the ruling parties of recent political history, including those of the newly formed coalition government of 2010, have based their policy-making. In the 1980's Thatcherism was characterised by law enforcement and individualism, the legacy of which remains prevalent within UK society.

Gramsci (1971), a neo-Marxist, proposed that when ideas about the world come to be accepted as 'common sense', they become hegemonic and, as such, enable those whose interests the ideas serve to become more powerful, as this 'common sense' is unquestioned. The hegemony of the current age is one of a market-based system, value for money and the requirement to be self-sufficient without reliance on state for care or security (Symonds, 1998). This acts to advance a capitalist society, in a post-industrial era of productivity and technological advancement. In essence this supports the Marxist idea that power is driven by economics. As such the assumptions and values, uncovered by analysis of the dominant discourses in this research, are presented to society as the 'common sense' view, necessary for the development of our society. Further, Smail (1999) suggests that the disciplines of psychiatry, psychotherapy and psychology have instilled political ideas of individualism within their constructions of mental health, resulting in the individual believing all pain and distress to be internally located.

B.5.2.1 Blame discourse

Blame was discursively constructed by: mental health services; individual responsibility; institutional responsibility; and malignant alienation. Most of the participants struggled with the dialectical dilemma of 'being to blame' versus 'being a victim'. This finds them unable to resolve whether they are to blame or whether something, or somebody, outside themselves is to blame for their psychological difficulties. Linehan (1993) suggests this is a common dilemma.

Considering this ideologically, the underlying values of this dialectic appear to be those of individualism and responsibility, these are dominant amongst the most powerful groups within society; those charged with governing, organising and directing society. These values ordinarily call upon an individual to identify problems within themselves and to accept responsibility for these by assuming a 'sick role' with more powerful groups then assuming responsibility as 'experts' for their 'management' and 'cure'. However, with BPD, individuals are considered not to respond to 'expert' attempts at 'management' and 'cure', subsequently the 'sick role' is seemingly revoked and blame for non-response placed back with the individual. This presents the 'rescuing' mental health services as only helping those who want to be helped; individuals

who are 'good patients' and respond to care giving with gratitude, compliance and recovery; maintaining the powerful position of 'healer'. This confusing dialectic presents its dilemma directly to the individual: Am I to blame or not? Such dialectical dilemmas are described by Fairclough (2001a) as evidence of ideological struggle; the dominant view not only suggests contradiction but presents a 'common sense' view which is being contested.

Blame, as identified by Alicke (2000) is an everyday discourse related to matters which are considered morally wrong or socially shameful. The process of determining whether somebody is blameworthy and, therefore, punishable, occurs through attributions of culpability and control within the realms of moral philosophy. As human agents we seek to locate blame for harmful events, and actions, such that social order can be maintained through punishment and act as a deterrent to others in the social group. Thus, our lack of understanding of the construct of BPD within scientific and medical discourse, results in misplaced moral attributions of blame, as individuals are viewed as in control and thus potentially culpable. Potter (2009) identifies three values of Western culture which she believes underlie blame discourse in BPD: autonomy and intolerance of neediness and dependence; the undesirable and value-laden moral emotion of disgust; gender, and in particular femininity, rules within society including respectful behaviour, nurturing and compliance. Each of these values is challenged by individuals with the 'symptoms' of BPD.

Johnstone (2010) states that applying a diagnosis to socially and culturally constructed experiences '...is an immensely powerful act which has profoundly damaging implications for a person's confidence, identity, relationships, place in the community, employment, health and future' (p.15). Johnstone further argues that the act of pathologising social problems as medical ones locates them within the individual and prevents escape from the originating social situation and positioning. Furthermore, DSM IV-TR (APA, 2000) actually sites mental disorder as occurring 'in an individual'; as Kutchins and Kirk (1997) point out, the manual very clearly positions psychological problems as occurring from within an individual, and not outside, as such the implicit assumption being that if a problem is located within you then, particularly with reference to PD diagnoses, blame can be equally located within the individual.

In relation to the discursive constructions of blame through mental health services, identified in B.4.3.2.1, Linehan (1993) suggests mental health professionals' loss of patience and intolerance of the constant seesaw of behaviours, as a result of unrealistic expectations, recreates an invalidating environment in which individuals are expected to respond positively to 'treatment'. The professional observes lack of change, attributes this to the individual's

desire not to want to change, consequently, blame occurs. Blaming and invalidation has to be prevented if treatment is ever to be successful. Maskowitz (2001) proposes that another reason for negative responses to individuals exhibiting the characteristics of the BPD diagnosis is the way that they challenge our own inadequacies, our inability to be effective impacting upon perceptions of the self-as-therapist.

Paris (2008) identifies the attraction of mental health professionals to simplicity when faced with individuals in distress. They are attracted to linear explanations of cause and effect, as the Western human mind is generally. Attribution theory, as outlined by Potter (2009), identifies that in order to gain a sense of control over their environment individuals attribute causes to events. In relation to those considered to have BPD, research suggests that staff attribute the individual to have control over their behaviours and therefore, are less likely to feel empathy and more likely to feel anger (Feather & Johnstone, 2001). Similarly, Nehls (1999) identified how mental health professionals' negative responses to those with BPD were influenced by their view of them as 'manipulative'; implying that choice and responsibility lie with the individual. This is based not only in moral philosophy, as identified by Potter (2009), but also in the reductionist approach and Aristotelean logic of positivism. Within the medical model there is a drive to reduce everything to its simplest form in order to understand it. However, this acts to exclude the complexity of human existence, and creates unsubstantiated interpretations of behaviours. For example, Nehls (1999) found that the meaning of self-harm was not explored but nonetheless viewed as manipulative and aggressive, evidenced in B.4.3.2.3. Hence, when unable to understand things with simple causal explanations we devalue them and attribute negative interpretations, resulting in blame which is then internalised (Haigh, 2002b).

This blame positioning of individuals has given rise to the 'self-help' shift within mental health services. Such that if an individual does not 'help themselves' then they may be considered as making a choice not to control their behaviour and as such within moral philosophy are considered 'blameworthy'. This was further identified by Nehls (1999) as the common health promotion strategy of individualism, to 'help yourself', and one that appears to apply particularly to mental health professional attitudes to BPD. The internalisation of this self-help view in relation to control was particularly evident in B.4.3.2.2 Extract 12. Blame was further constructed through 'Malignant Alienation'. This was conceptualised by Gethin Morgan in 1979 as a process having commonly occurred prior to suicide amongst 'patients' whom mental health professionals found difficult to like. He describes how patient, staff, interactions between patient and staff, and the environment act together to result in damaging outcomes for all. Watts and Morgan (1994) identify how the individual, unable to communicate their

needs does so in ways which act against staff perceptions of the 'good patient'. This results in a poor alliance between staff and the individual, the reactions of staff are viewed in an environment attributing interactional problems to the individual rather than providing the opportunity to reflect upon the relationship in order to understand the meaning of behaviours and how these are re-enacted by staff. This results in staff alienating the individual and them being considered as an inevitable suicide risk. This process was reflected within the constructions of my participants and is dialectically related to stigma and recovery discourses.

Furthermore, this blame discourse is particularly relevant to the diagnosis of BPD as a result of potential parallel processes within staff groups, as identified by Rigby and Longford (2004). When mental health professionals are faced with being held accountability for an individuals self-harming behaviours, as part of institutional responsibility as highlighted by several of the participants in B.4.3.2.3; there is a human tendency to defend the self against attack, and this can often result in blame attributions. By setting up a position whereby the individual is considered within a discourse of blame a common sense view is created - that this event is not their responsibility, in essence there is a parallel process relating to the dilemma of blame. While this discourse could be considered in relation to many diagnoses, the risks to self and the lack of consensus regarding the diagnosis of BPD mean that blame discourse is potentially most readily drawn upon as a result of an unresolved and unspoken dialectic between staff and clients. The discourse can become powerful in enabling the staff to potentially retain a 'blameless' position and the clients a 'blameworthy' position, presenting the polar opposites of the dialectic while each experiences an ideological struggle. However, this is a discourse theory that would require further investigation in relation to staff discourse, as this is based upon assumption.

In short, we take a group of individuals who do not behave in their social environment according to the established rules and norms for interpersonal interaction; we fail to understand why they do not behave according to those rules and norms; determine this is unfathomable, according to the hegemony present within that society, as the rules and norms are legitimated, considered 'common sense'; and hence, decide that as their presentation is not bizarre it must be something that they are choosing to do demonstrating the individualism inherent in today's culture. Thus we judge, condemn and blame the individual for a social and cultural rule violation because we are unable to attribute any other simple causal explanation and the context is ignored. This results in a reciprocating, and damaging, relationship between the individual and the interactor which perpetuates and reinforces the violations.

B.5.2.2 Stigma discourse

Stigma was discursively constructed by: attitudes, 'knowledge', social exclusion, shame and discrimination. Johnstone (2000) suggests that it is the medical model which brings with it stigma and marginalisation. The medical model places emphasis on naturalism, the view that all 'disorders' can be identified as occurring as a natural fact, its origins within evolutionary theory (Bolton, 2010). Ben-Zeev, Young and Corrigan (2010) propose that this view acts to maintain public perceptions of 'mental disorder' through the process of categorisation. Categories place individuals into groups, implying homogeneity and stability of the problem, this being part of the purpose for categorisation. However, this results in culturally constructed public stereotypes of mental health problems which elicit fear, negative judgements about competence, and blame. These stereotypes are further reinforced through media representations; political influence, for example proposals for the control of 'Dangerous People with Severe Personality Disorders' (DOH and Home Office, 1999); the lack of consensus amongst academics and clinicians about the validity of the construct, its aetiology and prognosis; and, until recently, an academic and clinical view that personality disorders are 'untreatable'.

Diagnostic labelling, or classification systems more generally, give an experience a name which suggests it actually exists as an entity. It implies an assumption that more than one person has had this experience and creates an initial feeling of relief. Maskowitz (2001) highlighted this as relief: through being provided with a 'framework for understanding their suffering'; of experiencing something which was not unique but experienced by others. This was something that was similarly constructed in the discourse of my participants and was also identified by Crawford et al. (2008). However, stereotypes, negative attitudes, social exclusion and discrimination then act to reinforce the values of the society that unless you behave in certain ways, consistent with that society and culture, you will be considered an 'outsider' to be avoided. Horn et al. (2007) also identified rejection and 'not fitting in' as characteristic of the experience of being labelled with BPD.

In the 18th century 'truth' about 'normality' was constructed through religion, the dominant discourse of the time; this then gave way to science and medicine as the dominant discourses and, hence, the way in which the 'truth' was constructed (Symonds, 1998). In fact, this 'truth' and 'knowledge' appears to be demanded by western society with its formal logic, and then reinforced through the 'supporting evidence' provided by science. Within this, all mental health professionals are positioned through the positivist and essentialist paradigms as 'all-knowing'. "Clinicians present their version of reality as being akin to some kind of ultimate

truth” (Davies & Bhugra, 2004, p.134). As a collective, they are seen to hold the answers, because this is what the society has been led, and one can argue wants to be led, to believe; we invest the power of responsibility for care to these individuals, and believe them to hold ‘indeterminate’ knowledge; that is, all the answers for things related to human beings that we do not understand (Kelly, 1998). When considering this in relation to the discussion of the dominance of the biomedical model in B.2.6.1 the role of the psychiatrist is one of expert. A positioning that is created by virtue of their expertise in biological understanding.

Nehls (1999) found the most significant problem for individuals was not having the diagnosis but the stigma and attitudes attached to it by mental health professionals and services. Nehls (1999) quotes a participant who experienced their GP as wanting to get them out of the surgery as quickly as possible; an experience also described by one the participants in this research. Gallop, Lancee and Garfinkel (1989) also found that those with BPD do not meet the value-laden criteria of a ‘good patient’ - also discussed in B.4.3.4.1 - they are not considered compliant, grateful or cooperative; in fact, they are considered manipulative and, therefore, less deserving of empathetic treatment. Evidence of this was apparent within my research interviews.

Davies (2004) identifies how mental health professionals are also members of the public, and as such are open to the same discourses around mental health stigma as any other member of society, and so can bring these into the treatment environment. Aviram et al. (2006) further identified the dialectical relationship between the public stigma internalised by mental health professionals and the negative responses of clients. Consequently, mental health professionals internalise stereotypes and prevailing ideologies, they then respond to individuals labelled as BPD in ways consistent with the stereotypes which then results in a reciprocating enactment of the behaviours expected of the individual. The Consultation and Advocacy Promotion Service (2010a; 2010b) highlighted both staff and services users identified the impact of negative attitudes on the treatment received.

Raven (2009) suggests that BPD stigma discourse is created in an environment where clinicians feel powerless to help effectively. Flanagan, Miller and Davidson (2009) identified the stigma amongst mental health practitioners as primarily related to structural and systemic pressures upon services. This requires staff to emphasise symptoms, problems and compliance with treatment in the provision of services to the detriment of focus upon the individual and recovery. This provides further evidence of mental health services being driven by economic forces, rather than a concern with humanity.

Stigma acts to devalue an individual; as a result of being positioned within a stigmatised group, they are considered to have less value, resulting in social exclusion (Aviram et al., 2006). Stigma, and social exclusion in particular, is highlighted by Baker, Procter and Gibbons (2009) as resulting in profound social losses in relation to employment, housing and other opportunities. Earlier Miller (1994) found that all the individuals that she interviewed experienced estrangement and inadequacy at being unable to meet societal expectations. Aviram et al. (2006) identified that people have a tendency to distance themselves from the stigmatised within society. Attempts to address social exclusion have been made through various documents and campaigns: Time to Change campaign led by Mind and Rethink (2010); No longer a diagnosis of exclusion (DOH, 2003); Mental Health and Social Exclusion (Social Exclusion Unit, 2004); however, these attempts have been slow to permeate and impact upon discourses. Employers, housing providers, society and mental health services continue to hold negative attitudes, discriminate and stigmatise those with perceived mental health problems.

Dialectically related to social exclusion is shame. Rusch et al. (2007) identify shame as prominent within individuals diagnosed with BPD. However, as identified by Crowe (2004), this is not considered within the criteria of the diagnosis. Linehan (1993) identifies that “shame reaction” (p.42) occurs as a result of a social learning environment that positions emotional vulnerability as ‘shameful’. This links with Potter’s (2009) identification of the values underlying blame discourse discussed in B.5.2.1. Shame occurs as a result of difference which implies judgement and exclusion (Crowe, 2004). It is a moral emotion, characterised by experiences of worthlessness, and powerlessness, and concern about denigration by others. Shame is constructed through devaluation and fear of exposure (Rusch et al., 2007). Crowe (2004) identifies shame as positioning the self inferiorly to others based on what they perceive would be the others view. As a result Holm, Berg and Severinsson (2009) emphasised the importance of exploring meaning for those with a BPD diagnosis who have experienced traumatic childhoods, enabling individuals to overcome shame, guilt and feeling trapped by these emotions. Crowe (2004) alternatively proposes a new construction of BPD as a chronic shame response. Linehan (1993) describes shame as resulting from a dialectical dilemma: inability to integrate helplessness with competence, non-control and control, creating moral shame. Blum (2008) highlights the importance of identifying shame discourse within individuals as this can prevent recovery and is often hidden. Within this research the impact of shame was observed to impede constructions of recovery and effect subject positioning within the recovery discourse.

B.5.2.3 Recovery discourse

The recovery discourse dominant within the interviews was identified through constructions referenced as: knowledge, understanding, treatment, dilemmas of permanence, disorder management and hope. It was apparent that the subject positions within the discourse were created differently according to the dialectical relationships between the constructions, which were further related to the individuals positioning in the dilemma contained within them. To elaborate, those individuals who: constructed the knowledge of BPD to be the 'truth'; found treatment unhelpful; felt misunderstood; thought BPD to be permanent; considered disorder management the only option and had limited construction of hope, or none at all constructed BPD as unrecoverable. Although partial hope constructions created more of a dilemma for them with regard to recoverability. However, those individuals who questioned the 'truth' of the knowledge, believed themselves to have been understood by some, thought treatment to have been helpful, questioned the permanence and requirement for disorder management and retained a construction of hope constructed BPD as recoverable; thus revealing the dialectical dimensionality of constructions within the recovery discourse.

Paris (2008) highlights that one of the problems with diagnosis is that psychiatrists are required to make a diagnosis based on symptoms and then 'make it go away'. However, BPD is not something that responds to medication (NCCMH, 2009) and, therefore, does not fit this category. Nonetheless, medications that do not appear to be effective will be retried in case they work next time, unlike psychotherapy. Although, more recently CBT has been offered many times in the NHS in a similar way to medication as a result of empirically validated research evidence; the evidence suggests it is effective with certain 'disorders' and, therefore, 'it must work'. Often therapists can be heard to blame the client when it does not have the desired results, suggesting 'they were not ready'. Thus, billions of pounds have been spent on these approaches. Further, we need only look at the names of psychotherapeutic drugs 'anti-depressant', 'anti-psychotic', to identify the value assumption that these states are undesirable, and as such must be resisted, with pharmaceutical drugs being seen as the 'cure' (Johnstone, 2000).

Millon (1996) identifies how pessimistic the current system of personality diagnosis is. He points out that, for an individual, receiving a diagnosis of 'disorder' or 'disease' is difficult enough but then to suggest that this is pervasive, unchanging and inflexible, effecting every part of your being - such is the current understanding of personality- will doubtless bring with it hopelessness and helplessness. In concordance with this Haigh (2002b) found service users to construct mental health professionals as lacking in understanding and conveying messages

of 'untreatability'. Often the diagnosis had been withheld and, once it was identified it remained permanent, resulting in service withdrawal; this was apparent in participant constructions in this research. Similarly, Horn et al. (2007) identified the permanency conveyed by the diagnosis. Despite recent research, for example, by Hopwood et al. (2009) investigating the stability of personality traits in BPD which suggest the historical conceptualisation of BPD as enduring, and unchangeable, may be incorrect. Therefore, it is not perhaps the diagnosis itself that is the primary problem but the implied assumption of permanence. Equally, there appears to be no formal process for the removal of a diagnosis. This inherently deems mental health problems to be permanent due to the lack of diagnostic de-categorising. This suggests that we actually classify people rather than 'disorders'.

Flanagan and Davidson (2007) conducted an examination of the language used by researchers in their academic writings about diagnoses including BPD between 1975 and 2004, to determine whether the language that was used acted to classify people or disorders. They found that while the tendency to classify people through language such as 'Borderline' or 'the BPD patient' or 'the patient is BPD' has declined since 1975, in 50% of academic articles authors continued to infer the classification of people rather than disorders. Flanagan and Davidson identify a number of implications of this including the implicit assumption of permanence as the person is consequently identified as the disorder. They also highlight how this creates confusion within the general public as to whether disorders are in fact classifying people, or conditions that they may be affected by, and they further demonstrated this in a search of language use on the internet. Furthermore, they propose that the current classification system represents a folk taxonomy rather than a scientific one, as it is created not by confirmed evidence of naturalistic determinants but cultural values and perceptions. The use of language which implies people classification, thereby, results in the false assumption that these 'disorders' exist in the same way that a broken leg or a virus exists tangibly. Consequently, it acts to maintain stigma and represents assumptions; we legitimise 'mental illness' through psychiatry and psychology, positioning ourselves as knowing more about the concept than we actually do.

Johnstone (2010) suggests that medical labels act to 'rescue' people encouraging the seeking of an external 'cure', only to blame the individual when the external 'cure' does not work. Potter (2009) in her critical analysis of BPD defines our current construction of a 'healthy' identity in the West as: "unified, stable and individuated from others while maintaining stable and healthy relationships with others" (p18.); the Western idealised view of the self being highly compatible with scientific and capitalist hegemony dominant within clinical discourse

(Wright, Haigh &McKeown, 2007). Potter also concludes that being viewed as healthy involves self-awareness of this identity. However, the ability to do this requires the internalisation of representations of self, and others, and the boundaries between them. When contradictory messages are internalised by the 'patients' such that they are abnormal, to blame, unrecoverable and stigmatised, in need of cure but incurable, not responsible but then responsible, makes this idealised self virtually unattainable. In short the mental health system could be described as paradoxical. It is designed to provide treatment to enable people to 'recover' from mental ill-health and yet the stigma, blame and (non) recovery discourses within it, and the reluctance to re-diagnose or reclassify, suggests the impact of the system is opposite to that intended, certainly with regard to BPD.

B.5.2.4 Enigma

The lack of consensus about the diagnosis, the dilemma with regard to attributions of blame, the dilemma relating to the possibility of recovery, the stigma created by stereotyping are all apparent within my analysis and act together to construct an enigma. Crowe (2004) suggest the term 'borderline' does nothing to enhance a clinical understanding of the symptoms it draws together, instead suggesting ambiguity creating an enigma. Bjorklund (2006) highlights that 'borderline' reflects the lack of understanding, the confusion, the inability to define and the paradoxical nature of the problems experienced on the part of both individual and mental health professional. In outlining the less than satisfactory way in which the original validity of BPD as a diagnosis was first determined and entered DSM, Kutchins and Kirk (1997) identify the circular argument that is used for defence of the construct. A therapist describes a client as being difficult, when asked why they are difficult, the therapist responds that it is because 'they have BPD', to which they are asked 'how do you know that' and the response is 'because they are difficult'; this explains nothing it simply acts to create further mystery. Horn et al. (2007) similarly identified the lack of understanding about what the diagnosis meant and what this implied about responsibility for the experience labelled as BPD, as I found in this research.

The aim of the medical model is to reduce problems to simple causal explanations which identify symptoms, and indicate treatment, and yet the medical model has not provided this 'knowledge'. Instead it has created a construct which suggests the existence of something but leaves a void where the information should be. This lack of answers is disguised in technical language and is apparent in the tendency to withhold information; information which is not actually known. Similarly to the discursive constructions identified within my research Horn et al. (2007) found that 'knowledge' was experienced as power, either resulting from a sense of control provided by the diagnosis or as result of the lack of information provided by 'powerful'

others in giving the diagnosis, hence a withholding of 'knowledge' by experts being viewed as unhelpful. Maskowitz (2001) comments on the withholding of the diagnosis and suggests this simply acts to increase misunderstanding and misalliance amongst individuals and those providing 'care'. Lequesne and Hersh (2004) identified that clinicians who did not disclose, or were reluctant to disclose, a diagnosis of BPD to individuals identified a number of reasons why, including: concern related to stigma, similarly identified by Raven (2009); negative evaluation of the individual's ability to understand the meaning of the diagnosis; lack of certainty about the validity of the construct; the impact upon health and morale; in addition to fear about the reaction of the individual to receiving the diagnosis. They identify that not disclosing the diagnosis can prevent: the opportunity for individuals to gain understanding and 'knowledge'; as well as the opportunity for autonomy of the individual; access to treatment options; and self-discovery which, can result in constructions of the diagnosis being so bad that the services could not tell them. We may also consider that non-disclosure or limited disclosure creates further stigma.

The absence of transparency about the construct and the reluctance of professionals to be seen as 'not-knowing' results in service users, staff, and society having to draw their own conclusions about the construct and hence further perpetuates the mystery. As a critical realist I find myself questioning not only the validity of the construct but also whether the problems experienced could be conceptualised in an alternative way. If we used a different criteria set or a different method of categorisation would we in fact end up with several different constructs. For example Morrison (2009) identifies that those with a BPD diagnosis and developmental history indicative of childhood trauma are likely to present differently to those without childhood trauma. This presents the possibility of an alternative conceptualisation. Hodges (2003) proposes the reformulation of the problems as post traumatic responses removing the temptation to invoke a blaming approach to treatment. However, it could be the case that we have become so wedded to 'proving' the existence of BPD that the political and bureaucratic ideas and paradigms prevent us re-conceptualising. Perhaps as a mental health community we fear saying 'we may have got it wrong' or 'we do not know' because of the potential paradigmatic implications of this. I would also suggest that by attempting to provide certainty, and denying the possibility of 'not-knowing', we further the mystery of the 'problem' and leave space for formal logic to account for it.

Modern medicine is controlled by political and economic pressures to produce maximum outcomes measured by targets for the minimum outlay (Allen, 2004); this is the product of political ideology, scientific paradigms and the demands of capitalism. As such, institutions

including the NHS are subject to national policy and complex internal structures, when the ideologies are in conflict with humanistic values these can impact upon the treatment received by individuals in their care (Davies, 2004). This can lead, and has led, to a loss of meaning and humanism (Flanagan, Miller & Davidson, 2009) from within mental health services as focus is placed upon symptom removal, public protection from harm, and a fear of accountability if an individual harms themselves as evidenced by the constructions of participants within this research (see B.4.3.2.3). The individual's personal experience remains at the bottom of the hierarchy of pressures within practice as well as academic research. Therefore, while we continue to draw, perhaps unknowingly, upon blame, stigma and (non) recovery discourses in a system dominated by individualism we act to exclude the individual from their treatment (Roberts, 2000) and promote social inequality (Miller & McClelland, 2005).

Crowe (2004) highlights that the criteria within the DSM for BPD represents the current ideology of goal directed and rational behaviour as well as displays of affect in keeping with professionalism; these underpin productivity and advancement within a western capitalist culture. Barker (2008) states that "emotions involve cognitive and moral judgements and the culturally approved way of acting them out" (p.131). They are culturally constructed; identified through cognitions, interpretations and rules, named and understood through discourse. In light of this, Crowe (2004) raises important questions about the BPD construct and how the difficulties experienced are conceptualised. He purports that beyond social and culturally accepted ways of behaving there is also an expectation of feeling and thinking in culturally accepted ways and that to err from this, to be emotional, dramatic or erratic is a violation of the social and cultural norm and as such worthy of judgement. Conversely, Western-style capitalism, as described by Weber (2001), requires individual qualities of conscientiousness, professionalism, investment and delayed pleasure and fulfilment.

In the UK, we live in a Post-industrial age. Technological advancement and increased pace of life have resulted in the traditional social support mechanisms of times gone-by being no longer available; with increasing pressure to fit more in, get more for your money, and be more productive. An individual, who challenges the ideology of the time or this way of living, is considered non-conforming. As such, an individual who behaves in an impulsive, emotional or angry way, as pathologised by the diagnosis BPD, would be considered as not behaving in the interest of capitalism; in rejecting a common societal goal they are judged as rejecting 'normality'. They are, therefore, positioned in a number of ways through discourse. Firstly, that they are choosing not to conform (blame). Alicke (2000) suggests that in all social groups there is a concern to prevent and control harmful behaviour for the purposes of maintaining

social order. Those who commit ethical, moral or legal violations within their social groups must be held responsible for their violations; in essence punishment for violations implies blame for such actions. The discourse is, thereby, considered necessary for social control and ultimately economic growth. Secondly, that they are different to everybody else, to our 'selves' and hence, are excluded (stigma). This idea of otherness, locating difference from the self, as described by Wright et al. (2007) led to the traditional view of PD as a diagnosis of exclusion. Sustaining this view of difference from our 'selves', through discourse, removes fear of things we do not comprehend. It provides, what Padesky (2005) describes as, 'good reasons' for maintaining our views, to prevent the experience of our 'selves' being different and socially excluded. Finally, they are deemed to be in need of rapid assistance to conform and when this is not forthcoming they are positioned permanently outside social conformity (recovery). Therefore, blame, stigma and recovery discourses and the construction of enigma can be identified not only as a product of a capitalist, reductionist and positivist society, but also as maintaining the hegemony. The belief that 'blame', 'otherness' and 'recovery' are necessary and common sense discourses enables the ideological goals to remain hidden and unquestioned.

B.5.3 Navigating the problem

Our thus far limited understanding of BPD exists only in theory, there is no somatic referent; and neither is there conclusive evidence that childhood environments and development 'cause' BPD (Pilgrim, 2001). There is no consensus, each proposed model contains within it research discrepancies and does not wholly account for the 'disorder'. This lack of consensus acts to enable policy-makers to treat BPD in a way which enables them to advance their political goals (Pilgrim, 2001). As counselling psychologists within the field we have the opportunity to either comply with the government directives relating to the 'treatment' of BPD, and ideology, or to present a critical reflection upon the diagnosis; resisting attempts to consider the enigma of BPD simplistically, preserving humanist values, and presenting alternatives.

We must be also be aware of a tendency towards disciplinary imperialism, as described by Sayer (2005), whereby the position of our own disciplinary endeavours is considered to hold the answers, present the 'truth' and the real 'knowledge' about the existence of BPD. Connor-Greene (2006) states that no single academic discipline can fully account for the complexity of human problems, rather it requires interdisciplinary understanding and enquiry. Furthermore, Koenigsberg and Siever (2000) identified the importance of seeing a whole picture rather than just part of it through the lens of the discipline investigating; otherwise BPD will always remain

an enigma. Bolton (2010) also identifies the importance of a 'whole' approach which integrates ostensibly competing paradigms. This furthers the case for a dialectical philosophy approach to underpin any conceptualisation of BPD. By considering only a part of an individual we invalidate, dehumanise, and devalue, them and their experience. BPD, if we assume momentarily that it does exist as a valid construct, is nonetheless only part of a person not the whole of them; it should not make them less valid or their experience any less meaningful.

To suggest that the only way forward is through a social and cultural approach to mental health is in itself an essentialist and reductionist endeavour; suggesting that the only way to understand the psychological dilemmas that people experience is through their social and cultural context, when in fact they are irreducible to merely a social and cultural context. This is demonstrated by Sayer (2005) as an upwards reductionism. In an attempt to counter individualism, we suggest social determinism, both of which reduce human beings to simplistic understandings. We must identify a way in which we can leave room for individual and social/group understandings of responsibility within health and social care (Sayer, 2005). We can use the opportunity to construct models of distress which challenge the dominant ideas within a scientific and economic world which seek to pathologise distress (Miller & McClelland, 2005). While Engel, in 1977, proposed the biopsychosocial model as an alternative to the biomedical one within psychiatry this has not necessarily been translated into the training of psychiatrists, or transferred consistently to psychiatric and mental health services.

Strawbridge and Wolfe (2003) highlight the tensions prevalent within an employment context for counselling psychologists to apply technological expertise in priority over 'being-in-relation' with clients. Roberts (2000) identified the tension between modernist mental health services with positivist ideas of rationalism, materialism and reductionism with post-modernist paradigms encouraging a move away from the idea that 'truth' is waiting to be discovered. Roberts identifies the difficulty in rectifying the individual meaningful experience of therapeutic endeavours with those that are measurable and consequently, reproducible. The economic and modernist demands of the NHS call upon the 'scientist-practitioner' to apply science to clinical practice. However, Strawbridge and Wolfe (2003) suggest the importance of retaining a view of the scientist-practitioner not simply to apply scientific and essentialist research, but to apply oneself to the individual from a phenomenological and existentialist position which emphasises humanism. Otherwise, as some have suggested, therapy becomes a way of maintaining the politically dominant ideology (Masson, 1988).

Johnstone (2010) proposes formulation as an alternative to psychiatric diagnosis and as a way of retaining meaning for an individual, increasing understanding, improving staff-patient interaction and providing an alternative means of communicating which does not rely upon the identification of 'symptoms'. While she identifies that this is not without its problems, and is therefore not a perfect solution it acts to remove the stigma, disempowerment, individualisation and social consequences created by diagnosis. It provides an opportunity for understanding the difficulties experienced by an individual within a historical, social and cultural context (Johnstone, 2005). However, Johnstone (2005), Summers (2006) and Dallos, Wright, Stedmon and Johnstone (2005) identify the need for reflexivity within this process. Miller (2004), Fonagy and Bateman (2004) and Miller and McClelland (2005) identify positioning the individual as 'expert' and taking a 'non-expert' position as therapist, moving away from 'them-and-us' thinking. Alternatives may also include a social inequalities approach to formulating client distress, as identified by Miller and McClelland (2005).

The service user movement also campaigns for a new way of conceptualising mental health, without the medical model (Johnstone, 2010). They propose recovery to be defined not by the 'curing', or 'removal', of 'symptoms' rather as restoring the agency of the individual to bring about self-determination, hope for the future, adjustment to the experience of the 'disorder' and acceptance of the past (Roberts, 2000). Haigh (2002b) identified that services users felt treatment could be improved through acknowledgement of treatability. Wisdom, Bruce, Saedi, Wies and Green (2008) also identified the essential role of publicising narrative accounts of recovery which, highlight the importance of creating, maintaining and enhancing hope. Lack of hope is inversely related to recovery and, as such, is brought about through community beliefs and low expectations. In tandem with this the ability of therapists to instil positive attitudes towards recovery are important for therapeutic outcomes (Reisner, 2005).

Wright et al. (2007) identify that clinical discourse is entwined with lay discourse characterised by value judgements and morality, and that this constructs individuals as undeserving of care and 'patient' status. This highlights the importance of supervision (Aviram et al., 2006; Wright et al., 2007) and attention to stigma discourse within mental health professionals own practice and how this may influence the relationship. The need to ensure that, both explicitly and implicitly, BPD is conveyed as something that happens to and does not define a person (Flanagan & Davidson, 2007).

Reisner (2005) states that therapists, within the current western psychotherapy paradigms, have developed within the scientific tradition; their credibility is dependent upon the power of

this tradition. Therefore, in order to compete with psychopharmacology and psychiatry we must establish this credibility, identifying those therapeutic approaches which are most effective with particular diagnoses in order to be accepted within the economic culture represented by an empirically validated model of treatment. Roberts (2000) identifies how the National Service Framework (NSF) (DOH, 1999) of the NHS clearly lays out a hierarchical system of the evidence based practice with randomised control trials and meta-analytic research at the top, and personal accounts and stories at the bottom. This places generalised 'knowledge' as more desirable than specific 'knowledge', quantitative as preferential to qualitative and objective as preferential to subjective. An empirically validated model enables decisions about treatment to be made outside of the therapeutic relationship, determined by policy-makers, insurance companies and actuarial systems (Reisner, 2005). However, success in treatment then relies upon techniques and the ability to apply these to complex human beings outside of a controlled research environment, incorporating the complex interactions between individuals, social and cultural factors and biology.

Over the years psychology has become more concerned with individualism to the detriment of understanding the importance of families and communities on preventing, creating and supporting psychological difficulties (Bankart, Koshikawa, Nedate & Haruki, 1992). Lieberman (1998) describes how therapists in general are currently encouraged and trained to effect change in the 'here and now'. However, often problems are recurring and people become stuck in history and repeating patterns as with BPD. Lieberman describes the importance of understanding the history of the system in which they live so that new narratives, new histories and new values can be created for the future evolution of the system in which they inhabit. Nehls (1999) also proposes the use of narratives as opposed to diagnostic classifications as a way to encourage mental health providers, academics, researchers to view clients as providers of knowledge rather than objects of knowledge. This involves taking the position of 'not-knowing' as opposed to the traditional 'all-knowing' position of essentialist and positivist paradigms communicating an attitude of validation and curiosity.

Narrative therapy, developed by Michael White and David Epston, aims to establish a therapeutic relationship based on respect and non-blaming, in an environment which is non-pathologising. The approach presents an alternative to cause-and-effect models. Narrative therapy potentially provides an opportunity to regain meaning and reauthor lives, such that individuals can construct stories which enable them to be more adaptive to their social and cultural contexts (Roberts, 2000). Additionally, Laub and Hoffman (2002) propose integration of dialectical co-therapy and narrative therapy drawing on a model of dialectical polarity. Such

approaches have been developed in keeping with social constructionist ideas. Therefore, while continuing to explore the effectiveness of treatments such as DBT and MBT, we can also look to other areas of applied psychology globally.

As identified within B.2.6.1 not all psychiatrists advocate a purely biomedical model, and as such they present an alternative ideology. Consequently, there is an alternative position to the 'all-knowing' role already present within less mainstream schools of psychiatry. This was originally advocated by Harry Stack Sullivan (Evans, 2005) in his proposition of interpersonal psychiatry, now more generally referred to as social psychiatry; he proposed the role of psychiatrist as participant observer, rather than the expert role taken by the biological psychiatrist. Sullivan described a psychiatrist's knowledge and training being brought together with the client's narrative to provide a collaborative understanding of diagnosis and treatment. This is a role that is similarly proposed by those critical of traditional psychiatry and its reliance upon drugs to treat symptoms (Bracken & Thomas, 2010). Furthermore, this group of social or critical psychiatrists may be inclined to actively reject the overall role of paternalism that prevails within psychiatry (Baltrušaitytė, 2010) and support the user movement of recovery.

The therapeutic community model identified in B.2.5 presents the possibility of integrating treatment paradigms, which do not necessarily need to be viewed in competition; and also avoids upwards reductionism. There are a number of 'mini therapeutic communities' as described by Pearce and Haigh (2008) which have appeared over the last few decades. These offer the opportunity for developing the traditional values of social psychiatry upon which therapeutic communities are founded, respondent to a social constructionist epistemology, and considering the principles of an effective therapeutic environment within service development (Haigh, 2002c). By continuing to develop the quality assurance systems and continue to focus on demonstrating effectiveness, mini therapeutic communities may become more attractive politically with regards to economic savings (Pearce & Haigh, 2008). Furthermore, the therapeutic community principles described by Haigh (1999) of attachment, containment, communication, inclusion and agency can be drawn upon to facilitate a positive parallel process within community teams (Haigh, 2004).

Future research far from relying almost entirely on essentialist and positivist approaches, and disciplinary imperialism, needs to draw on qualitative methodologies which enable a socially constructed diagnosis to be investigated in its social context (Pilgrim, 2001). In so doing we can draw together evidence-based practice, which is cross-disciplinary, and critically reflect upon accepted 'truths'. Counselling psychology is founded upon humanistic values, upon a belief in

well-being rather than illness and on the importance of personal meaning and context (Orlans, 2009). It has already grappled with the difficulties of drawing together the philosophical underpinning of mainstream psychology with those of counselling and psychotherapy. The task of a counselling psychologist is to bring together the potentially competing paradigms of positivism and humanism; rationality and subjectivity; naturalism and phenomenology (Orlans, 2009). Hence, it provides an opportune position from which to balance these competing demands to bring a new approach to understanding, reconceptualising whilst providing assistance to those with the 'symptoms' of 'BPD'.

My epistemological position within this research has been one of social constructionism, a way of considering post-structuralist and post-modernist ideas within Psychology (Harper & Spellman, 2005). The way that we talk, or otherwise communicate, constructs ways of perceiving the world and consequently constructs ways of being in the world. This research highlights the importance, for me, of considering the ideologies and dominant discourses present within an individual's communications which seek to hide social inequality (Miller & McClelland, 2005). By drawing on social constructionist approaches to the conceptualisation, understanding and consequences of human experience we potentially open up alternative subject positions, and discourses, empowering individuals to make choices within their social and cultural context.

While it will always be difficult to resist, and challenge, the prevailing dominance and power within our work as therapists - to go against the accepted views and beliefs - it is vital for counselling psychology that we provide a critical reflection on 'truth', 'knowledge' and 'reality' claims with which we are presented, and identify how they came to be constructed such that we can bring a social and cultural consideration to an individual's experience; challenging our reliance on simple causal explanations. Ultimately the concern is to demystify enigma and offer an alternative subject position which provides the individual with an opportunity to recover meaning, and humanity, enabling them to adapt to the demands of the social and cultural environment in which they live. We must provide this with transparency and from a position of 'not-knowing', placing the individual with the 'diagnosis' as the expert; while balancing the political and economical demands of the UK health and social care system. Support must be sought from others attempting to do the same, for example user involvement groups who also face the difficulties of resisting a commonly held view (Miller & McClelland, 2005).

In Chapter 4, I identified many questions raised by the discourses and their apparent ideological basis. These questions related to the underlying philosophy of the medical model approach to mental health and BPD in particular. Western philosophy is founded on Aristotelean formal logic (Peng & Nesbit, 1999), and is apparent within my discussion of the dominant discourses. This provides the basis upon which the majority of our scientific paradigms are based and also underscores the folk wisdom of our culture, as identified by Peng and Nesbit (1999). Formal logic involves three principles, the law of identity, the law of non-contradiction and the law of the excluded middle. Essentially the law of identity states that regardless of context if something is true it will remain true; the law of non-contradiction states that regardless of context if something is true it cannot also be false; and the law of the excluded middle states that there is no middle ground, a truth can only be a truth it cannot be part truth. Applying this to the dominant discourses it can be seen, perhaps, why we have, as yet, been unable to move beyond the pejorative connotations of BPD as a diagnosis. If somebody has a 'disordered personality' they cannot also have a 'non-disordered personality'; if somebody has a 'disordered personality' this will be the case regardless of situational context or environment; if somebody has a 'disordered personality' they cannot also be 'normal'.

As such when we try to eliminate contradiction within our culture by reducing our understanding to 'truths' and by consequence 'right' and 'wrong', we act to break the rules of dialectics. So in relation to the blame discourse the difficulty that participants have in resolving the dilemmas, and how they are positioned, we can understand in relation to formal logic. Both mental health professionals, and those for whom they provide a service, struggle in the absence of alternative theses to resist formal logic and accept that an individual can be 'disordered' in certain contexts and not others, that both mental health professional and service user could be correct and wrong at the same time; be 'in control' and 'out of control' at the same time. Similarly, in regard to stigma discourse we are unable to see an individual as both different and the same as everybody else; dangerous to themselves and not to anybody else. With regard to recovery discourse, we struggle to determine whether somebody has 'recovered' from a problem created within a social and cultural context, when potentially being moved to a different social and cultural context could 'cure' them overnight of the 'symptoms' of the disorder.

B.5.4 Considering the research question

In B.2.2 I identify my curiosity as to why 'treatment did not work', whether this was as a result of the way that individuals were constructed and positioned by mental health services, whether their positioning resulted in a reciprocal response in ways expected of them dictated

by the label construction of BPD; whether this label was in fact preventing them from experiencing and being in the world in alternative ways. I believe the answer to this is dialectical and thus not reducible to simple affirmation or disconfirmation. Discourse and subject positions are complex and multi-layered. However, by understanding how the BPD diagnosis is constructed by those who are diagnosed, and how they are positioned by it, can provide important information about their being in the world, informing interventions. When we consider that the most effective 'treatments' of BPD have been found to be those that employ dialectical principles, it would suggest that perhaps we could enable people to find an answer to the enigma of BPD not in reducing the problem but in thinking holistically about it and moving away from formal logic. The point remains that by attempting to reduce BPD to neuroscience, biology, genetics, developmental trauma, or psychology, we have been unable to account for it; this presents the prospect that it is perhaps not a reducible construct, if it exists as a construct at all.

B.5.5 Evaluating the research for quality

As identified in B.3.7, qualitative research requires different criteria for the consideration of quality to that of quantitative research employing positivist paradigms. As such Henwood and Pidgeon (1992) and Elliott, Fisher and Rennie (1999) have outlined frameworks for determining quality. Wodak and Meyer (2009) identify that CDA has not specifically addressed the issue of quality beyond that identified by other qualitative methodologies more generally, for which Silverman (1993) has proposed a framework. Taylor (2001) does, however, present suggested criteria for evaluation of research employing discourse analytic strategies. Therefore, my evaluation incorporates aspects from each of these authors' frameworks.

The CDA approach involves considering the 'social problem' within its social, cultural, historical context with regard to other published work and research findings within different disciplines. I have attempted to consider my findings within the broader arena of social and psychological study, referring to social anthropology, philosophy, sociology, political theory, cultural theory, psychiatry, social psychiatry in addition to psychology and lay theories of personality and disorder. This meant considering the analysis from outside of the discipline of psychology. Reference to previously published work enabled me to identify any confirmation or disconfirmation of my findings. I also spent time discussing my analysis with my supervisor for the purposes of credibility of my suggestions. This led to further confirmation and disconfirmation throughout the process. Due to the complexity of the analysis I did not think that it would be appropriate to apply further triangulation by verifying my analysis with the participants after completion. However, as identified in the B.3.7 I checked my understanding

of their constructions by means of summary at the end of each interview, and the participants had the opportunity to correct any misunderstandings or misinterpretations.

As identified by Fairclough (2003) reflexivity of the researcher within CDA is crucial. While it remains the case that one can never be 'objective' as defined by positivism, because the researcher will be influenced by their own ideologies and beliefs (Wodak & Meyer, 2009), it is possible to identify these so that the reader of analysis can determine credibility. Throughout the research I have made reference to my own positioning. I continue to believe that labelling when used ineffectively is unhelpful and unnecessary, acting as a mode of social order. However, I do also believe that when used in an effective way it can be beneficial and offer individuals the opportunity to move beyond the label. As a member of society and the mental health community I am also subject to the prevalent ideologies and beliefs of the dominant discourses. Therefore, in examining the problem of BPD I am positioned as an insider of those communities and as such in critiquing the common sense views and methods of operation I am also critiquing myself.

I have tried to be explicit in documenting how I conducted my analysis and created a paper trail of analysis including extracts, which would enable others to clearly identify how I reached the conclusions that I did, as such they would be able to carry out further analysis on the data and identify any discrepancies. With regard to completeness, due to time restrictions and the degree of fine analysis required of CDA, I believe that had I continued to analyse the data I would have found more constructions and discourses potentially. However, the dominant discourses would remain with perhaps sub-dominant discourses being revealed. As such completeness has been achieved with regard to identifying the dominant discourses. Within the analysis I looked for the deviant cases or the disconfirming evidence of discourses and have referred to these within the analysis.

What remains is the fact that this is my interpretation of the data, my social construction of social constructions, as identified by Burr (2003) this is an inherent problem with any social constructionist account. However, I believe that while I do not propose to have provided the 'correct' way of understanding the discourse of individuals of BPD, I do believe that encouraging practitioners to consider different constructions and the impact of these on the individual will enhance the humanity within mental health communities. As such the information is transferable in suggesting ways in which we as mental health professionals act to position individuals through our language, ignorant perhaps of the ideologies we are

enacting, and consequently while best intentioned may inevitably act to maintain people in the roles and positions they are placed in as a result of a dialectical process.

B.5.6 Limitations and future research

The outcomes of this research identify the dominant discourses present within the talk of 8 individuals with a diagnosis of BPD. A commonality of the 8 participants was the extra-discursive experience of childhood trauma; two of the participants mentioned having received additional diagnoses of PTSD. As such it is possible that the dominant discourses could be dialectically related to the experience of trauma, with blame and recovery being common themes within research and practice related to these types of experiences. Therefore, further research investigating the influence of such extra-discursive events upon discourse and subject positions could usefully inform understandings of possible differences between those receiving the diagnosis with and without the experience of developmental trauma. While also an alternative research design or methodology may investigate the extent to which these dominant discourses are apparent within the talk of individuals diagnosed with other mental health problems, society more generally, and amongst mental health professionals.

All the participants were aware of my professional role and as such I was positioned by them in varying ways related to this role. I was perhaps positioned as ‘all-knowing’, ‘supporter’, ‘mental health professional’, within their discursive constructions. This, considering my epistemological stance, would suggest that however I posed questions their positioning of me will have influenced their discourse. This genre is reminiscent of other genres which they may have experienced such as different types of mental health appointments, and as such can provide useful information. However, as individuals intentionally construct talk according to the social and cultural context and the purpose of the talk (Cheek, 2004); one might consider that if this interaction had occurred between two individuals with the diagnosis of BPD the discourse and positioning may have been different. Emancipatory research, as proposed by Ramon et al. (2000) and Castillo, Allen and Warner (2000), may usefully investigate this.

B.5.7 Summary and Conclusions

The foundation for this research was established from my experience of working within a residential therapeutic community. Within this setting individuals whose lives were disrupted to such an extent that they were prevented from functioning in accordance with society’s rules and norms, were supported through a socially designed environment of attachment, containment, communication, inclusion and agency (Haigh, 1999). This enabled them to develop more adaptive functioning such that they could achieve social goals and gain a sense

of self. This represented a highly contrastive approach to that which I later experienced working in the community. Individuals with the same problems were here considered manipulative, attention-seeking, and treatment resistant. I set out to investigate why this was the case and to identify the potential impact.

Within the introduction I identified the problems of the BPD diagnosis; the dilemmas regarding aetiology, theory, treatment and diagnostic validity, and the tendency to use the diagnosis pejoratively. A range of theories about BPD and its aetiology have been proposed, however, most authors prominent within the field generally agree that it will most likely involve a complex interaction of biological, psychological, social, cultural and historical factors. Further, the lack of agreement with regard to treatment resulted in the creation of NCCMH (2009) guidelines being produced. However, there remains a significant gap within the evidence-base for BPD, too many questions and too few answers continue to exist. Thereby, further research is required, irrespective of the ultimate fate of the diagnosis as a valid construct.

The purpose of the research was to identify dominant discourses within the talk of individuals diagnosed with BPD, which may indicate the reasons for mental health services assuming them to be unresponsive to treatment and perceiving them negatively; furthermore, to identify possibilities for navigating a path around the problem. Upon completing my analysis I determined three dominant discourses to be present: blame, stigma and recovery; functioning dialectically to construct borderline personality disorder as an enigma. In-depth analysis revealed the underlying dominant ideological values of these discourses, and those upon which UK enterprise capitalism is founded, to be: individualism, responsibility, tradition and anti-welfare. These ideologies inherently impact upon the provision of mental health services. The identified values support a system concerned with economic growth and productivity, requiring individuals to be responsible and self-interested. The current dominant scientific paradigms of truth and knowledge, those of positivism, essentialism, naturalism, and reductionism, support enterprise capitalism by denying or omitting to consider the involvement of social factors in psychological functioning and well-being. Nonetheless, what we consider at the current time to be psychological problems are socially constructed. The problems are considered to 'exist' by systems designed to support the political ideology and economic goals and consequently, require a relentless search for tangible evidence of the causal factors of BPD necessarily located within the individual, in the absence of conclusive evidence it is an implied assumption indicating it has not yet been identified, these assumptions are founded in Aristotelean laws of formal logic. As such a boundary is created between the 'normal' and the 'abnormal' as determined by society and culture and anchored

historically, such that these entities will inevitably change over time with new knowledge and cultural shifts. As a consequence, the BPD diagnosis was originally constructed as a way of separating that which could not be understood within the traditional paradigms, individuals who appeared to act out against social norms and rules were considered in need of social control; this has remained as part of the dominant ideology.

Enigma in this research was constructed through a number of dominant discourses: blame, stigma and recovery; these discourses and the discursive constructions contained within them identify struggles against the prevailing ideologies and provide information with regard to potential ways around the problem. Individuals with BPD diagnoses demonstrate dialectical dilemmas with regard to the positioning of: blame – individual or social; stigma – normal or abnormal; recovery – permanent or temporary. My findings identify each of these social constructions acts to position the individual such that hegemony is maintained. Many individuals are then unable to position themselves differently due to the perceived power of the dominant groups, and thereby, a perpetuating cycle of non-recovery is enacted with the individual considered manipulative, attention-seeking, and treatment resistant. Despite attempts by some including: service user groups and national organisations, guidance documents and local/national campaigns, the problems for individuals classified as BPD nonetheless at the current time remain the same.

In order to navigate the problem and address some of these issues, while maintaining a realism about our ability to change societal norms and rules, I was able to identify a number of possibilities. These included: a move towards more systems-focused approaches to working with individuals including narrative therapy; use of comprehensive formulations rather than relying on diagnosis alone, or even at all; creation of more mini-therapeutic communities addressing problems both socially and individually to prevent upwards reductionism; the importance of continued research exploring qualitative approaches to understanding; alternative positioning of the role of the psychiatrist; the consideration of parallel processes amongst staff and the promotion of the same five therapeutic community principles as identified as important for clients within staff teams (Haigh, 2004). In addition the importance of mental health professionals presenting themselves as non-experts was identified and the ability and willingness to reflect on their own internal processes is essential (Rigby and Longford, 2004). Furthermore, the dominant discourses and the construction of BPD as an enigma, does impact significantly upon individuals creating uncertainty, dialectical dilemmas, and confusion. Unless we address and challenge these discourses; and unmask the enigma as an actual lack of 'knowledge' about the construct of BPD then those diagnosed as such will

continue to report being devalued and dehumanised, with personal meaning being dismissed. Counselling psychology with its foundations in humanistic principles and emphasis upon subjectivity and meaning; along with its integration of scientist-practitioner and reflectionist-practitioner, provides a perfect backdrop against which to develop some of the suggested alternatives for navigating the problem of borderline personality disorder.

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C: Professional Practice

Working with trauma: the importance of the therapeutic alliance in both primary and secondary care contexts

C.1 Introduction

From primary care to secure setting, my doctoral studies have provided me with a spectrum of presenting problems within which to develop as a counselling psychologist. Throughout this experience the lifetime prevalence of trauma amongst the individuals I have encountered has been striking. Beyond the diagnosis of Post-Traumatic Stress Disorder (PTSD), as identified by Lindy and Wilson (2004), trauma has been manifest in ways as unique as the individual. Considering this within individual conceptualisations and formulations has been crucial to the outcome of interventions and essential to the therapeutic process, as identified by Pearlman (2004). Due to varying service constraints, including limited timeframes, resource parameters, approach and individual's preferences, I have had to work flexibly and collaboratively with each client to identify appropriate and realistic goals for treatment, while also considering the empirical research base for effective practice with trauma. The reason I have selected the following two cases for my doctoral portfolio is because I believe that they represent important aspects of my practice development in relation to this.

The cases highlight several key learning points including the importance of the therapeutic relationship irrespective of service constraints; the importance of 'being-in-relation' rather than simply applying technological expertise of empirically validated treatment models, as discussed by Strawbridge and Wolfe (2003); and the importance of meaning and understanding for the client, enabling them to reconnect with their humanity and establish a way of being in the world which perhaps involves more adaptive functioning in keeping with their social and cultural contexts. Beginning by identifying the contexts of the cases I will then move on to explore each separately. At the end of this section I will draw the cases together by examining how further they have influenced my practice.

Pages 178 – 192 have been removed from this Thesis for the purposes of sensitivity of client information. The full copy is available to view in hard copy at City University Library.

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D: Critical Review of Literature

Sifting through the fragments of complex trauma: Reviewing the advancement of effective practice in working with adult survivors of childhood abuse

D.1 Introduction

Incidence of childhood abuse is believed to be a greater problem in the UK than is reported (National Society for the Prevention of Cruelty to Children [NSPCC], 2007) with statistics as high as 38% estimated to experience at least one incident (Cawson, 2002). The NSPCC (2007) identified that 32,000 children across the UK were *known* to be at risk of harm. While not all will go on to develop problems associated with these experiences, research suggests that multiple incidents and prolonged abuse places individuals at risk of experiencing mental health symptoms in adulthood including, but not limited to, posttraumatic stress disorder (PTSD) and extending beyond this to self-regulation problems in all realms of functioning (Cloitre et al., 2009). Adult survivors of childhood abuse typically experience betrayals of trust within core attachment relationships with devastating effects (Paivio & Pascual-Leone, 2010). Van der Kolk (2009a) states that while this type of *complex trauma*, within psychiatric classification, does not exist; it is perhaps one of the most common psychological problems presenting to clinicians within therapeutic practice.

This often results in complex diagnostic co-morbidity and confusion with regard to treatment protocols and sequencing. There is no clear understanding of which of the co-morbid diagnoses is the primary problem (Kilpatrick, 2005a). Furthermore, the effects of childhood trauma are often ignored or misdiagnosed (van der Kolk & Courtois, 2005). This acts to compound a lifetime of unimaginable trauma for survivors and in many cases repeats the abusive cycle (Dalenberg, 2004). The United Kingdom Trauma Group (UKTG, 2009) identify that literature review is urgently needed to better define complex trauma and identify best practices to guide practitioners in its assessment and treatment. Without this consensus there is a risk of implementing unhelpful or harmful treatments (van der Kolk & Courtois, 2005; Wagner, Rizvi & Harned, 2007).

The third edition of the *Handbook of counselling psychology* devotes two chapters to trauma (Wolfe, Strawbridge, Douglas & Dryden, 2010). This not only signifies further the prominence of the topic within the therapeutic field, but also its relevance within the discipline of counselling psychology. Both Jordan (2010) and Heller (2010), supporting their conclusions with empirical research, focus upon attachment relationships in the context of interpersonal

trauma, the importance of the therapeutic relationship, as well as the establishment of safety for client and therapist in the processing of traumatic experiences.

Counselling psychology as a discipline draws upon a humanistic value base rather than a medical model, focusing upon well-being rather than illness (Strawbridge & Wolfe, 2010). It seeks to integrate mainstream scientific psychology with counselling and psychotherapy, and as such brings together the positions of scientist-practitioner and reflective practitioner; further this offers a broader definition of evidence-based practice than conceived by a medical model of illness and treatment (Wolfe et al., 2010). It is about individuals, how they function in the world and the process of human interactions, it emphasises self-development and growth beyond the *correction of symptoms* (BPS, 2007). Thereby, counselling psychology brings a philosophical base which may be important for the effective and ethical treatment of individuals experiencing complex trauma, it also presents an alternative perspective from which to conceptualise and formulate, that is worthy of exploration.

As identified by Kilpatrick (2005), the research area of trauma is now broad and fragmented, lacking the requisite depth at this point. Consequently, this review necessarily narrows the field to focus upon adult survivors of childhood abuse specifically, and aims to provide a brief informative overview of the current state of the field of study and what this suggests with regard to recommendations for best practice. Different conceptualisations of complex trauma and some of the resulting problems and challenges that this presents will be identified. Following this there will be an overview of current treatment approaches. Further this critical literature review seeks to bring together best practice guidance and recommendations, while also identifying how far the field has progressed in addressing complex trauma and how counselling psychology may contribute.

D.2 Defining and conceptualising complex trauma in current practice

Prevalence of childhood trauma amongst individuals seeking psychotherapy is estimated to be as high as 90% (Pilkington & Kremer, 1995); this means that within clinical settings most practitioners will work with childhood abuse survivors. At the current time the diagnosis directly pertaining to traumatic experiences within Diagnostic and Statistical Manual of Mental Disorders, fourth edition text revision (DSM-IV-TR, American Psychiatric Association [APA], 2000) is PTSD, the appropriateness of this diagnosis for adult survivors of childhood abuse will be discussed later. The diagnosis of PTSD originated mainly from studies of Vietnam War veterans and was included in DSM III in 1980 despite much earlier discoveries of the impact of psychological trauma, as highlighted by Brewin (2003). Most recent estimates of the prevalence of PTSD are based mainly upon US statistics, they suggest a lifetime prevalence of

5-12% (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Lee & Young, 2001); while 93% of the population, according to a review by Lee and Young (2001) may have experienced a traumatic event during their lifetime.

Courtois (2004), Ford and Courtois (2009a) and Paivio and Pascual-Leone (2010) identify that the intrusive re-experiencing; avoidance and numbing; and hyperarousal; characteristic of a PTSD diagnosis are not a defining feature of complex trauma. US statistics suggest that 80% of clients with a PTSD diagnosis will also have another Axis I diagnosis, and many will also have Axis II diagnoses (Kessler et al., 1995). Major depression, substance use and anxiety appear to be the most commonly co-occurring Axis I diagnoses (Creamer & O'Donnell, 2002); but psychosis and bipolar affective disorder also occur (Mueser et al., 1998). Self-harm, eating disorders and substance use also appear in those with child abuse histories particularly at an early age, indicative of self-regulation attempts (van der Kolk, 1996). Problems with affect regulation; dissociation; interpersonal relationships; unexplained physical problems (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005); reduced global functioning; and environmental problems are also evident (Bremner et al., 1995). In addition to these the DSM-IV trials demonstrated that individuals may also experience problems with self-perception; hopelessness and inability to think about the future (van der Kolk et al., 2005). This results in diagnostic difficulties and complexities in identifying effective treatment paths. Consequently, Lasiuk and Hegadoren (2006) explore the concept of a *trauma spectrum* to conceptualise and understand the impacts of different types of traumatic experiences rather than single diagnostic categories.

Most commonly survivors with the worst histories of childhood abuse have found themselves diagnosed with Borderline Personality Disorder (BPD), Somatisation Disorder or Multiple Personality Disorder (this has been replaced in DSM-IV by Dissociative Identity Disorder) (Herman, 1992). These labels are often considered pejorative and notoriously create stigma. Herman (1992) suggested that the problems with identity, interpersonal relationships, psychosomatic representations and dissociation, prompting these diagnoses are in fact features of complex trauma. In BPD incidence of childhood trauma has been found to be as high as 75% (Wagner & Linehan, 2006; Zanarini et al., 1997). Herman (2009) identifies that the similarities between complex trauma presentations and BPD presentations are becoming more and more apparent, having first been suggested several decades ago by Herman, Perry and van der Kolk (1989), as such there may exist similarities between effective treatment approaches.

Due to the extent of co-morbidity and diagnostic difficulties impacting upon the establishment of effective treatment, van der Kolk (2009a) argues for a separate diagnostic category for complex trauma in adults – Disorders of Extreme Stress Not Otherwise Specified (DESNOS) or complex PTSD (Herman, 1992) – to enable a more focused effort on scientific and systematic study of the problem, enabling more rapid developments in understanding and treatment. DESNOS, developmental trauma disorder (children) and complicated grief disorder are all being considered by the APA (2010) as new trauma-related diagnoses for inclusion in DSM-5. DESNOS was originally considered in DSM-IV (APA, 1994) field trials but, despite what Herman (2009) describes as compelling evidence, the APA were uncertain whether the additional features were a more severe form of PTSD rather than a separate diagnosis (Roth, Newman, Pelcovitz, van der Kolk & Mandel, 1997). The APA also considered the findings could not be generalised to men as women were over-represented in the sample. Furthermore, Herman (2009) suggested that the classification grouping for the diagnosis could not be agreed, and hence was considered ‘not to fit’. Thereby, the decision was taken to incorporate the additional features with the PTSD diagnosis. However, one may consider that the possibility of belonging to multi-classification groups indicates the fundamental and far-reaching impact of childhood abuse on development and adulthood. Since 1994 support for the diagnosis of DESNOS/Complex PTSD has grown (Courtois, 2004). Van der Kolk and Courtois (2005) identify approximately thirty studies providing evidence and a number of psychometric tests. However, Kilpatrick (2005a) disagrees suggesting that the construct and specificity of DESNOS has yet to be validated sufficiently to justify its inclusion as a separate diagnostic category.

As such there are innumerable ways of classifying and conceptualising the problems experienced by adult survivors of childhood abuse. The holistic view taken by counselling psychology and the principle-driven philosophy focusing upon well-being, growth and development provide alternative conceptualisations in the absence of diagnosis, and require identification of strengths and adaptive functioning within malfunctioning contexts. As Ford and Courtois (2009a) suggest the core issues of *complex psychological trauma* arising from prolonged harm during crucial childhood development phases will remain the same irrespective of the specific diagnosis or conceptualisation. This will likely include addressing difficulties with emotional regulation, dissociative experiences, somatic difficulties, halted development of self, and problems in attachment relationships.

D.3 Problems and challenges in the treatment of complex trauma

As previously identified some of the major difficulties experienced by complex trauma sufferers include an inability to regulate emotions, to describe verbally what they feel or experience, and to be ‘soothed’ by care giving figures, due to an inappropriate level of care

during child development (van der Kolk & Courtois, 2005). Luxenberg, Spinazzola, Hidalgo, Hunt and van der Kolk (2001) identify additional issues of trust which disrupt relationships and arise from individuals fearing themselves to be beyond understanding and value; further they fear mistreatment and so create protective interpersonal barriers to prevent this. This results in difficulties establishing relationships with mental health providers leading to attrition from treatment services and revolving-door care, with mental health systems often being considered to re-enact the abusive experiences (Herman, 1992).

In order to break this cycle, childhood trauma needs to be recognised and effective treatments offered which seek to change the experiencing of the individual (van der Kolk, 1996), as well as increasing understanding and changing perceptions of clients (Chaikin & Prout, 2004; Enns, et al., 1998). However, presentation to services with severe mental health symptoms may seriously obscure the presence of trauma and increase treatment resistance as a result (Chaikin & Prout, 2004). Treatment approach often also depends on whether trauma is accepted as the underlying problem (van der Kolk, 1996). In addition manifestations of complex trauma also occur which are below diagnostic thresholds (Ford & Courtois, 2009b), consequently excluding people from treatment when diagnostic systems are applied.

There is also the risk of metaphorical blindness that can occur with serial treatment (Ford & Courtois, 2009b); failing to see the bigger picture and the interconnection of problems due to attending too closely to discrete categories of symptoms. For example suicidality is not a diagnosing feature of PTSD; however, it is often a significant problem in complex trauma. Foa, Keane and Friedman (2000) suggest clients should be hospitalised to manage risk. However, this has implications for survivors of childhood abuse that may fear locked environments. Kilpatrick (2005a) argues that attending to the trauma issues may in itself resolve the secondary co-morbid diagnoses, if posttraumatic stress is the central issue. As such the treatment of choice, according to Foa et al. (2000), should be one that addresses all problems, rather than serialisation (e.g. Shalev, Friedman, Foa & Keane, 2000). Furthermore indiscriminate application of CBT to survivors of childhood trauma may have detrimental effects if conducted without regard to safety or emotional regulation capabilities (Courtois, 2004).

A further problem within clinical practice is the interpretation of research findings due to definitions of childhood abuse; particularly in research emanating from the US and Canada childhood *abuse* is defined by the presence of sexual or physical acts, with *maltreatment* defining other types of abuse. Ford and Courtois (2009a) suggest that while emotional abuse

and neglect may not be 'life-threatening' as defined by the criteria of DSM-IV-TR (APA, 2000) it nonetheless has a far-reaching and devastating effect on the development of adaptive functioning and selfhood arising from subtlety of these experiences (Paivio & Pascual-Leone, 2010). Furthermore, complex trauma is often a specific exclusion criterion within PTSD treatment studies (Gringrich, 2009). Thereby, when considering the empirical base it is important to consider these definitions and the potential implications of these for interpreting efficacy (e.g. Cloitre et al., 2009).

Current drivers in the treatment of psychological problems are economic efficiency and increased productivity evident in such policies as Improving Access to Psychological Therapies (IAPT) (Strawbridge & Wolfe, 2010). Within a cost and target driven political climate it is obviously important that treatment is cost and resource effective. However, this does not necessarily mean treating the symptoms in the fastest time possible irrespective of outcome which appears to be how the policies have been interpreted locally; furthermore for this particular client group this is unlikely to be possible. As such the focus on rapid treatment and outcomes measured by employment figures places those with histories of severe and chronic childhood trauma at risk of being underserved by such policies, or being harmed further due to inappropriate treatment.

D.4 Current position of treatment for traumatic experiences

Globally a number of bodies have identified treatment recommendations for PTSD including the International Society for Traumatic Stress Studies (ISTSS, Foa et al., 2000); the US department of Veteran Affairs (VA, 2004); Northern Ireland Health Service (CREST, 2003); the APA (2004); National Institute for Health and Clinical Excellence (NICE, 2005); and the Australian Centre for Posttraumatic Mental Health (ACPMH, 2007). Despite the inclusion of complex trauma under *associated features of PTSD* (APA, 2000) the empirical research base predominantly involves approaches to the treatment of PTSD not complex trauma. No formal guidelines on the treatment of complex trauma have been produced, although a number of suggested theories, books, chapters, articles pertain to treatment (Ford & Courtois, 2009a).

As a result work has been undertaken to determine whether the recommended treatments for PTSD are appropriate for adult survivors of childhood abuse (van der Kolk & Courtois, 2005). Spinazzola, Blaustein and van der Kolk (2005) report that within the ISTSS practice guidelines (Foa et al., 2000) only 2 of the 34 studies reviewed focused on childhood sexual abuse and no studies focused on other types of sustained childhood trauma. Treatment approaches for survivors of childhood abuse appear, for the most part, to have been extrapolated from research conducted with rape survivors. However, Chard (2005) found rape survivors do not

demonstrate the same interpersonal relationship or social adjustment problems. Cloitre et al. (2009) have also identified significant differences in clinical profiles between survivors of childhood and adult trauma. Further, Moller (2002) found poorer treatment outcomes in cases with familial childhood abuse.

D.4.1 PTSD treatment and complex trauma

NICE (2005) and the ISTSS (Foa et al., 2000) recommend the use of trauma-focused cognitive behavioural therapy (TF-CBT) or trauma-focused eye movement desensitisation and reprocessing (EMDR), as the first-line interventions with PTSD. The NICE TF-CBT group of interventions included: prolonged exposure; image habituation training; imaginal flooding therapy; imaginal exposure and biofeedback-assisted desensitisation treatment; cognitive processing therapy; cognitive-behavioural treatment; cognitive therapy for PTSD; cognitive restructuring plus exposure; cognitive restructuring; cognitive trauma therapy and brief eclectic psychotherapy. Evidently there is significant variation in the techniques used; had the groups been split into specific techniques, some TF-CBT treatments may have been identified as less effective than others. For example stress management techniques, which are used frequently within CBT, were treated as a separate analysis group and were found to be less efficacious than other TF-CBT techniques.

Within the review by NICE (2005) there were also few studies available for determining efficacy of non-TF-CBT interventions, and so are not indicated within the recommendations. Overall there appears also to have been limited attention to the reasons for non-completion of treatment; or the characteristics of the non-completers. Consequently, it is possible that these were individuals with more prolonged and repetitive trauma who were unable to tolerate the treatments (Bisson et al., 2007; Spinazzola et al., 2005). Furthermore, future research needs to be conducted regarding the application of the recommended treatments in clinical settings (NICE, 2005). While RCT's can demonstrate internal validity, their strict parameters for inclusion and exclusion can result in questionable external validity. Notwithstanding these limitations, further research has lent support to the effectiveness of trauma-focused interventions (Dorahy, 2006); with prolonged exposure and cognitive therapy having been shown to be the most effective (Bryant, Moulds, Guthrie, Dang & Nixon, 2003; Creamer & O'Donnell, 2002; Kimble, Riggs & Keane, 1999; Taylor et al., 2003) However, the samples appear to be unrepresentative regarding socio-economic status and there is still limited consideration of attrition.

With regard to EMDR, the role of rapid eye movements has been questioned (Chemtob, Tolin, van der Kolk & Pitman, 2000; Hembree & Foa, 2003). Shapiro (2001), its founder, maintains that the eye movements in EMDR are an essential part of the treatment. However, there is suggestion that the other elements of EMDR are inherently similar to those of TF-CBT and that it is these that make the treatment efficacious (Davidson & Parker, 2001). There is also conflicting evidence for treatment efficacy of EMDR compared to TF-CBT. Some studies have found EMDR to be comparable to TF-CBT in reducing symptoms, while others have found TF-CBT to be more efficacious (Zayfert & Becker, 2007). Devilly and Spence (1999) found that the treatment effects of EMDR were not long-lasting and had dropped at follow-up.

As is apparent the majority of recommended empirically-based techniques for PTSD treatment focus on behavioural elements of anxiety and avoidance. This disregards the involvement of other precipitating and maintaining factors (Kimble, et al., 1999). For example: van der Kolk (1996) suggests the importance of secure attachment in modulating the effects of trauma. Children who have not developed a secure attachment due to abusive or neglectful parenting tend to lack abilities in self-regulation. This leads to problems with over arousal, attention difficulties and inability to attend to most appropriate stimuli (van der Kolk, 1996). Further, Ford and Kidd (1998) identify that PTSD treatment outcome in those who have difficulty with self-regulation is poor. Kilpatrick (2005) and van der Kolk (1996) identify that further research is needed to identify the relative use of self-regulation training in the treatment of complex trauma. Luxenberg et al. (2001) identify that we do not yet know whether exposure techniques will be empirically validated as important within the treatment of complex trauma, although high dropout rates and continued presence of symptoms following treatment, suggest that TF-CBT alone may not be enough. Overall PTSD treatments adapted for use with complex trauma presentations lack empirical-validation (Ford & Courtois, 2009b), further research is necessary to identify the effectiveness, efficacy and economics of these adaptations.

D.4.2 Specific complex trauma treatment approaches

Cloitre, Koenen, Cohen and Han (2002) published the first childhood abuse treatment outcome RCT. They received criticism for this research, from Cahill, Zoellner, Feeny and Riggs (2004), on the basis of not providing evidence that actually tested their hypotheses. This study trialled a new sequential treatment approach employing skills training in affective and interpersonal regulation (STAIR) with Imaginal Exposure (IE)⁹ tested against waiting list controls to determine whether the treatment was effective for working with adult survivors of child abuse. They found it was effective in improving mood regulation, interpersonal skills and PTSD symptoms, although comparison with other treatments was not undertaken (Cloitre, Stovall-McClough &

Levitt, 2004a). As this group of clients are thought to fair less well with exposure therapies, as concurred by Cahill et al. (2004), the first stage was considered to improve outcomes through development of self-regulation skills. However, the study did not include those with BPD, current substance abuse issues, suicidal ideation or severe mental health problems.

McDonagh et al. (2005) conducted an RCT comparing TF-CBT, with present centred therapy (PCT) a problem-solving therapy, and waiting list controls in adult female survivors of sexual abuse, both were found to be effective in reducing the severity of PTSD symptoms and anxiety, contrary to researchers' expectations. While the TF-CBT group appeared to demonstrate more change at follow-up, there was a much higher dropout rate, 41% compared to 9% for PCT; further those undergoing PCT maintained treatment improvements at 6 month follow-up. Analysis of the attrition statistics suggests that those with characteristics diagnosable as personality disorders were most likely to dropout of the TF-CBT treatment group compared to waiting list or PCT suggesting that PCT would be a better alternative for those at risk of drop-out; however, this requires further study. In addition those who dropped out of the TF-CBT group had increased severity of other symptoms, suggesting treatment outcome co-morbidity effects and the importance of treatment formulations which consider the whole person. Also this study excluded those with severe and enduring mental health problems, substance use problems and medical problems, all of which are of high incidence in this clinical group. In addition the usefulness of the results is limited due to the lack of representation with regard to socio-economic status. The sample was composed mainly of well-educated, employed, middle-class females who experienced multiple child traumas.

Callahan (2004) conducted a review of empirically tested group-based interpersonal-psychodynamic therapies with survivors of childhood sexual abuse indicating promising results. Similarly, in a review of 6 uncontrolled and 7 controlled group treatments for female adult survivors of sexual abuse, Kessler, White and Nelson (2003) found these treatments may be helpful in reducing PTSD symptoms. However, the results require replication to address methodological problems of the earlier studies included in the review.

Previously it had been suggested that group work may be a useful social support structure for individual therapy (Enns et al., 1998). Consequently, Chard (2005) conducted the first combined individual and group cognitive processing therapy RCT with adult survivors of child sexual abuse. They hypothesised that the combination treatment would reduce the number of dropouts due to the availability of support, in group sessions, and individual processing time for exposure exercises. Exclusions from the study included current suicidal intent, current

trauma, current substance dependence and other pressing serious medical conditions. Over half the sample participants reported over 100 incidents of abuse in childhood. Treatment lasted for 17 weeks and included a 90 minute group each week and an individual 60 minute session each week with one of the group facilitators for the first 9 weeks and the 17th week. The findings of this study suggest that this adapted form of Cognitive Processing Therapy for child sexual abuse survivors may be an effective treatment. Of the clients completing treatment most demonstrated clinically important changes in severity of PTSD symptoms, depression and dissociation and no client experienced symptoms worsening. However, it is unclear how important the group itself was in producing the results as no comparison study has yet been completed. Internal validity was limited by participant numbers (N=71) and lack of ethnic diversity. Further, it is also unclear what role therapeutic alliance played in these results, the study also did not report the attrition rates, only stating that it was lower than for other studies.

DBT has been proposed as a potential treatment given the empirical evidence for effectiveness with BPD and the high incidence of childhood trauma amongst those individuals receiving the diagnosis (Wagner & Linehan, 2006; Wagner et al., 2007). However, it has not been validated specifically with adult survivors of complex trauma. Earlier, Cornell and Olio (1991) presented a model involving working with developing the survivor's ability to tolerate affect without denial or dissociation. The model provides a clear theory of how this process could work; however, it lacks the manualised approach that would lend itself to rigorous empirical testing. Paivio and Pascual-Leone (2010) suggest that Emotion-focused therapy for trauma (EFTT) at the time of writing was the only evidence-based treatment for males and females across all types of childhood abuse experiences. EFTT, as described by Paivio and Pascual-Leone (2010), is a four-phase theory and research based treatment for those identified as suitable for short-term trauma interventions, for example where there is no evidential suicide or self-harm risks. The resolution of damaged attachment relationships is the primary focus of the therapy. EFTT is proposed to assist individuals with difficulties in linguistically identifying emotions, also referred to as alexythymia (Paivio & Pascual-Leone, 2010). However, its validity with individuals presenting as high risk or otherwise unsuitable for short-term therapy is unclear.

The relevance of attachment theory to problems of emotion regulation and perception of social support has been empirically validated (e.g. Cloitre, Stovall-McClough, Zorbas & Charuvastra, 2008). By implication this suggests that targeting insecure attachment styles may assist in improving functioning in these realms. Other treatment approaches based in alternative views of problem aetiology, for example Functional Analytic Psychotherapy (FAP)

based in behavioural theory, rather than attachment theory have also been proposed (Kohlenberg, Tsai & Kohlenberg, 2006). Further, Lee (2005) suggests the use of Compassion focused CBT; addressing shame which is often subtle and hidden, and may play a significant part in the maintenance of trauma states. In addition in the last 10 years approaches have begun to look at the importance of the mind-body connection; that working with physical experiences in the body is central to recovery (e.g Emerson, Sharma, Chaudry & Turner, 2009; Levine, 1997; Rothschild, 2000; van der Kolk, 2009b). Other manualised treatments have also been validated for some co-morbidities including Najavits' (2002) Seeking Safety for PTSD and substance use; and Mueser, Rosenberg and Rosenberg (2009) cognitive restructuring program for PTSD in special populations.

Many scientist-practitioners, those who have identified progress in the treatment of complex trauma (e.g. Chaikin and Prout, 2004; Courtois, 2004; Dorahy, 2006; Ford, Courtois, Steele, van der Hart & Nijenhuis, 2005; Kimble et al., 1999; van der Kolk & Courtois, 2005) recommend the use of a phased approach to treatment, although this approach remains largely the basis of clinical experience. The three phases identified by Herman (1992) are: 1) development of working alliance, stabilising and establishing safety, including psychoeducation and skills building, 2) processing of traumatic memories, and 3) life integration and relapse prevention skills. Proponents of this tripartite model suggest it can be utilised across all approaches to complex trauma treatment. The main focus being the acquiring of skills needed to be able to self-regulate affect. Further, Ford et al (2005) identify several treatments that have been manualised and tested for use with self-dysregulation and shown promising results with this treatment population. However, they identify within this phased model problems occur when trying to determine if a client is ready to move into phase 2.

Reviewing the research base Courtois (2004) identifies that a range of theoretical approaches have been identified to be helpful, suggesting a transtheoretical conceptual model employing multi-modal approaches encompassing biopsychosocial and spiritual considerations.

Treatment proposed by Courtois, and Pearlman and Courtois (2005), employs a whole person approach to traumatic experience, regarding the traumatic experience as *part* of the whole person rather than the *whole* person. Thereby, it is individualised according to the particular strengths and difficulties of the person. The model is further founded on the tripartite model and places overall emphasis on posttraumatic growth and improved life-functioning, with the aim of preventing the characteristic ongoing decline often seen in complex trauma cases.

Courtois (2004) identifies that some individuals may never move beyond the first phase of treatment by necessity or choice.

The most promising treatments seem to require an ability to recognise the traumatised patient's tendency to re-enact abusive interpersonal relationships. The first task of therapy: to establish interpersonal safety in the relationship so that an individual may experience secure attachment and learn to self-regulate (van der Kolk, 1996). However, Luxenberg et al. (2001) comment on the importance of not only addressing safety and security problems behaviourally, but also to inquire and understand the significance of this for the individual, exploring personal meaning.

D.4.3 The therapeutic relationship and complex trauma treatment

Kilpatrick (2005b) suggests that within the traumatic stress field there has been little empirical focus on the impact of the therapeutic relationship, beyond clinical observation. NICE (2005) makes only brief reference to the importance of a therapeutic relationship stating '...a good therapeutic relationship is at times more important than the specific treatments offered' (p.2). However, Cornell and Olio (1991) clearly identify the importance of the therapeutic relationship in mediating positive treatment outcomes. Furthermore, Herman (1992) identifies empowerment as a fundamental principle in the therapeutic healing relationship, while avoiding temptation to try to 'fix things', a medical model tendency. The role of therapist is in encouraging clients to take control of their own lives (Enns et al., 1998). Cloitre, Stovall-McClough and Chemtob (2004b) and Ford et al. (2005) also found the establishment of an early strong therapeutic alliance to be correlated with improvement of PTSD symptoms. However, it remains unclear what exact role the therapeutic relationship plays and requires further exploration (Kilpatrick, 2005a); possibly the reason for only brief mention by NICE (2005).

Pearlman and Courtois (2005) advocate that the therapeutic relationship is essential for providing the basis for which the self and attachment problems can be addressed. Without resolving these issues they believe that change for the individual will be unlikely to progress beyond the amelioration of psychiatric symptoms and skills deficits. They place emphasis on the importance of the attachment bond in child development in the prevention of dysregulation, interpersonal problems and somatic expressions. They implicate these processes in dissociation and place emphasis on resolution through the therapeutic relationship. The theory remains untested but is well-founded in attachment theory, which is now beginning to converge within trauma research. Heller (2010) identifies the importance of the maternal role within attachment theory to enable a developing child to accomplish skills in mentalisation, providing a secure base, empathic capacity, reflective engagement and 'theory of mind' which are then reflected within the child. In many ways the therapeutic relationship

can be considered another opportunity in which this can occur (e.g Winnicott, 1960; Fonagy, 2001).

Further, Chaikin and Prout (2004) identify the important of being aware of transference and countertransference issues. The therapist must resist the urge to parent the survivor, instead providing a model for parenting the self. The therapist role is to encourage growth and change (Bratton, 1999). Herman (1992) describes complex transference reactions in cases of complex trauma involving dominance and submission, hope and fear, suspicion and faith, and distrust and trust. Additionally, the survivor has expectations of perfection in this 'life-saver'. Herman also cautions that survivors of prolonged sexual abuse may believe that their only value, in an unbalanced power relationship, is as a sexual object; or the only way to please an abuser; or demonstrate gratitude. Consequently, the therapeutic relationship may be filled with sexual transference. Dalenberg (2004) also highlights the importance of being aware of countertransference of anger. The therapist needs to model effective anger expression in order to assist the client with interpersonal relationship development. This was evidenced through interviewing many clients' accounts of therapy experiences.

In addition clients report finding the *blank slate* therapist dissatisfying, this suggests a need to take a different approach with this client group (Dalenberg, 2004). Without this, it seems the therapist is in danger of re-enacting the role of the disinterested, neglectful parent. Olio and Cornell (1993) identify that the blank slate therapist is unhelpful and punishing to adult survivors of childhood abuse reminiscent of earlier experiences of care-givers. They support the need for a different kind of therapeutic relationship providing a safe environment in which to experience secure attachment and develop self integration with affect. The therapist must aim to sensitively pass the power of the relationship back to the client (Bratton, 1999). This is also supported by Cloitre et al. (2004b).

Further, Chaikin and Prout (2004) suggest that many clinicians underestimate the effect of hearing another's traumatic experiences (countertransference). The therapist's ability to self-care is crucial in the process of treatment. Bratton (1999) highlights the importance of self-care for the therapist of trauma survivors. Therapists are urged to care for themselves in the same way they encourage their clients to. The risk of vicarious traumatization is high, even for the therapist skilled at separating client and personal feelings. In addition, therapists may find themselves isolated in an environment where colleagues lack understanding of the effects of captivity upon development (Herman, 1992). It is imperative that systems are in place to buffer the effects of traumatic transference and countertransference including therapist

supervision and support, therapeutic boundaries and goal setting (Herman, 1992). Countertransference may result in therapist feelings of incompetency, helplessness and hopelessness (Kimble et al., 1999). This can lead to acts of rescuing and advocacy.

Traditionally, Cognitive Therapy has been thought to placate the issue of transference and countertransference in the methods employed in the approach (Beck, Rush, Shaw & Emery, 1979). When problems occur the therapist challenges the underlying dysfunctional thinking, with the aim of replacing it with more functional thinking. In fact in Zayfert and Becker's (2007) CBT for PTSD manual barely mention issues of transference or countertransference. It is unclear whether this is due to the belief that, even when working with complex trauma, cognitive therapists are not susceptible to these issues or if it is simply omission. However, it seems incredulous to suggest that a cognitive therapist by virtue of their approach would be unsusceptible to vicarious traumatisation (countertransference). In fact to the client this may even present the similar problems to that of the psychoanalytic approach of blank slate.

Wolf (2001) in describing her own experiences of therapy and childhood trauma states the importance of therapist self-awareness in order to provide effective 'adult parenting'. In her experience it was this that finally made the difference between good and bad counselling experiences. Other branches of psychology are concerned with the reduction of symptoms as a main treatment goal. Counselling psychology is about the whole person, body and mind. It is concerned with process in preference to content. Counselling psychology promotes self-awareness in addition to competency in applying understanding of interpersonal and personal communication systems and processes (BPS, 2007). Furthermore, Saakvitne, Gamble, Pearlman and Lev (2000) use the acronym RICH to identify the most important components of treatment for complex trauma: respect, information, connection and hope, signifying the level of significance of the therapeutic relationship. It is apparent that further research is necessary to establish the importance of empathic engagement with an individual with complex trauma experiences (van der Kolk & Courtois, 2005); and how this is moderated by therapeutic approach, caseload factors, training, supervision, personal factors including history, personality, emotional maturation and resilience, and other life stressors (Ford & Courtois, 2009b).

D.5 Conclusions

A subgroup of the UKTG (2009) issued a position statement identifying that the brief trauma-focused approach recommended by NICE (2005) relates to simple, not complex trauma; which requires a broader range of treatment approaches, this was also a position held earlier by Luxenberg et al. (2001). In the absence of consensus Kilpatrick (2005b) and Pearlman (2004)

highlight the importance of empirically-based theory in the development of therapeutic interventions. This enables an individualised approach to be employed, while drawing on the scientist-practitioners *inquisitive* and the reflective practitioners *open* mind, the essence of counselling psychology (Strawbridge & Wolfe, 2010).

There exists general clinical consensus that treatment with survivors of child abuse is complex, lengthy, phased and multi-modal (Enns, et al., 1998). At the current time the tripartite model appears to have gained agreement across all approaches to complex trauma, including Courtois (2004), Ford & Courtois (2009a), Ford et al. (2005), Luxenberg et al. (2001), Shapiro (2001), UKTG (2009), van der Kolk (1996; 2009a). The establishment of safety and stabilisation indicated within phase 1 is the most commonly applied principle within all treatments demonstrating positive outcomes including: DBT (Wagner & Linehan, 2006; Wagner et al., 2007), EFTT (Paivio & Pascuale-Leone, 2010), compassion focused CBT (Lee, 2005), constructivist self development theory (Courtois, 2004; Pearlman & Courtois, 2005), STAIR-NST (Cloitre et al., 2002; Cloitre et al., 2006), seeking safety (Najavits, 2002). Further when time is limited it is generally agreed that focus should be upon the establishment of safety, support, psychoeducation, the development of key emotion regulation skills and case management as priorities (Ford & Courtois, 2009a). The development of support systems beyond the therapeutic environment should also be addressed and encouraged (Chaikin & Prout, 2004; Ford & Courtois, 2009a; Dalenberg, 2000). Furthermore, Kilpatrick (2005b) highlights the importance of integration across disciplines and continuity of care.

Ford and Courtois (2009a) further identify a number of key points identified by empirical research to be addressed during therapy including: physical experiencing; the emotional regulation; internal working models of attachment; problem-solving ; risk behaviours; dissociative experiences; sense of self ; avoidance of trauma re-enactment and revictimisation; relationship difficulties related to betrayal trauma and disorganised attachment patterns; and restoration of meaning. Here counselling psychology offers prioritisation of subjectivity and personal meaning are prioritised beyond diagnosis and *treatment* increasing understanding through phenomenology (Lane & Corrie, 2006). Further, the therapeutic relationship appears to have identifiable importance (Olio and Cornell, 1993). While this remains to be tested more fully, it would seem to be linked to treatment outcome by the fostering of secure attachments and a safe place in which to integrate affect with the experiencing self and develop self-regulation (van der Kolk, 1996).

It is doubtless that complex trauma is inherently difficult to research (Chard, 2005; McDonagh et al. 2005). Consequently much of the previous research has been methodologically flawed, and there are many unanswered questions beyond those of effective treatment. To progress further towards best practice guidance with regard to adult survivors of childhood abuse research needs to be integrated and collaborated upon across disciplines (Kilpatrick, 2005b). This will enable reassembly of the fragmentation that has occurred within the field.

The research on treatment outcomes with this clinical group has predominantly involved females and childhood sexual abuse. Therefore, the efficacy requires further testing with regard to gender and other types of childhood abuse. There is little information on treatment outcome by gender, age or ethnicity or socioeconomic background (Foa, et al., 2000). In addition, majority of the research is North American (Creamer & O'Donnell, 2002), and cross-cultural applicability is unknown. Further, there is a general consensus amongst RCT research critics regarding the limited ecological validity in treatment trials; research tends to be unrepresentative of the clinical population (Dorahy, 2006; Spinazzola et al. 2005); and inclusion and exclusion criteria often completely preclude certain groups and methods (Dorahy, 2006).

This review has identified additional methodological gaps within the research including the exploration of attrition and unfavourable treatment outcomes (Bisson et al., 2007). Further to enhance treatment development there needs to be investigation of the differences between and within group differences which render some interventions, such as prolonged exposure, intolerable (Ford et al., 2005). Bradley, Heim and Westen (2005) suggest interplay between different personality patterns amongst childhood sexual abuse survivors alone. This finding needs to be considered further to understand possible modulating effects of different types of experiences. This will also provide an opportunity to empirically test theories regarding different lengths of treatment (Courtois, 2004; Dorahy, 2006), as optimal treatment length is arbitrary. However, this is connected to funding restrictions and the lengthy follow-up times necessary to measure changes.

Self-regulation skills have been identified as important within complex trauma treatment (e.g. Courtois, 2004; Ford & Kidd, 1998). However, further research may identify the mechanism for this and assist with understanding how it may moderate development and maintenance of symptoms (van der Kolk, 2009a), or whether other moderators, such as social support, are as important (Kilpatrick, 2005a). Similarly, clinically relevant treatment outcomes require comparison studies (Chaikin & Prout, 2004; Dorahy, 2006; Ford et al., 2005; Kimble et al., 1999;

van der Kolk & Courtois, 2005). For example comparing STAIR-NST (Cloitre et al., 2006), with Cognitive Processing Therapy, perhaps using the individual and group model proposed by Chard (2005), and with a waiting list control group. In addition, exploratory research identifying how non-manualised therapies could be rigorously tested is also required to provide further comparison opportunities.

The philosophical values and practice of counselling psychology are apparent within the best practice summary by Ford and Courtois (2009a) identify important therapist attributes for working with complex trauma. They highlight the importance of recognising the individuality and uniqueness of each person, and a focus upon identifying resilience and adaptive functioning, such that empowerment can be fostered. Further, it requires therapist emotional maturity, in addition to suitable qualifications and competence that can manage effectively the constellation of problems, challenges and difficulties that occur in the material presented and the therapeutic relationship. Thereby, counselling psychology presents a philosophical foundation that already emphasises the converging constants within the field of complex trauma.

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Appendices

Appendix B1 – Research Adverts

Research Study

Do you have a diagnosis of Borderline Personality Disorder? What is it like for you having this diagnosis?

I am looking for individuals to take part in my research study. If you are over the age of 18, are English speaking, diagnosed in the UK and not currently receiving therapy or counselling, and would be willing to talk about your experiences of being diagnosed with Borderline Personality Disorder, then please read on:

My name is Lisa Wilson, I am a Counselling Psychology Doctoral student at City University, London. I would really like to give a voice to people who have received a diagnosis of Borderline Personality Disorder, and I am interested in hearing what effects this may have had on you.

The research aims to find out what impact this diagnosis has on people by looking at how they talk about their experience of it. The study is confidential and anonymous, and will take place on an individual basis with me, I will provide a safe and non-judgemental space for you to talk about your experience.

My intention is to provide those diagnosing and treating Borderline Personality Disorder with an opportunity for increased understanding of the effect this may have on the way that people see themselves.

If you are interested in taking part, and would like further information, please contact me on lisa.research@btinternet.com or abbw193@city.ac.uk or by phone on 07702-416632

This research is being supervised by Fiona Bailey at City University and she can be contacted by email at Fiona.Bailey.1@city.ac.uk or phone on: 020 7040 4557



Have your say



Would you like the chance to talk about what it is like for you to have a Borderline Personality Disorder diagnosis?

I am researching the effects of having a borderline personality disorder diagnosis on how you talk about your experiences.

If this is something you would like to take part in, I will arrange for us to meet at a safe and convenient place and talk about what it is like for you

This is a chance for you to say what you really think in confidence!

Further information on the disorder and resources will be available for you to take away with you.

If you think you might like to do this and you can answer yes to all the following questions then please contact me for more information:

Lisa Wilson

Tel No: **07702-416632** Email address: **lisa.research@btinternet.com**

Are you over 18? Yes No

Are you English speaking? Yes No

Were you diagnosed in the UK? Yes No

If the answer is yes to all of these, and you are not currently receiving therapy or counselling, then I would really like to hear from you.

This research is being supervised by **City University London**
Research Supervisor: Fiona Bailey Tel No: 020 7040 4557 for further information: Fiona.Bailey.1@city.ac.uk

www.borderlinepersonalitydisorder.co.uk also included the following:

About Me and the research

My name is Lisa Wilson, I am a Counselling Psychology Doctoral student at City University, London. I would really like to give a voice to people who have received a diagnosis of Borderline Personality Disorder (BPD), I am interested in hearing about what effects this has on individuals.



My research aim is to find out what impact this diagnosis has on people by looking at how they talk about their experience of it. The study is confidential and anonymous, and will take place on an individual basis with me, I will provide a safe and non-judgemental space for people to talk about their experience.

My intention is to provide those diagnosing and treating Borderline Personality Disorder (BPD) with an opportunity for increased understanding of the effect of this on the way that people see themselves.

If you would like to take part please contact me, I will provide further information about the research and also information and resources relating to the diagnosis.

Contact Us

If you are interested in taking part, and would like further information, please contact me on:

lisa@borderlinepersonalitydisorder.co.uk

or lisa.research@btinternet.com

I am more than happy to answer any questions and there is absolutely no commitment to participate if you contact me.

This research is being supervised by Fiona Bailey at City University, London and she can be contacted by email at Fiona.Bailey.1@city.ac.uk

Counselling Psychology, School of Social Sciences, City University,
Northampton Square, London, EC1V 0HB



Click here to Tell a friend about this research

Appendix B2 – Participant Information Sheet

Dear _____

Thank you for taking the time to think about talking to me as part of my research study.

I am Doctoral Psychology Student at City University London. I am looking at the effects that being diagnosed with Borderline Personality Disorder has on the way that people express themselves, in the way they talk. This is important because it will help Psychologists and other mental health professionals to better understand and think about the impact that giving somebody a diagnosis of Borderline Personality Disorder has on people. I will be talking to up to 15 people about their experiences.

It is important that you think about whether you really want to take part in this study and are aware of what this means:

- Your personal details will not be part of the research, that means that nothing that can identify you will appear in the final write up of this study. What may appear is parts of what you say to me, this gives real examples of what is important for everybody to understand.
- You have the right to stop being part of the study **at any time**, if you change your mind about being involved.
- You will be taking part completely voluntarily, nobody should be making you feel like you have to take part.
- What you say, the audio recording that I take, the notes and transcription, that I keep will all be kept securely and nobody else will have access to these except for my research supervisor. This is covered by the Data Protection Act.
- After the research process is complete, all records will be destroyed.

What will happen if you decide to take part:

We will meet and I will ask you a few questions about your experience and thoughts about having a diagnosis of Borderline Personality Disorder. The interview itself will last for approximately 1 hour. You only say what you want to, there will be no intentionally difficult questions and you do not have to share anything that you do not want to.

At the end of our meeting, you will have the chance to ask me any questions that you have and to say how you found talking about your experience. I will spend as much time as you need talking about this and ensuring that you leave the interview feeling safe. This could mean that the time taken will be longer than 1 hour.

That is it! A few days after we meet I will contact you to make sure that you have no further questions and that you have not been upset by meeting with me. After this if you have any further questions or concerns you can contact either myself or my research supervisor up until July 2009, when I expect to finish the study.

If you would like you will have the chance to find out at the end of the study what I have discovered.

What should you do now?

Discuss with somebody, whose opinion that you trust, that you would like to take part, and ask them what they think. If you are able to answer all the following questions on the next page with yes, contact me then we will arrange to meet at City University,

London at a convenient time. If needed I will refund your travelling expenses. If you would like any further information you contact either myself or my research supervisor as indicated below.

It is very important that you are not currently experiencing any mental health problems that are not being effectively treated and stable; this is for your own well-being. This means any problems that you may experience that are not directly resulting from your diagnosis of Borderline Personality Disorder. I will go through this with you before we agree to meet.

While I am a Counselling Psychologist-in-training I will not be providing you with treatment, just the opportunity to talk about your experience. I will enable you to leave the interview safely by using specific interventions if necessary. However, should you require further specialist support following the interview; I will provide you with details of a qualified therapist with expertise in working with those diagnosed with borderline personality disorder. They will see you within 72 hours. This individual will be aware of the research and will provide a one-off session paid for by me.

Researcher: Lisa Wilson 07702-416632 lisa.research@btinternet.com
Research Supervisor: Fiona Bailey 020-7040-4557 Fiona.Bailey.1@city.ac.uk

Appendix B3 – Informed Consent Form

What effects does the label of Borderline Personality Disorder have on the way people talk about themselves?

I agree to take part in the above City University research project. I have had the project explained to me, and I have read the Participant Information Sheet, which I may keep. I understand that agreeing to take part means that I have answered yes to the following statements:

Please tick the boxes if you are able to answer yes to the following:

- I am over 18
- I am English speaking
- I was diagnosed by a Psychiatrist in the UK with Borderline Personality Disorder
- I am not currently receiving therapy/counselling or inpatient treatment
- I do not have any other untreated mental health problems
- I am able to give my consent to take part in this study.
- I understand that I will be interviewed by the researcher and that this interview will be audiotaped, (and later written out in full), and take about 1 hour.
- I understand that I have the right to withdraw from the study at any time, including during the interview, and that if I do all records will be destroyed.
- I am agreeing to take part voluntarily in this study, nobody is making me feel that I have to take part.
- I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. The only time that this agreement will be broken is if I disclose being a serious risk to myself or to another including a child.
- I understand that this research will be written up and may be published.
- I am aware that I do not have to talk about anything with the researcher that I do not feel happy or safe talking about.
- I have asked any questions that I had about the research and have understood the answers.

Name: _____

Signature _____ Date: _____

I, the researcher, agree to comply with the above statements and sign on behalf of all the professionals who may be involved with this research.

Researchers name: _____

Signature: _____ Date: _____

Research Supervisor: Fiona Bailey 020-7040-4557

Fiona.Bailey.1@city.ac.uk

Counselling Psychology Department, City University, Northampton Square,
London

Appendix B4 – Interview Questions

Interview Questions

- 1) What is your experience of being diagnosed with Borderline Personality Disorder?
 - how did you come to be diagnosed
 - what were the effects, positive or negative, for you
 - what differences are there in your experience between being first diagnosed and now
 - what are your thoughts about other people knowing you have the diagnosisBPD?

- 2) What is your perspective of the effect of being diagnosed with Borderline Personality Disorder?
 - How helpful/unhelpful have you found the diagnosis
 - how have other people responded to your diagnosis
 - what differences are there in how things were when you were first diagnosed and now

- 3) What is your perspective of treatment now that you have a diagnosis of Borderline Personality Disorder?
 - If you have not received treatment what are the reasons for this?
 - What has been helpful/unhelpful about the treatment you have received
 - how have treatment providers responded to you

- 4) Do you think you can recover from BPD?

- 5) Imagine you met somebody who had no knowledge or experience of BPD, they lived in a place where the diagnosis does not exist. What would you tell them about it? How would you assist them to understand the problems that you have experienced? What would be important to you for them to know?

- 6) If this was the perfect interview what question would you expect me to ask that I haven't already

Appendix B5 – Participant Resource Pack

Useful Contacts and Support Agencies

Your current mental health professional may be your first choice for support
The following organisations may provide you with further support, particularly
out of hours:

Samaritans: 08457 90 90 90 www.samaritans.org jo@samaritans.org
Chris, PO Box 9090 Stirling FK8 2SA – will offer emotional support 24/7

Mind (National Association for Mental Health): 0845 766 0163, email
contact@mind.org.uk, www.mind.org.uk – they will put you in touch with your local
branch of mind who may be able to offer you support.

SANEline: 0845 767 8000 **SANEmail:** sanemail@sane.org.uk
www.sane.org.uk – they can provide you will telephone or email support if you are
finding it difficult to cope

NHS Direct – 0845 4647 www.nhsdirect.nhs.uk – can advise you about what to do if
your feeling low, or who to contact in your local area; also can offer health advice
following self-harm

Cruse Bereavement Care – personal and confidential advice to anybody who is
bereaved 0870 167 1677

Relate – assistance for people experiencing relationship problems (they are not mental
health experts) www.relate.org.uk – to find your nearest branch – fees vary

BPDWorld – is the first registered charity for Border Personality Disorder
sufferers they offer on-line, email and telephone support 0870 005 3273
(national rate) www.bpdworld.org

Borderline UK – national user led network offering the opportunity to talk with others
about BPD
www.borderlineuk.co.uk

SupportLine Telephone Helpline: 020 8554 9004 - Provides emotional support to male
and female survivors of abuse and associated issues. Also keeps details of counsellors
and survivor support groups, helplines, and details of counsellors listed with the
National Register of Male Sexual Assault Counsellors throughout the UK. Also provides
email support info@supportline.org.uk and postal support SupportLine, PO Box 1596,
Ilford, Essex IG1 3FW

Bristol Crisis Service for Women: 0117 925 1119, PO Box 654, Bristol BS99
1XH, email bcsw@btconnect.com, www.users.zetnet.co.uk/bcsw - National helpline
for women in distress, especially those who self injure and run and support self help
groups.

Childwatch: 01482 325 552, email info@Childwatch.org.uk,
www.Childwatch.org.uk - Free and confidential counselling for young people and
adults who have suffered abuse, physical, mental, emotional, sexual.

NAPAC (National Association for People Abused in Childhood): 0800 085 3330, 42 Curtain Road, London EC2A 3NH, www.napac.org.uk - Provides referrals and free extracts from the DABS Resource Packs to survivors.

Rape & Sexual Abuse Support Centre: Helpline 08451 221331, Counselling 020 8683 3311, email info@rasasc.org.uk, www.rasasc.org.uk - Helpline support and information for all survivors of rape or childhood sexual abuse.

The Roofie Foundation: 0800 783 2980, www.roofie.com - Advice information and support on drug assisted rape.

SAFE: 01722 410889 - SAFE provides a telephone helpline for survivors of ritual abuse and their supporters.

Survivors Poetry: 020 7281 4654, email info@survivorspoetry.org.uk, www.survivorspoetry.com - National organisation promoting poetry of survivors of mental distress through workshops, meetings and publications. Phone for details of nearest group.

www.dissociation.co.uk - Details of therapists with experience of dissociation and useful links

www.havoca.org – website offering support and advice for survivors of abuse

www.nshn.co.uk – national self harm network offer support and advice to those who self-harm to cope with emotional distress

Useful reading: These books give accounts of two individuals diagnosed with Borderline Personality Disorder

No one knows: Borderline Personality Disorder. The story of a secret survivor by Joshua Cole (2008)

Get me out of here: My recovery from Borderline Personality Disorder by Rachel Reiland (2004)

Please note: If you feel that you are at risk of seriously harming yourself then you should call 999 or get to your nearest A&E department. While you may be reluctant to do this it may be the quickest way to staying safe.

<http://www.mind.org.uk/Information/Booklets/How+to/How+to+cope+with+suicidal+feelings.htm> – this is a link to a useful booklet produced by mind on Coping with suicidal feelings and also provides other emergency numbers and organisations who may be able to help

Other items in this resource pack:

Borderline UK Ltd - 'An introduction to BPD leaflet' is provided as part of the resource pack

BPDWorld – ‘Crisis: What to do when life gets too much’ is provided as part of the resource pack; Borderline Personality Disorder; Dialectical Behaviour Therapy

Mind Leaflets – Understanding Borderline Personality Disorder; Understanding Talking Treatments; Understanding Dissociative Disorders; How to cope with loneliness; How to cope with suicidal feelings

Therapist contact details

Dr Imogen Sturgeon-Clegg

Chartered Counselling Psychologist

Cornerstone Psychological Services

32 Kings Road

Brentwood

Essex

CM14 4DW

07773 312468

Jonny Brough CPsychol

Chartered Counselling Psychologist

Finding Space

Counselling Psychology Practice

info@findingspace.co.uk

Tel: 020 8365 3545

Treatments for Borderline Personality Disorder

(information from: www.personalitydisorder.org.uk)

Please note: Not all of these may be available from you local NHS provider

Dynamic psychotherapy

- This is based on a developmental model of personality
- Treatment is generally long term
- The aim of therapy is to understand the way in which the past influences the present
- Treatment focuses on: the relationship between client and therapist; the individual's emotional life; and their use of defences
- Therapy uses the relationship between client and therapist as a way to understand how the internal world of the individual affects relationships

Cognitive Analytical Therapy

- This therapy assumes that a set of partially dissociated 'self-states' account for the clinical features of borderline personality disorder
- Rapid switching between these self-states leads to lack of control of emotions including intense expression of them and virtual absence (depersonalisation or a feeling of not being there)
- Therapy aims for the therapist and client to address these processes, examining them as they occur in treatment as well as in life experiences

Cognitive Therapy

- This is similar to cognitive behaviour therapy, it is goal directed and focused more on altering underlying belief structures rather than reduction of symptoms
- It is likely to take up to 30 sessions of treatment, of which the early sessions help to identify the areas of intervention required by uncovering what are the fundamental structures of past, present and future experiences
- The therapist and client maintain a collaborative relationship throughout treatment, the approach includes homework and testing of core beliefs and structures

Dialectic Behaviour Therapy (DBT)

- This is a special adaptation of cognitive therapy, originally used for the treatment of women with borderline personality disorder who self-harmed
- DBT is a manualised therapy which includes looking at behaviour, skills training and support (empathy, validation of feelings, management of trauma)
- Directed at reducing self-harm through increase self-regulation of emotions and behaviour

Therapeutic Community Treatments

- Therapeutic communities provide intensive psychosocial treatment which may include a variety of therapies but where the therapeutic environment itself is seen as the primary agent of change. This is normal residential.
- They include democratic and concept types, the former including members of the community as decision makers
- External control is kept to a minimum: members of the community take a significant role in decision making and the everyday running of the unit

The **National Personality Disorder Website** – contains further up to date information and developments in the general area of personality disorder. The following link is to a webpage providing downloadable leaflets on coping with bereavement, stress and anxiety, anger, traumatic events and other important and potentially relevant topics -

http://personalitydisorder.org.uk/index2.php?page_id=19

The site also identifies where in the country new treatment pilots are being conducted.

Researcher: Lisa Wilson 07702-416632 lisa.research@btinternet.com

Research Supervisor: Fiona Bailey 020-7040-4557

Fiona.Bailey.1@city.ac.uk Counselling Psychology Department, City University, Northampton Square, London

Appendix B6 – Debriefing and Interview Closure Procedure

Throughout the interview I will ensure that I listen empathically, without exerting undue influence on the qualitative research process. I will ensure that I communicate clearly throughout. My interviewing style will be calm and accepting. These principles are identified by Beck, Freeman and Davis (2004), Livesley (2003) and Padesky (2005) as being important when working with individuals diagnosed with borderline personality disorder.

At the end of the interview, I will:

- briefly summarise the main points the participant has said during the interview. I will take care to ensure that this provides the opportunity to validate their feelings;
- ask the participant if my understanding and summary is correct;
- ask how they feel after the interview; assuming that they are feeling in as good a state as when they entered the interview then:
 - ask if they have any questions and answer these appropriately
- where they are feeling unduly effected by the interview, I will spend time with them using a variety of functional interventions to address this:
 - If the participant is feeling dissociated I will use ‘here and now’ grounding techniques to re-orientate them to the present time;
 - If the participant is feeling a mood affect then I will take time to validate their feelings and try to identify an action plan with them that will assist in ensuring their safety upon leaving the interview. This may include identifying ways in which the client may keep themselves safe and ideas for coping with moods;
 - If the participant expresses a wish for relaxation then simple and brief breathing and imagery relaxation will be used;
 - If after exploring each of these there is no change it may be necessary to contact the emergency number from their contact sheet, or to seek advice from a colleague or member of psychology staff. This will be done with the knowledge of the participant.
- The resource pack will be provided and extra information offered in the form of leaflets and further reading for them to take away with them. The resource pack will be explained and the support agencies listed will be identified to ensure that the participant knows who they can contact if they need to.
- The participant will be reminded that if they have any questions or comments that they would like to add after the interview they can contact either myself or my research supervisor up until the research has been written up.

In the event that a participant becomes markedly distressed during the interview, I will seek to ensure safety and containment and not continue with the interview process. This will involve:

- Increased empathic listening
- Validating of the emotional reaction
- Focus on understanding the participants point of view through providing summaries
- Using the participants own words and not paraphrasing
- Communicating clearly in short sentences, so that the participant is aware of my communication and I can check their reception of my statements
- Help the client to draw on former positive experiences or strengths
- If after an appropriate amount of time has passed and this has not assisted in containing the situation or assisting the participant to feel safe then it will be necessary to either stop the interview or seek support from staff, a colleague or security if there is any physical danger. It may also be appropriate in the situation to make contact with the participants identified emergency contact. Alternatively, the participant may wish to be seen for a therapeutic session. Details will be provided in the resource pack (Appendix 5) who they contact and be seen by within 72 hours, and the participant's attention will be drawn to this.

The above procedure is a safety measure taking into account some of the diagnosing features of borderline personality disorder. It is possible that the participant has difficulties with self-regulation, emotional, cognitive and/or behavioural. These techniques as identified by Padesky (2005) and Beck et al (2004) are generally effective in providing safety and containment and reducing emotional arousal. The most important factor will be to prevent escalation of the response. Should this situation arise the interview will not be continued for research purposes, only to ensure the participants safety and containment.

The researcher has identified that the interview will take 1 hour, however, with debriefing this will possibly be longer. This has been identified on the participant information sheet (Appendix 3) and will be explained to the participant upon initial contact; when arranging the interview and prior to commencement of the interview. The length of time will depend on the amount of debriefing that is required.

Appendix B7 – Checklist

Name:					
Contact Details:					
DOB:		Gender:		First Language:	
				Yes	No
Over 18?					
Diagnosis of BPD by UK Psychiatrist?					
Date diagnosed:					
Currently receiving therapy/counselling?					
Date last received therapy counselling:					
Untreated co-existing Axis I disorders: Substance-Related Disorder					
Psychosis or Schizophrenia					
Depression or Bipolar Disorder					
Anxiety Disorder (PTSD; OCD; generalised; panic; phobia)					
Dissociative Disorder					
Eating Disorder					
Capacity to consent?					
Consent form discussed and signed, including right to withdraw:					
At initial contact?					
At start of interview?					
Participant information discussed and provided:					
At initial contact?					
At start of interview?					
Procedure explained?					
Opportunity for questions?					
Emergency Contact form explained and completed?					
Contingency Plan explained, including therapist contacts?					
Resource Pack provided?					
Interview date; directions provided; room booked; colleague identified:					
Details of debriefing provided:					

Appendix B8 – Ethics Form

Ethics Release Form for Psychology Research Projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc MPhil MSc PhD DPsych n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

What effects does the label of Borderline Personality Disorder have, as demonstrated through discourse?

2. Name of student researcher (please include contact address and telephone number)

Lisa Wilson, 36 Riviera Drive, Southend-on-Sea, Essex, SS1 2QT, 07702-416632

3. Name of research supervisor

Fiona Bailey, Counselling Psychology Department, City University, Northampton Square, London, EC1V 0HB, 020 7040 4557

4. Is a research proposal appended to this ethics release form? **Yes** **No**

5. Does the research involve the use of human subjects/participants? **Yes** **No**

If yes, a. Approximately how many are planned to be involved? **Between 8 -15**

b. How will you recruit them? **Recruitment flyer/advertisement requesting volunteers**

c. What are your recruitment criteria? **Over 18 yrs; English speaking; diagnosed with Borderline Personality Disorder by a Psychiatrist in the UK; has no untreated co-existing Axis I disorders; has the capacity to consent to participation in research; is not currently an inpatient; not currently receiving therapy or counselling.** (Please append your recruitment material/advertisement/flyer)

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? **Yes** **No**

e. If yes, will signed parental/carer consent be obtained? **Yes** **No**

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Each participant will take part in a semi-structured interview for approximately 1 hour with the researcher. They will be asked open-ended questions relating to their experience and perspectives of their diagnosis. (See Appendix 6)

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes

No

If yes, a. Please detail the possible harm? **As with any research involving human participants there is the possibility of negative effects, when discussing past experience, this is not considered to be undue harm.**

b. How can this be justified? **There is no expected harm outside of what a participant may experience in their usual environment as a result of their free-will. The potential for risk will be monitored and a list of resources for support provided.**

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

Yes

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

No

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Research notes; computer typed and stored transcripts; digital audio recordings

12. What provision will there be for the safe-keeping of these records? **All written and printed notes will be kept in locked storage at researcher's home address. All computer files will be password protected.**

13. What will happen to the records at the end of the project? **The records will be stored until successful submission, completion and examination of the research has occurred and no further raw data is required, they will then be destroyed securely.**

14. How will you protect the anonymity of the subjects/participants? **The participants will not be identified by name in the research and their information will not be stored under their names, only a number to identify between the participants. No identifying details will be stored outside of the required demographic data of age, gender and ethnicity. Only fragments of their interview transcripts will be recorded in the final submission and will not contain any identifying details.**

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be offered debriefing at the end of the research interview. This will give them the opportunity to feedback their experience of the interview and any negative/positive effects they may have encountered. This will also give them a chance to ask any further questions with regard to the research. A resource list of potential support services will be provided in case of a change in effect following the interview. Contact will be made with the interviewee 2-3 days following the interview to ensure that there have been no negative effects. Where there is a concern about negative impact additional signposting will be given to relevant organisations including their current mental health provider/therapist. (See Appendix 5)

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in bold print, please provide further explanation here:

The research involves human participants. Recruitment exclusion and inclusion criteria have been selected to minimise any potential harm to those who may be most vulnerable, and therefore unsuited to a research interview environment. It is not believed that the information being sought from participants is outside of what they may normally encounter during their normal contacts in everyday environment. However, the research does relate to Borderline Personality Disorder and this diagnosis points to individuals who have difficulty in regulating their emotions and managing interpersonal relationships. The sample requires the use of volunteers, this is likely to involve participants coming forward who would like the opportunity to talk about their experiences and thereby avoid involvement any participants who find this difficult to discuss. However, this will be monitored and the research halted if there appears to be any undue harm. All participants will be required to have a form of support from a mental health professional, to try to ensure that support is available from another professional following the interview, if necessary.

Signature of student researcher

Date

24/1/08

Section B: To be completed by the research supervisor

Please mark the appropriate box below.

Ethical approval granted

Refer to the Department of Psychology Research Committee

Refer to the University Senate Research Committee

Signature

Date

On the grounds that changes are made to the participant sheet as specified and the informed consent sheet. Also issues of copying not to be used.

Section C: To be completed by the 2nd Department of Psychology staff member (Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices)

I agree with the decision of the research supervisor as indicated above

Signature

Date

9/5/08

Appendix B9 – Research Costs

Website and advertising £116.33

Including purchase of domain name, Google ads, website hosting

Meeting Rooms £209.30

Including room hire and refreshments

Travel and Accommodation £261.18

Including train travel, petrol, parking and overnight accommodation

Appendix B10 – Leaflets provided as part of resource pack

Borderline UK Ltd. (2007). *An introduction to BPD*. Retrieved from http://www.emergenceplus.org.uk/index.php?option=com_content&view=category&layout=blog&id=46&Itemid=64

BPDWorld. (2007). *Borderline personality disorder: Self-harm*. Retrieved from <http://www.bpdworld.org/leaflets-a-downloads>

BPDWorld. (2007). *Crisis: What to do when life gets too much*. Retrieved from <http://www.bpdworld.org/leaflets-a-downloads>

BPDWorld. (2007). *Dialectical behavioural therapy*. Retrieved from <http://www.bpdworld.org/leaflets-a-downloads>

BPDWorld. (2007). *What is borderline personality disorder?* Retrieved from <http://www.bpdworld.org/leaflets-a-downloads>

Flory, L. (2007). *Understanding borderline personality disorder*. (Rev. ed.). London: Mind Publications.

Livingstone, K. (with First Person Plural). (2009). *Understanding dissociative disorders*. (Rev. ed.). London: Mind Publications.

Meakins, E., & Gorman, J. (2007). *How to cope with loneliness*. (Rev. ed.). London: Mind Publications.

National Institute for Health and Clinical Excellence. (2009, January 27). *Press Release: New NICE guidelines set to improve treatment and management of people with borderline personality disorder*. Retrieved from <http://www.nice.org.uk>

Perry, K. (2008). *How to cope with suicidal feelings*. London: Mind Publications.

Read, J. (2009). *Understanding talking treatments*. (Rev, ed.). London: Mind Publications.

Appendix B11 – Examples of feedback received from participants

Received by email on 27/3/09

Hi Lisa

Thank you for the list of books, it's really helpful and I will check them out. It was good to have a chance to talk openly about my BPD experience and I wish you well with your research. It's good to know that these areas are being re-considered for the sake of both the sufferers and therapists of the future and I certainly benefitted from the interview. I was a little drained afterwards but it was well worth it and I appreciate the work that you are doing and was amazed really that you took the time and effort to travel so far!

Very best wishes for all that you do and I look forward to reading your findings when they are complete.

Take Care

Received by email on 3/3/09

Dear Lisa,

thank you very much for your email and informative attachments. It was very nice to meet you and I felt very relaxed during the interview despite talking about a distressing subject and felt you dealt with me in a very understanding manner.

can't thank you enough for your help, You have made a difference in m agonizing life and given me hope for a better future with this newfound knowledge. If there is ever anything I can do to help you in any way in terms of follow research about DBT in bpd cases in the UK please do not hesitate to contact me.

Best wishes,

(N.B. Individual went on to access treatment which they did not realise was available until after our interview)

Received by email 26/2/09

Dear Lisa

I wonder if it is possible for me to forward your contact details to xxxxx? I attend a meeting in London and was talking about your work and interest was noted.

Once again thank you

Examples of verbal feedback received after the interviews:

“Yeah it feels pretty cool.” – March 09

“Oh it’s great really I’m ((laughingly)) I’m sort of yeah I just feel I don’t know maybe I buried it all I haven’t really talked about it ever so knowing that there’s all this I don’t I don’t perhaps I don’t feel so lonely or abandoned....I would like to follow some of it up erm yeah you know erm yeah I think I would like to write about it because it is so subjective isn’t it. Yeah it’s great so I didn’t really expect to get so much back so thank you” - April 09

Appendix B12 – Approximate Transcribing Times

	Interview length	Hours of transcribing
Anne	67 mins 1 sec	70
Beatrice	77 mins 53 secs	80
Clemence	104 mins	100
Dorothy	63 mins 50 secs	65
Ellen	49 mins 43 secs	55
Francis	58 mins	50
Grace	86 mins 30 secs	78
Helen	86 mins 24 secs	75
Total Transcribing Time		573

Transcribing time includes time taken to audio-type a first hearing including attention to pauses, intonation, emphasis. Followed by checking print out for errors and omissions, and making corrections.

Appendix B13 – Brief Contextual Information for Participants

Anne

Anne has had a diagnosis of BPD for over 10 years; she is married with 2 adolescent children. She works part-time campaigning for better rights and services for families effected by mental health issues and to improve services for mental health service users. Her interview clearly evidences her search for an answer; while demonstrating an underlying fear that she will never recover. Her experience of BPD is being controlled by something external to herself. Anne's motivation to participate in the research came from her role as campaigner, and a wish to be heard as an individual, she relies on explanations of collective experience to express herself. Anne identifies her children as her reason for survival. She is searching for meaning and hope. Anne appears to be caught in a dialectical dilemma between the desire for personal control and the desire for others to take responsibility for her. Her life is dominated by mental health concerns: her own, her children's, her sisters, her parents and her friends.

Beatrice

Beatrice received her diagnosis 8 years prior to the interview fairly late on in her life, she lives alone and describes an experience of overwhelming isolation and loneliness. She had no contact with mental health services at the time we met. Beatrice is searching for an answer to her problems; at the time we met she was preoccupied with the possibility of an additional diagnosis of Aspergers Syndrome. Beatrice feels let down by the mental health system and the people she believed were supposed to have helped her. Her motivation to participate in the research came from a desire to express her frustration with the mental health system and to disclose her anger at being let down by it. However, in addition to this it was the opportunity to make contact with somebody who could provide an answer, and potentially alter the course of her life. Beatrice describes her experience in terms of having being abused a second time by the services who were intended to help her.

Clemence

Clemence was informed of her diagnosis 8 years prior to the interview. She lives with her partner and is a practising psychologist. This was the first time that she had spoken about her experience since completing long-term therapy years previously. Clemence's motivation to participate in the research came from her desire to challenge the prejudice and stigma that existed within the profession, to stand up and say 'I did it, I recovered'; making it clear to the profession that the current understanding of BPD and its prognosis was incorrect. However, she experienced a dilemma, could you actually recover from a disordered personality.

Clemence's belief being that BPD was in fact a reaction to extreme trauma. Clemence's interview was punctuated by analogies, metaphors and use of verbal processes, directly quoting what others had said, or might have said. Her analogies are real and vivid bringing her experience to life.

Dorothy

Dorothy was formally diagnosed 3 years prior to interview; she has a daughter who stays with her several nights a week. She spent most of her own childhood in care. Her support networks are mainly friends whom she had been through residential treatment with and friends from Alcoholics Anonymous. Dorothy's interview suggested to me that she believed she would always have BPD, there were no answers but she hoped that each time she experienced a bad time she would learn a little bit more about how to manage her symptoms. She describes her experience of the problems and treatment associated with her symptoms as punishing. Her motivation for participating in the research appeared to be related to her poor experience of community mental health treatment. She wanted to know what else might be available and to make me, as a mental health professional, aware that she had been let down, perhaps wondering what I might be able to offer.

Ellen

Ellen lives with her husband and had only recently been formally diagnosed with BPD. She had been left trying to understand what it meant and whether she was to blame, it was important to her that people understood that her 'diagnosis' was a result of neurological differences in the brain. Ellen was confused, she was not sure what the diagnosis meant for her or her future, but wanted to participate in the hope I would be able to provide some sense of meaning, understanding and information that would enable her to understand and to give her hope for the future, as well as benefiting others in her situation. Her interview was punctuated with unfinished sentences, almost as if fearful about what would happen if she voiced her fears.

Francis

Francis lives with his wife and was diagnosed 7 years prior to the interview. He is employed full-time and is a martial arts instructor. Shortly after his diagnosis he was discharged from mental health services, which he describes as having been his choice, as he did not feel there was anything more they could do. Francis describes the diagnosis as having given him an answer, a reason for his problems and something he could work hard to overcome. However, he did not think that it was possible to recover from it because there was something 'wrong' with his personality. His motivation to talk to me, although not explicit, appeared to be a

reaching out to me as a psychologist to see if there was anything else; if I would offer him something he had previously been unable to find, possibly the opportunity to be dependant upon somebody else. Francis viewed his problems very much in light of his past traumatic experiences; his interview is filled with examples of him having coped alone, independently, with the minimum of support.

Grace

Grace was diagnosed with BPD four years prior to interview; she is a mental health professional. Grace's interview was the opportunity for her to make sense of her experience and to have a voice against the stereotyping and stigma present amongst mental health professionals towards those with BPD. Her interview clearly demonstrates a dilemma relating to the holding of two positions as professional and ex-service user. Grace seeks an answer, to understand what the diagnosis means for her now in her role as a professional. This is a dilemma which during the course of the interview she uncovered and voiced. Her struggle with the shame she experiences in relation to her past behaviour, is further impacted by the prejudice of other professionals around her towards service users with the diagnosis.

Helen

Helen received her BPD diagnosis 6 years prior to interview. Her motivation to participate in the research influenced by a fear that her problems were beginning to resurface as a result of a new romantic relationship, she wanted to find out what might be available to support her and reduce the impact of this. Her interview is punctuated with metaphors and analogies demonstrating her skill at voicing her experiences in a language which others, namely mental health professionals, could understand. Helen seeks answers and increased understanding. She perceives the diagnosis as something that she is able to hold on to for safety when things become difficult in her life. However, she also directly constructs BPD as 'an enigma', and the mental health system as a community which is difficult to 'escape' from once you are part of it.

Appendix C1 - Cognitive Behavioural Formulation for Alison

based on Boschen's (2007) Model of Emetophobia

