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**A Portfolio of Work on Stigma, Personality Disorder and
Counselling Psychology**

Volume 1

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Portfolio submitted in fulfilment of DPsych Counselling Psychology,
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December, 2007.

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(1) For Appendices to C: Empirical Research, please see 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(2) For Appendices to D: Professional Practice, please see 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

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Declaration

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A: Preface

A.1 Preface to Portfolio of Work

This portfolio comprises three pieces of work: a critical review of literature, an empirical research project and an extended case study. Each piece may be viewed as distinct in evidencing different 'core competencies' required to practise as a counselling psychologist (British Psychological Society 2006), and it is for this reason that they have been chosen. The pieces are, however, also linked by a broad pervasive theme, that of concern for the stigmatisation of individuals with mental health difficulties, a theme which I have felt passionate about since my career began.

The portfolio opens with a literature review which sought to identify, evaluate and interpret the available research and anecdotal reports relating to media depictions of mental illness. The review examines research on the extent, nature, and accuracy of media representations of mental illness, explores evidence for the impact of media images on public attitudes and beliefs regarding mental illness. It highlights the importance of the issue for counselling psychologists by discussing the wide-ranging consequences that media portrayals, and resultant stigma, have for mental health service users and posits that, as counselling psychologists, we need to recognise the power of media images to affect the lives of our clients. It urges us to address such issues in our client work and to reflect upon the potential for such images to influence our own attitudes and beliefs. The review concludes by arguing that counselling psychologists are ideally placed to take an active role in reducing the frequency and impact of disparaging media portrayals and makes recommendations to this effect. This review succeeds in demonstrating an 'ability to critically analyse and evaluate published research relevant to the field of counselling psychology' (British Psychological Society 2006, p. 3).

The empirical research included in this portfolio was inspired by a fascination for language, a sense of injustice at the apparent stigmatisation of individuals diagnosed with personality disorder, and a sense of urgency considering recent legislative moves

concerning this client group. The study was social constructionist in epistemology utilising the research method of Foucauldian discourse analysis to explore the discourse around personality disorder in a variety of texts (i.e. academic journal articles, broadsheet and tabloid press articles, parliamentary debates published in Hansard). Constructions and discourses exemplified were shown to prescribe particular positions for individuals with personality disorder, which were, more often than not, limiting and served to close down opportunities for action and experience for these individuals. The researcher argues that the largely disempowering constructions exemplified in the research both reflect, and contribute to, the stigmatisation, negative discrimination, rejection and exclusion experienced by people with personality disorder and can have a profoundly damaging effect on their mental health and their care. The research concludes by emphasising the importance of a critical awareness of the power of discourse in counselling psychology theory and practice and highlights the unique role of counselling psychologists (as agents of psychological treatment, as important sources of education, learning, and supervision, as researchers) in providing an opportunity, through future discourse, to reach a wide range of individuals and so have the potential to bring about positive change in the lives of individuals with personality disorder. This piece of work not only demonstrates an 'ability to design, conduct, critically evaluate and report on a research project' (British Psychological Society 2006, p. 4), but also an 'appreciation of the significance of wider social cultural and political domains within which counselling psychology operates' (British Psychological Society 2006, p. 1).

The final piece of work included in this portfolio consists of an extended case study detailing my professional practice in a community mental health team setting with a client diagnosed with paranoid personality disorder. The client work was actually completed some five years ago, immediately prior to commencing my doctoral studies. My rationale for revisiting and reformulating this case, as opposed to choosing from the numerous pieces of client work I have completed since this time, was that it has been, I believe, one of the most challenging cases of my career to date and, perhaps more importantly, it has been instrumental in shaping my subsequent career as a psychologist. It is with this early work that my fascination with the topic of personality disorder arose. This fascination has since permeated my research interests, training received and delivered, and career choices. I have chosen to revisit this case

work within my practitioner doctorate portfolio as it has been so influential in my career, continues to fascinate me, and as a result of subsequent training and experience, I felt I could offer a more informed and thoughtful position on how best to engage and work with this client. The piece of work itself details my original formulation, treatment plan and approach, and so demonstrates an 'ability to initiate, develop, maintain and end a purposeful therapeutic alliance' (British Psychological Society 2006 p. 6), and an ability to formulate clients' concerns and practice safely and competently within a chosen therapeutic model (British Psychological Society 2006, p. 2). It discusses complications encountered in the work and how these were managed through supervision, consultation and liaison, so displaying an 'ability to respond appropriately to the complex demands of clients' (British Psychological Society 2006, p. 6). The reformulation, from a superior knowledge and skill base, considers possible reasons for the challenging nature of the work and reflects upon what I did well and what I would now do differently. In so doing it demonstrates the ability to critically reflect upon and to evaluate my therapeutic practice (British Psychological Society 2006, p. 6).

It is hoped that the pieces of work included in this portfolio, will succeed in evidencing my competencies within the different facets of the role of a counselling psychologist, but will also encourage and motivate the reader to join me in taking an active stance on eradicating the stigmatisation of those who suffer mental health difficulties.

A.2 References

British Psychological Society (2006). *Core Competencies: Counselling Psychology: A Guide*. Leicester: British Psychological Society.

B: Critical Literature Review

Disparaging Mental Illness: The Power of the Media

B.1 Introduction

Many authors have expressed concern about the media's portrayal of mental illness. There is a common perception amongst them that the media's depiction of mental illness is overwhelmingly negative and inaccurate and that this is an important element in forming and influencing peoples' attitudes toward mental health issues. Pervasive and persistent images depicting individuals with mental illness in disparaging and disrespectful ways may contribute to unfavourable public attitudes toward mental illness and create stigma, which in turn, can have profound effects upon the lives of individuals with mental illness.

A significant amount has been written on this topic in recent years. This literature review identifies, evaluates and interprets the available research and anecdotal reports relating to media depictions of mental illness. It begins by examining research on the extent, nature, and accuracy of media representations of mental illness, before moving on to explore evidence for the impact of media images on public attitudes and beliefs regarding mental illness. It highlights the importance of the issue for counselling psychologists by discussing the wide-ranging consequences that media portrayals, and resultant stigma, have for mental health service users. The review posits that, as counselling psychologists, we need to recognise the power of media images to affect the lives of our clients and urges us to address such issues in our client work and to reflect upon the potential for such images to influence our own attitudes and beliefs. The review concludes by arguing that counselling psychologists are ideally placed to take an active role in reducing the frequency and impact of disparaging media portrayals and makes recommendations to this effect.

B.2 Media Representations of Mental Illness

Many researchers have examined, through descriptive studies, the extent, nature, and accuracy of representations of mental illness in various forms of media. Studies of print and electronic news media have revealed that images of mental illness are characterised by negative stereotypes and inaccuracies (Day & Page 1986), that items portraying mental illness in a negative light are given greater prominence than positive items (Day & Page 1986; Philo et al. 1996; Ward 1997), and that media items relating mental illness to themes of danger, violence and criminality prevail (Day & Page 1986; Philo et al. 1996; Allen & Nairn 1997; Hazelton 1997; Ward 1997; Coombes 2006).

Studies of entertainment media have identified overwhelmingly negative themes in the depiction of characters with mental illness. Wilson et al. (1999a) studied the portrayal of characters with mental illness in 14 prime-time television dramas over a 1-year period and identified 10 themes: 'dangerous-aggressive'; 'simple-childlike'; 'unpredictable'; 'failure-unproductive'; 'asocial'; 'vulnerable'; 'dangerous-incompetent'; 'untrustworthy'; 'social outcast'; with 'caring-empathic' being the only positive theme. Dangerousness and unpredictability were the most common themes with 15 of the 20 characters with mental illness depicted as physically violent toward the self or others. In a case study, conducted by Wilson et al. (1999b), the researchers explored the use of technical devices, in addition to discursive resources, used to portray a character with mental illness in a prime time television drama programme. They found that the character with a mental illness was presented as bizarre in appearance when compared to the 'normal' character, that music and sound effects were used to build suspense, that film cutting techniques tended to present the character as being in a distorted and unstable environment and much of the film was set in darkness. The authors argued that the technical devices and discursive resources contributed to the presentation of mental illness as dangerous. In analysing one week of children's television programmes, Wilson et al. (2000) concluded that characters with mental illness served as objects of amusement, derision or fear and that their vocabulary and behavioural depictions were stereotypically and blatantly negative.

Hylar et al. (1991) identified common stereotypes of mental illness in films from very early cinema movies until 1989, labelling them: 'rebellious free spirit'; 'homicidal maniac'; 'the female patient as seductress'; 'enlightened member of society'; 'narcissistic parasite'; and 'zoo specimen'. Rosen and Walter (2000) conducted a case study of the portrayal of mental illness in the Australian film 'Shine' and argued that negative stereotypes and formulaic portrayals of mental illness were used in the film. Beveridge (1996) looked at portrayal of mental illness in Walt Disney films and argued that Disney perpetuated the image of mental illness as dangerous and communicated the message that 'madness' is a label given to individuals who exhibit behaviour the rest of our society cannot understand. Similarly, Lawson and Fouts (2004) studied 34 animated feature films produced by Walt Disney using content analysis. They found that 85% of the films contained verbal references to mental illness (e.g. 'crazy', 'nuts'); with an average of 4.6 references per film, and that 21% of the principal characters were thus referred to as mentally ill. The authors argued that references were mainly used to set apart and denigrate the characters to which they referred.

In addition, the characteristic link between mental illness, violence and criminality found in news media is echoed in the realm of entertainment (Signorielli 1989; Rose 1998; Wilson et al. 1999a). Diefenbach (1997) found a significant difference between the actual rate of violent crime among people with a mental illness in the US (<3.65%) and the population of individuals with a mental illness depicted on prime time television (33.9%) suggesting that depictions are not only negative, but also grossly inaccurate.

Although the above studies suggest that depictions of mental illness are pervasive and consistent in the negative stereotypes and inaccuracies they present, methodological limitations abound. The most common limitation is the method of sample selection with many of the studies including only a small sample of media items (e.g. Hazelton 1997) and many of the authors failing to explain the rationale for their choice of items included (e.g. Philo et al. 1996; Ward 1997). Wilson et al. (1999a) obtained their sample of prime time television drama by choosing programmes for inclusion on the basis of descriptions obtained from television guides. The danger here is that some relevant programmes may have been excluded, as no explicit references were made to

mental illness in the programme listings. In the study by Wilson et al. (1999b), only one television programme was selected for discourse analysis, but the reasons for selecting this programme were not clearly stated. Studies by Diefenbach (1997), Rose (1998), and Wilson et al. (2000) contained incomplete samples including all televised programmes from only a certain number of networks. Hyler et al. (1991) explored the use of particular stereotypes of mental illness in films through detailed examples, but the sample of films described was clearly selective. The use of non-representative samples has important implications for the generalisability of the findings. Another important issue relates to the method of analysis used in various studies. Although content analysis was a common (e.g. Day & Page 1986; Philo et al. 1996), the units of analysis differed (individual statements versus entire articles) rendering it difficult to compare the results of studies. In addition, in many of the studies, measures used in the analysis appear to be largely subjective (e.g. Signorielli 1989; Beveridge 1996; Ward 1997; Wilson et al. 1999a; Rosen & Walter 2000), with no measures of reliability provided.

In addition to the above research studies, anecdotal reports add further weight to the literature regarding media representations of mental illness. Wahl (1995) offers an extensive sampling of common depictions of mental illness in various media highlighting the multitude of slang and unflattering references to mental illness, the misinformation and trivialisation of mental disorders in comedy portrayals, and the exploitative use of psychiatric concepts in advertising material. There is a whole host of pejorative words employed to describe mental health patients: 'nutters', 'psychos', 'fiends', 'schizos', 'monsters' and 'maniacs' – the sort of words if they were racist or sexist would not get near a paper (MIND 2007). Similarly, White (1997, p. 35) states, 'rarely a week goes by without one of the tabloid newspapers screaming out a story about madmen, psychos and nutters perpetrating acts of violence'. Byrne (1997) provided examples of psychiatric stereotypes from the British press which he labelled 'comedic / whimsical', 'poor mad devils', 'maniacs at large' and 'pull yourself together' and argued that such presentations contribute to the stigma of psychiatric illness. Gilman (1997, p. 247) notes that even media representations of 'good' images of mental illness tend to glorify and idealise them turning individuals with mental illness into prophets and seers whose mental illness is not pain, thus 'demeaning the reality of the pathology'. Haas (1999) comments on the disproportionate negative

coverage of people with mental illnesses in cinematic films citing as examples the plethora of horror movies that have a serial killer brutally slaying people (e.g. 'Friday the 13th', 1980), movies where the creative genius is brilliant because of his mental illness (e.g. 'Shine', 1997) and movies that depict the character with mental illness as the fool (e.g. the Joker in 'Batman', 1989). One might argue that the depiction of the creative genius is semipositive, but that creates the assumption that someone with a mental illness needs to be brilliant to be accepted in this society (Schoeneman 1999). Schoeneman (1999) states that 'the maniac', 'the melancholic' and 'the fool' are recurrent ways of depicting mental illness in films and comments that none of them are positive depictions.

Byrne (2000a) and Anderson (2003) further discuss the representation of mental illness and psychiatry in film stating that contemporary pieces such as 'Shine' (1997), 'Some Voices' (2000), 'Iris' (2002) have presented sensitive images of individuals living with serious mental health problems. Whilst such films have been seen as a reasonable and compassionate portrayal of mental illness, other films such as 'A Beautiful Mind' (2002) and 'Me, Myself and Irene' (2000) have been attacked for reinforcing many of the enduring myths about severe mental illness (Byrne 2000b; David 2002; Wilkinson 2002). In the case of 'Me, Myself and Irene' (2000), comedian Jim Carrey plays an individual with 'advanced delusionary schizophrenia with involuntary narcissistic rage' (Byrne 2000b, p. 364). The film succeeds in perpetuating the myth that schizophrenia equates to multiple personality disorder through descriptions of the film as 'a split personality comedy' and promotional materials such as T-shirt tie-ins ('I'm schizophrenic: so am I'). The character's behaviour is portrayed as obscene (he defecates on a neighbour's lawn), violent (all his scenes centre on his uncontrolled rage) and sexually disinhibited (at one point he suckles from a stranger's breast). The object of the character's affection, Irene, apologises for this behaviour, explaining that he is a 'schizo' (Byrne 2000b, p. 364).

B.3 The Influence of Media Representations on Attitudes to Mental Illness

Literature discussed so far has illustrated that depictions of mental illness are pervasive and consistent in the stereotypes they present, but the question remains as to whether such depictions actually influence attitudes to mental illness. A number of

studies have attempted to demonstrate that negative media representations have contributed to the formation of negative public attitudes towards individuals with mental illness; however they are shrouded by methodological imperfections.

Cross sectional surveys provide support for the theory that the media have an important role in providing information about mental illness (Lopez 1991; Benkert et al. 1997; Granello et al. 1999). Granello et al. (1999, 2000) found that individuals citing electronic media as their primary source of information had less tolerant attitudes towards people with mental illness and that greater levels of television viewing were associated with such attitudes.

Using a different methodology to investigate the relationship between media content and audience beliefs about mental illness, Philo et al. (1996) randomly selected participants for six focus groups who answered a series of questions relating to beliefs about mental illness and the sources of those beliefs. Forty per cent of participants believed serious mental illness was associated with violence and reported that the media were the source of this belief. As twenty one percent of the sample had non-violent experience of mental illness, the authors concluded, 'the power of media images had apparently been so great that beliefs derived from the media could overwhelm knowledge that came from direct experience' (Philo et al. 1996, p. xiv).

Prospective studies have attempted to look directly at the impact of particular media items on the attitudes of sample populations. Domino (1983) investigated the impact of the film 'One Flew over the Cuckoo's Nest' (1975), a fictional portrayal of the life of patients in a psychiatric institution, on attitudes to mental illness. Participants self-selected into either intervention or control groups and completed a questionnaire assessing attitudes to mental illness prior to the film's cinematic release, three months later and a further eight months later. The researcher found that participants who viewed the film developed less positive attitudes to mental illness, that its impact did not diminish over time and that viewing a more positive explanatory film at a later date, designed to balance the portrayal of mental health care in the film, did not alter attitudes. Wahl and Lefkowitz (1989) investigated the impact of a television film associating violence with mental illness. The film, depicting a murderer with mental illness, was shown to participants with or without a movie trailer explaining that

violence is not characteristic of people with mental illness. Like the findings of Domino (1983), Wahl and Lefkowitz (1989) found that participants who viewed the film developed less positive attitudes to mental illness than those who viewed a control film (i.e. film about a murder not related to mental illness) and that viewing the explanatory trailer did not alter the development of negative attitudes.

Thornton and Wahl (1996) examined the impact of a newspaper article detailing a murder committed by a person with mental illness. Participants were placed into one of four groups each receiving a different package of information. The 'stigma' package contained the target article and an information article about mental illness. The 'prophylactic-information' package included the target article and an article addressing misconceptions about mental illness and dangerousness. The 'prophylactic-media' package consisted of the target article and an article describing media distortion of mental health issues. The final package contained two control articles not related to mental illness or violence. Participants completed questionnaires about their responses to each newspaper article, their attitudes toward the mentally ill, their experience with mental illness and sources of information about mental illness. In addition, their reaction to a vignette involving an encounter with a person with mental illness was measured through an instrument designed by the researchers (i.e. 'fear and danger scales'). The researchers found that the 'stigma' group were more likely to agree that people with a mental illness should be restricted, were less accepting of people with mental illness in the community, and showed greater fear and danger on the 'fear and danger scales', in comparison to other groups. Like other researchers, the authors concluded that reading the target article resulted in more negative attitudes to mental illness. However, in contrast to results from studies by Domino (1983) and Wahl and Lefkowitz (1989), Thornton and Wahl (1996) found that the stigmatising effect of the article was reduced by providing explanatory information and concluded that providing public education could therefore assist in reducing the impact of stigmatising information in the media.

Although these studies suggest that negative media images of mental illness have an important influence on community attitudes to mental illness, there are a number of methodological limitations that must be considered. An important limitation of many of the studies was the use of self-report measures to determine the sources of

attitudes, as individuals might in fact be unable to determine the primary source of their beliefs. There is also the likelihood of response bias with participants providing socially desirable responses, rather than reporting their actual attitudes. The small sample sizes in studies by Lopez (1991), Philo et al. (1996), and Granello et al. (1999, 2000) preclude the possibility of generalising findings to the population as a whole. Samples selected from certain populations in the studies by Domino (1983), Wahl and Lefkowitz (1989), Lopez (1991), Thornton and Wahl (1996), and Granello et al. (1999, 2000) render them non-representative of the general population. In studies by Wahl and Lefkowitz (1989) and Thornton and Wahl (1996), the researchers failed to measure attitudes of participants prior to the intervention and therefore it is not known whether attitudes actually changed during the study or whether participants in different groups actually held similar opinions about mental illness prior to taking part in the study. In addition, the studies only looked at attitudes immediately following the intervention therefore it is unclear whether any attitudinal changes could be considered long lasting. Another important consideration is that studies by Wahl and Lefkowitz (1989) and Thornton and Wahl (1996) involved a single exposure to intervention material in a laboratory situation, which would be likely to differ from real world experience involving multiple factors. The limitations identified in studies by Wahl and Lefkowitz (1989) and Thornton and Wahl (1996) were not present in the research by Domino (1983). The study measured both baseline and subsequent attitudes over a period of eleven months and, as a result, Domino (1983) was able to demonstrate long-term changes in attitudes. In addition, this study did not administer the film in a laboratory situation, allowing participants to view the film as part of their normal social activities. As participants were self-selected rather than randomly allocated into intervention and control groups, the potential for selection bias is apparent, however the researcher stated that baseline attitudes were assessed and found to be similar.

B.4 The Impact of Media Coverage on the Lives of Individuals with Mental Illness

Research studies and anecdotal reports discussed so far have demonstrated the problematic nature of media depictions of mental illness and have suggested that such

depictions contribute to misconceptions and unfavourable attitudes towards those with mental illnesses. So what are the ramifications of this literature?

Many authors have commented on the significant practical and undesirable consequences that media images have for individuals with mental illness (Wahl 1995; Philo 1996; Sayce 1998; Byrne 1999). Inaccurate and unfavourable images of people with mental illnesses contribute to stigma, which in turn, influences the individual, their relatives and carers, and even the treatment of those with mental illnesses.

Wahl (1995, p. 99-100) eloquently describes the harmful effects of stigma upon those with mental illness stating:

‘Stigma is burdensome. Added to the weight of already painful and sometimes overwhelming psychiatric disorders is the hurt of other people’s disdain, dislike and avoidance... Not only is it difficult for those with mental disorders to face a world that misunderstands and devalues them, but it is isolating. Strangers and casual acquaintances, and even friends, keep their distance, and may reduce their availability when they learn of one’s psychiatric label... Fear of unfavourable public responses and of losing friends often leads to an additional burden, the burden of keeping one’s illness a secret, of bearing it silently, of fearing disclosure’ (Wahl 1995, p. 99-100).

Research conducted on the impact of stigma, confirms the profound effects it has upon the lives of individuals with mental illness and their families. Wahl and Harman (1989) surveyed the views of 487 members of the National Alliance for the Mentally Ill (NAMI) concerning stigma. Most participants (77%) identified stigma as a problem for their mentally ill relatives. In addition, 56% of the sample felt that other family members without a mental illness were also affected by the stigma. The most frequently cited effects of stigma on ill relatives were damage to self-esteem, difficulty making and keeping friends, difficulty finding a job, and reluctance to disclose mental illness.

Similarly, Sayce (1998) has written critically of media coverage, which equates having a mental illness with being a highly dangerous criminal. She comments on the impact of the climate of fear and suspicion on users of services, ‘...the reality for some can be a crushing sense of difficulty in being accepted as potential employees,

work mates or friends, and in some cases a collapse in self-confidence' (Sayce 1998, p. 332).

Isolation, loneliness and damage to self-esteem are issues that have been raised by many authors (Wahl 1995; Philo 1996; Sayce 1998; Makal 1999; Wright, Gronfein & Owens 2000; Thesen 2001; Corrigan 2004; Hocking 2003).

Wahl (1995, p. 105-106) comments:

'Media images are painful and offensive to people who suffer from those illnesses and to others who are intimately connected to them... Among the effects of viewing oneself portrayed again and again in demeaning and unfavourable ways are hurt and anger. It is emotionally painful to see yourself or those you love consistently portrayed as villains or buffoons... Offensive to see trivialised the conditions that devastate your life... Being routinely confronted with unfavourable media images of oneself, along with the experience and anticipation of the negative public attitudes illustrated by such depictions likely contributes to lowered self-esteem. People who are bombarded with unfavourable information about themselves, begin to internalise such images, to doubt themselves, to conceive of themselves in the same distorted and demeaning ways that others appear to' (Wahl 1995, p. 105-106).

Such internalisation of stigmatising ideas, or self-stigmatisation, has since been discussed by many other authors (Corrigan 1998; Holmes & River 1998; Link & Phelan 2001; Corrigan & Watson 2002).

Wahl (1995) discusses the secrecy and deception employed by individuals regarding their mental illness in order to protect themselves from stigma. Fear of disclosure may lead those with mental illness to distance themselves from others, isolating them from valuable social and emotional support. In a study by Link, Cullen, and Struening (1989) psychiatric patients indicated that they indeed feared disclosure and that they selected strategies of withdrawal from social contact to protect themselves from the rejection they feared. Other research and literature has suggested that the stigma associated with mental illness may delay or prevent people from seeking professional help (Royal College of Psychiatrists 1995; Wahl 1995; Philo 1996; Byrne 2000c; Warner 2001; Corrigan 2004; Erickson 2006). Mental illness stigma, therefore, undermines recovery both by adding a burden of secrecy and by isolating individuals with mental illness from much needed social, emotional, and professional support.

The damaging effects of stigma upon self-esteem are compounded by the discrimination and exclusion that individuals with mental illness often face in the workplace and social settings. An interesting debate is raised by authors such as Sayce (1998) who discuss the limitations of the 'stigma' paradigm and suggest that literature should instead examine the impact of 'discrimination' or 'social exclusion'. Chamberlain (1997) has argued that, 'the concept of 'stigma' is itself stigmatising. It implies that there is something wrong with the person, while "discrimination" puts the onus where it belongs, on the individuals and groups that are practising it' (Sayce 1998, p. 331).

Mental illness, carrying with it associations of unreliableness, unattractiveness and dangerousness (Pescoscolido et al. 1999; Crisp et al. 2000; Martin et al. 2000; Corrigan et al. 2003), engenders stigmatising responses in others and leads to discriminatory behaviour. In a survey by Read and Baker (1996), in relation to their mental illness, 47% of participants had been abused or harassed in public (14% physically assaulted), 34% had been dismissed or forced to resign from employment, 26% had moved home because of harassment. Farina and Felner (1973) and Oppenheimer and Miller (1988) also discuss the likely obstacles that individuals with mental illness face in obtaining employment as a result of negative attitudes on the part of employers. MIND (1998), the mental health charity, provides further evidence for the impact of stigma upon employment prospects for individuals with mental illness: only 13% of people with mental health problems are in employment compared with approximately a third of all people with long-term physical health problems. Hocking (2003) and Corrigan (2004) discuss stigma and discrimination as robbing people with mental illness of important life opportunities that are essential for achieving life goals (e.g. job opportunities, housing availability, general health care, insurance benefits). This point is reinforced in Thornicroft's (2006) recent discussion of discriminatory practices against those with mental illness in areas of leisure and recreation, travel, insurance and financial services, the entitlements of citizenship (e.g. voting, serving on a jury), and physical health care.

In a study by Purvis, Brandt, Rouse, Vera and Range (1988), undergraduate students read vignettes that portrayed a person as having either cancer or schizophrenia and then asked them to rate the person with respect to a number of traits. The person

identified as having schizophrenia was perceived as less desirable as a friend, less acceptable as a club member or neighbour, and less able to function in the community than the cancer patient, despite the vignette descriptions being identical apart from the disorder suggested. Where comparisons with other conditions have been made, mental illnesses are far more stigmatised than other conditions and have been referred to as the 'ultimate stigma' (Falk, 2001).

In addition to the personal, social and vocational consequences discussed so far, negative media portrayals and resultant stigma regarding mental illness can influence treatment philosophy and availability, affecting the care of individuals with mental illness. Philo and Secker (1999) argue that the close association between violent behaviour and mental illness, which is stressed so prominently in media reports, has been instrumental in reshaping Government mental health policy in the UK. As a 'knee jerk response to ill considered fears' (Philo & Secker 1999, p.136), the authors state Government policy of 'Care in the Community' has been reshaped in ways which are designed to ensure compliance from those who resist voluntary engagement with the mental health services. In addition, the authors posit that media messages play a part in fuelling opposition to the development of community based mental health services, which has implications for the availability of services for individuals with mental illnesses. Similarly, Hallam (2002) explored the ways in which material published in national newspapers has impacted the development of mental health policy. The researcher examined the press coverage of two particular incidents involving individuals diagnosed with schizophrenia (i.e. Christopher Clunis who killed a stranger at a London underground station and Ben Silcock who climbed into a lions den at London Zoo). Press coverage at the time of the incidents and over the next eight years was analysed and the effects of the material on policy decisions were traced. Hallam (2002) argued that by highlighting the risks individuals with schizophrenia might pose to themselves and, in particular, to others, publicity contributed to an unbalanced policy debate with policy measures being introduced in response to public concerns about risk and dangerousness. Such policy measures, designed to ensure compliance from those who resist voluntary engagement with the mental health services, have served to impose additional constraints on people with mental health problems.

A great deal of research is currently underway at the Institute of Psychiatry, London investigating the experience of stigma in those with a diagnosis of mental illness. The GAMIAN-Europe Pan European Stigma Study ⁽³⁾ (due to report in late 2007) is collecting information from individuals with a diagnosis of mental illness across 20 European countries about the stigma they experience, perceived discrimination and devaluation, and self-esteem. The International Study of Discrimination and Stigma Outcomes in Mental Health (INDIGO) ⁽⁴⁾ sought to find out how discrimination affects the lives of people with a diagnosis of schizophrenia across the world. Researchers in 28 participating countries have carried out interviews with 25 people in their country to find out how their diagnosis has impacted on their everyday lives. The interviews (736) and information gathering are complete and the data is currently being analysed.

(3) Further information available at: <http://www.iop.kcl.ac.uk/projects/?id=10241>. Last accessed: 5 December 2007.

(4) Further information available at: <http://www.iop.kcl.ac.uk/projects/?id=10136>. Last accessed: 5 December 2007.

B.5 The Contribution of Counselling Psychologists

Research has shown the widespread use by the media of stigmatising images of mental illness, that these portrayals have a negative impact on public beliefs and attitudes to individuals suffering from mental illness, and that such images have a damaging effect on psychologically distressed individuals, their families and carers. These images can adversely affect an individual's self-esteem and confidence, can make processes of seeking help and recovery more difficult, and, by influencing policy initiatives, can even affect the care individuals with mental illness receive. Not only is it vital that this body of literature is recognised by counselling psychologists, but we are ideally placed to contribute to changing this grave situation.

Gingerich (1998) comments, that helping persons with severe mental illness cope with symptoms is essential, but is only part of the battle. Persons with mental illness also suffer from the negative effects of stigma and when clinicians fail to address stigma, they miss an opportunity to provide their clients with important strategies and skills.

As counselling psychologists, it is paramount that we recognise and address the impact of stigma. By so doing, we can become truly empathic to the struggles of our clients and develop a better understanding of the world they live in. We can facilitate their understanding of how stigma may contribute to their presenting problems (including low self esteem, isolation, withdrawal, family problems, and occupational difficulties) and empower them to cope with such negative effects.

Not only do we need to address the impact of stigmatising media images upon the lives of our clients, we need to reflect upon the potential impact of unfavourable media images upon our own attitudes. One would hope that, through training and experience, counselling psychologists develop immunity to such images. However, bearing in mind the research evidence demonstrating that negative media images have a direct impact on attitudes (Domino 1983; Wahl & Lefkowitz 1989; Thornton & Wahl 1996), that positive images and explanatory material have little effect upon changing these attitudes (Domino 1983; Wahl & Lefkowitz 1989), and that non-violent experience of individuals with mental illness can be overlaid by media influences (Philo 1996), perhaps this is a naïve view. Wahl (1995) comments that even though mental health professionals are trained individuals, they may share the same misconceptions that the general public has which can lead them to approach patients with the same stereotypes often portrayed in the media. Chaplin (2000) emphasised the role psychiatrists can have in both creating and perpetuating stigma and stated that negative attitudes of members of the public towards people with mental illness were mirrored by some psychiatrists. McKay (2000), in an examination of the portrayal of people with mental illness in advertisements in three psychiatric journals, commented on the negative imagery in advertisements for antipsychotic medications and suggested that psychiatrists should be prepared to examine their beliefs about serious mental illness as a prelude to changing attitudes in society at large.

The stigmatisation of mental illness among health professionals has been studied less than in the wider population (Royal College of Psychiatrists 2001) with much of the evidence being anecdotal (Tipper et al. 2006) and concerning health professionals (e.g. medical students, general practitioners), as opposed to mental health professionals. Mukherjee et al. (2002) found that more than half of their sample of

medical students and doctors considered people diagnosed with schizophrenia to be dangerous and Lawrie et al. (1996) showed evidence of negative attitudes towards those with schizophrenia in their sample of general practitioners. In a study by Kingdon et al. (2004) the attitudes that psychiatrists hold towards people with mental illness was investigated through a postal questionnaire sent to each member of the Royal College of Psychiatrists in the UK and a sample of the general population. A 43% response rate was achieved and findings suggested that psychiatrists' attitudes towards people with mental illness, especially schizophrenia, were substantially more favourable than those of the general population sample. However worrying results were presented in a study by Dickerson et al. (2002) who found that 20% of their sample of out-patients with schizophrenia considered mental health caregivers to be an actual source of stigma. It will be interesting to find out results from research currently underway at the Institute of Psychiatry, London which seeks to find out if training sessions for medical students and psychiatrists at the start of their career will make a difference to stigmatising attitudes against people with mental health problems (Anti-Stigma Training and Evaluation Collaboration (ASTECC) project ⁽⁵⁾). The training programme started in the academic year 2006/7.

If, as counselling psychologists, we neglect to recognise problematic media depictions, can our attitudes and beliefs, like those of the general public, be influenced and shaped? If so, what implications does this have for client work? Could it affect our ability to develop a therapeutic relationship, to be empathic? Could it contribute to therapeutic pessimism or a reluctance to engage with certain clients? Of enormous concern to the present author is the dearth of research exploring such issues. Not only is it vital that we recognise, reflect upon and avert the possibility of the media influencing our attitudes, or in the words of Hocking (2003, p. 47) 'put our own house in order first', we need to contribute by initiating and disseminating research in this area and debating such issues with our colleagues.

Salter and Byrne (2000) note that, while television, radio, and newspapers often perpetuate unhelpful stereotypes of mental illness, if properly harnessed they may also be used to challenge prejudice, inform and initiate debate, and so help to combat stigma experienced by people with mental illness and their carers. Hayward and Bright (1997) argued that, in order to combat stigma on a broad social level,

sympathetic depiction of mental illness in the media is important. Similarly, Kommana et al. (1997) stated overcoming stigma might be achieved by disseminating realistic information in the mass media. Ward (1997) made a number of recommendations for mental health professionals seeking to achieve more positive coverage of mental health issues in the media including: ensuring that newspapers do not unnecessarily associate mental illness with violence and that they avoid using stigmatising language; providing guidelines for the reporting of mental health issues; and working with the media to improve the level of understanding of mental illness. Read et al. (2006) question the usefulness of the medical model in challenging stigma. The authors argue that disease explanations and use of the 'mental illness is an illness like any other' approach may increase punitive behaviour and that viewing as illness, whilst discouraging blame, produces a patronising attitude. Read et al (2006) advocate avoiding biogenetic explanations, with its associated terms like 'illness' and 'disease', and focusing more on promoting psychosocial explanations - viewing psychiatric symptoms as understandable psychological or emotional reactions to life events. This, they argue, may reduce fear, distance and discrimination.

Counselling psychologists are ideally placed to act upon such recommendations. By increasing people's awareness of the pervasiveness, inaccuracy and disparaging nature of media stereotypes and of their impact upon individuals who suffer mental illness, we can encourage individuals to become more critical viewers, listeners and readers and to recognise and question stereotypes, rather than assimilate them. We can ensure that psychology has a voice in the media by becoming more accessible to the media ourselves, becoming more familiar with the way the media function (their priorities and practices), and developing closer relationships with journalists in order to create and transmit more helpful, realistic and accurate portrayals of mental illness in the media. We can monitor and routinely respond to problematic media depictions in order to sensitise media personnel to the issues of mental illness stigma and public portrayal of mental illness and to the reactions of audiences to that portrayal. Such responses will hopefully influence the writer, editor, or producer in their next presentation. We may be able to bring social and cultural pressure upon those producing content for film, newspapers and television to give greater coverage to what people with mental illnesses say, in their own words. Corrigan (2004), Nairn and Coverdale (2005), and Thornicroft (2006) recently commented on the absence of the

voice of clients in the media. We may even be able to persuade our clients to contribute to the coverage of mental health issues in the media or provide first-person accounts of self-stigma, public stigma, and stigma from mental health professionals.

In very recent years, the media representation of mental illness has received increased attention from a campaign perspective. Anti-stigma campaigns have been launched by a number of groups:

- `Changing Minds` (Royal College of Psychiatrists) ⁽⁶⁾
- `Open the Doors` (World Psychiatric Association) ⁽⁷⁾
- `See Me` (Scottish Executive) ⁽⁸⁾
- `Moving People` (Mental Health Media, Mind, Rethink & Institute of Psychiatry, King's College London) ⁽⁹⁾
- `Shift` (Care Services Improvement Partnership) ⁽¹⁰⁾

It remains to be seen whether such campaigns will be effective but perhaps counselling psychologists can endeavour to contribute to such campaigns or indeed utilise our research skills in evaluating such projects. We certainly have an obligation to keep abreast of such work.

(5) Further information available at: <http://www.iop.kcl.ac.uk/projects/?id=10141>. Last accessed: 5 December 2007.

(6) Further information available at: <http://www.rcpsych.ac.uk/campaigns/cminds>. Last accessed: 5 December 2007.

(7) Further information available at: www.openthedoors.com. Last accessed: 5 December 2007.

(8) Further information available at: <http://www.seemescotland.org.uk>. Last accessed: 5 December 2007.

(9) Further information available at: <http://www.movingpeople.org.uk>. Last accessed: 5 December 2007.

(10) Further information available at: <http://www.shift.org.uk>. Last accessed: 5 December 2007.

B.6 Concluding Remarks

From the literature gathered in this review, it is clear that the images of mental illness that the media currently present have very important, very personal, and very painful consequences for individuals with mental illness. What is also clear is that many

opportunities exist for counselling psychologists to be key figures in changing this situation. Developing and encouraging greater awareness of and sensitivity to the dramatic impact that media portrayals have on the millions of people who struggle with mental illness and contributing to further, and more methodologically sound, research in this area, are powerful weapons to overcome the barriers created by stigmatising media images.

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C: Empirical Research

The Construction of Personality Disorder:

A Discourse Analysis of Contemporary Professional, Cultural and Political Texts

C.1 Abstract

The present study aimed to explore the discourse around personality disorder (PD) ⁽¹¹⁾ and reveal its nature, functions and implications. The epistemological orientation of the work was social constructionist and the research method employed a form of Foucauldian discourse analysis. Through the examination of a variety of texts taken from a pre-defined time period, the research explored how the object 'personality disorder' was constructed at a particular moment in history in a sample of professional, cultural and political texts (academic journal articles, broadsheet and tabloid press articles, parliamentary debates published in Hansard). Constructions and discourses exemplified were shown to prescribe particular positions for individuals with personality disorder, which were, more often than not, limiting and served to close down opportunities for action and experience for these individuals. It is argued that the largely disempowering constructions exemplified in the research both reflect, and contribute to, the stigmatisation, negative discrimination, rejection and exclusion experienced by people with personality disorder and can have a profoundly damaging effect on their mental health and their care. The research emphasises the importance of a critical awareness of the power of discourse in counselling psychology theory and practice and highlights the unique role of counselling psychologists (as agents of psychological treatment, as important sources of education, learning, and supervision, as researchers) as providing an opportunity, through future discourse, to reach a wide range of individuals and so have the potential to bring about positive change in the lives of individuals with personality disorder.

(11) Throughout this thesis, there are times when I have used 'PD' to refer to individuals with personality disorder. This has been done as a form of shorthand and to render the text more readable. This use of language, however, is problematic from a social constructionist perspective. The dangers inherent in using this shorthand are that I myself am constructing these individuals in a certain way, whilst simultaneously attempting to deconstruct the object, to explore the discourse and reveal its nature, functions and implications. By referring to individuals as 'PD' I may, for example, objectify or dehumanise these individuals. In attempting to circumvent this dilemma, I have on occasion used alternatives such as 'people with a diagnosis of PD' or 'individuals with a diagnosis of PD'. This however, through mobilisation of a medical discourse, may serve to construct the object as an illness. In addition the prolific use of medical and scientific terminology (e.g. 'nosological', 'epidemiological', 'aetiological') particularly within the introductory chapter (C2) poses similar problems for social constructionist thinking. I include this footnote here in acknowledgement and justification of the fact that language used within this thesis cannot fail but to construct the object in a particular fashion.

C.2 Introduction

Personality disorders are among the most controversial of all mental health conditions. Classification, diagnosis and treatment are issues hotly contested by clinicians and academics alike. Add to this the recent political and media interest in debating legislative proposals for pre-emptive incarceration of such individuals believed to present a danger to the public, and the area becomes a hotbed of dissension. In 'nesting' (Wolcott 1990) the research problem within context, it is vital to commence by unpacking such issues.

C.2.1 The Nosological Context of Personality Disorder

Personality disorder (PD) has a long and convoluted history, plagued by changing and uncertain diagnostic nomenclature. The origins of the concept date back to French psychiatrist Pinel at the beginning of the 19th century who observed, in his patients, impulsive acts, episodes of extreme violence, and self harm, whilst noting the absence of impaired intellectual function or delusion associated with insanity. In case studies, Pinel (1801/ 1962, p. 9) described patients as suffering from 'manie sans délire' (insanity without delirium) and eloquently expressed 'I was not a little surprised to find many maniacs who at no period gave evidence of any lesion of understanding, but who were under the dominion of instinctive and abstract fury, as if the faculties of affect alone had sustained injury'. In the early 1800s, an American physician, Rush (1812, p. 112) also documented confusing cases that were described by clarity of thought along with 'moral depravity' in behaviour, referred to as 'moral alienation of the mind'. Rush (1812, p. 112) theorised that such cases stemmed from, 'defective organisation in those parts of the body which are occupied by the moral faculties of the mind'. In 1835, Scottish physician, Pritchard coined the term 'moral insanity' in reference to 'otherwise normal people who engage in wilful behaviour that violates social norms' (p. 85). In his 'Treatis on Insanity and other Disorders Affecting the Mind', Pritchard described the difference between moral insanity and traditional notions of madness:

'...the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally or alone in the state of the feelings, temper or

habits... in these cases the individual is found to be incapable...of conducting himself with decency and propriety, having undergone a morbid change'.
(Pritchard 1835, p. 85)

The late 19th century, saw the arrival of the present day moniker 'psychopath', a contraction of psychological pathology. The German psychiatrist Koch (1891) used the term 'psychopathic inferiority' to characterise individuals who engaged in abnormal behaviours as a result of a constitutional degeneration, i.e. due to heredity rather than insanity. The British psychiatrist Maudsley (1897) used the term 'moral imbecility' to label a patient with 'no capacity for true moral feeling'. In 1915, Kraepelin replaced Koch's 'psychopathic inferiority' with 'psychopathic personality' and identified 7 subtypes: excitable, unstable, eccentric, liars, swindlers, antisocial and quarrelsome. The word psychopath was popularised decades later largely by two authors, namely Henderson in UK and Cleckley in USA. Henderson's book 'psychopathic states', began by defining psychopaths as people who:

'...throughout their lives, or from a comparatively early age, have exhibited disorders of conduct of an antisocial or asocial nature, usually of a recurrent or episodic type which in many instances have proved difficult to influence by methods of social, penal, or medical care or for whom we have no adequate provision of a preventative or curative nature'.
(Henderson 1939, p. 18).

Henderson (1939, p.18) went on to broaden his definition to include three groups of psychopaths: the predominantly inadequate psychopath 'who siphons a living off society by swindling or pilfering, crimes that involve little overt aggression'; the predominantly aggressive psychopath 'a potentially dangerous individual subject to fits of violence'; and creative psychopaths who are highly individualistic, sometimes eccentric people determined to 'carve out a way for themselves irrespective of the obstacles which bestow their path'. In Cleckley's 1941 book 'The Mask of Sanity', he theorised that those who suffer from psychopathy appear sane, but have profoundly disordered thinking, and went on to outline the syndrome of psychopathy describing interpersonal, affective and behavioural abnormalities (i.e. interpersonal - superficially charming, grandiose, egocentric, manipulative; affective - shallow, labile emotions, lack of empathy, lack of guilt, little subjective distress; behavioural - impulsive, irresponsible, prone to boredom, lack of long-term goals, prone to breaking rules).

Cleckley's ideas, along with Henderson's, were incorporated into the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) published in 1952. DSM I (American Psychiatric Association APA 1952) attempted to catalogue in one volume the different disorders encountered in the field of psychiatry, the intention being to standardise psychiatric classification and language as a basis for research and practice, promote communication among psychiatrists and other mental health professionals, and collect statistical information. A European counterpart entitled the International Statistical Classification of Diseases and Related Health Problems (ICD-7, World Health Organisation WHO 1958) arose with similar aims.

Since their inception, there have been numerous periodic revisions of both ICD and DSM incorporating within them a variety of terms for personality pathology. The first DSM (DSM I, American Psychiatric Association 1952) referred to 'sociopathic personality disturbance' and the term 'personality disorder' was introduced in the second edition (DSM II, American Psychiatric Association 1968). The most recent editions of these diagnostic manuals, ICD 10 (World Health Organisation 1992) and DSM IV TR (American Psychiatric Association 2000) recognise 8 and 10 categories of PD respectively. In addition the DSM system now groups the personality disorders into 3 distinct clusters (i.e. A, B, and C) and has assigned a special and separate axis (axis II) to differentiate them from standard psychiatric syndromes covered in axis I.

Table C1: Comparison of DSM and ICD Classification Systems for Personality Disorders

| | DSM IV TR (APA 2000) | ICD 10 (WHO 1992) |
|-----------------------------------|---|--|
| Definition 'Personality Disorder' | 'An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. This enduring pattern is inflexible and pervasive across a broad range of personal and social situations and leads to clinically significant distress or impairment in social, occupational or other important areas of functioning. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood'. | 'A severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'. |
| Classification | | |
| Personality Disorder | 3 clusters, 10 types. | 9 types. |
| | Cluster A (odd-eccentric): <ul style="list-style-type: none"> • Paranoid PD • Schizoid PD • Schizotypal PD | <ul style="list-style-type: none"> • Paranoid PD • Schizoid PD |
| | Cluster B (dramatic-emotional): <ul style="list-style-type: none"> • Anti-Social PD • Borderline PD • Histrionic PD • Narcissistic PD | <ul style="list-style-type: none"> • Dissocial PD • Emotionally unstable PD - Impulsive type • Emotionally unstable PD - Borderline type • Histrionic PD |
| | Cluster C (anxious-fearful): <ul style="list-style-type: none"> • Avoidant PD • Dependant PD • Obsessive Compulsive PD | <ul style="list-style-type: none"> • Anxious (Avoidant) PD • Dependant PD • Anankastic PD |

Both DSM and ICD provide lists of criteria required for a diagnosis of each personality disorder. In order to provide a flavour of this client group, rather than engaging in the lengthy process of listing the criteria set out by DSM IV (American Psychiatric Association 1994) and ICD 10 (World Health Organisation 1992) for each PD, it is possible to draw upon the brief descriptions provided by Millon and Davis (2000) in Table C2.

Table C2: Brief Description of the Personality Disorders of DSM IV-TR (adapted from Millon & Davis 2000)

| Cluster A (odd-eccentric) | |
|--------------------------------|--|
| Paranoid PD | Guarded, defensive, distrustful & suspicious. Hypervigilant to the motives of others to undermine or do harm. Always seeking confirmatory evidence of hidden schemes. Feels righteous but persecuted. |
| Schizoid PD | Apathetic, indifferent, remote, solitary. Neither desires nor needs human attachments. Minimal awareness of feelings of self or others. Few drives or ambitions if any. |
| Schizotypal PD | Eccentric, self-estranged, bizarre, absent. Exhibits peculiar mannerism & behaviours. Reads thoughts of others. Preoccupied with odd daydreams and beliefs. Blurs line between reality and fantasy. |
| Cluster B (dramatic-emotional) | |
| Histrionic PD | Dramatic, seductive, shallow, stimulus seeking, vain. Overreacts to minor events. Exhibitionist as a means of securing attention & favours. Sees self as attractive & charming. |
| Narcissistic PD | Egotistical, arrogant, grandiose, insouciant. Preoccupied with fantasies of success, beauty or achievement. Sees self as admirable & superior and therefore entitled to special treatment. |
| Borderline PD | Unpredictable, manipulative, unstable. Frantically fears abandonment & isolation. Experiences rapidly fluctuating moods. Shifts between loving & hating. Sees self & others as alternately all-good & all-bad. |
| Antisocial PD | Impulsive, irresponsible, deviant, unruly. Acts without due consideration. Meets social obligations only when self serving. Disrespects societal customs, rules & standards. Sees self as free & independent. |
| Cluster C (anxious-fearful) | |
| Avoidant PD | Hesitant, self conscious, embarrassed, anxious. Tense in social situations due to fear of rejection. Plagued by constant performance anxiety. Sees self as inept, inferior, or unappealing. Feels alone & empty. |
| Dependent PD | Helpless, incompetent, submissive, immature. Withdraws from adult responsibilities. Sees self as weak or fragile. Seeks constant reassurance from stronger others. |
| Obsessive Compulsive PD | Restrained, conscientious, respectful, rigid. Maintains a rule bound lifestyle. Adheres closely to social conventions. Sees the world I terms of regulations & hierarchies. Sees self as devoted, reliable, efficient, productive. |

As can be seen from the brief history outlined above, early runners of the concept of personality disorder moved from the 'morally neutral view of Pinel to the more truculent and disparaging characterisations' (Arrigo & Shipley 2001, p. 326) described by Rush (1812), Pritchard (1835), Koch (1891), Maudsley (1897) and Kraepelin (1915). Striking features about current conceptions are the enduring moral attributions of the diagnosis and the behaviourally based defining features emphasising social disruption (See Box C1 for example from DSM IV TR), points which have led some to debate whether individuals are in fact 'bad rather than mad' (Hinselwood 1999; Moller 2002) and others to argue the diagnosis leads to stigma and discrimination (Gunn & Robertson 1976; Lewis & Appleby 1988; Mann & Lewis 1989; Pilgrim 2001).

Box C1:

Diagnostic Criteria for Antisocial Personality Disorder (DSM IV-TR, American Psychiatric Association 2000)

There is a pervasive pattern of disregard for and violation of the rights of others occurring since the age 15 years, as indicated by three or more of the following:

- 1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- 2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- 3) impulsivity or failure to plan ahead
- 4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
- 5) reckless disregard for safety of self or others
- 6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- 7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another

The DSM and ICD systems of classification now dominate academic literature and research on the topic of PD, and their use and acceptability are widespread among mental health professionals. There have, however, been numerous criticisms of such a categorical approach to classification as advocated by these systems. Considerable overlap exists between diagnostic categories (Coid 1992; Paris 1997). High rates of comorbidity have been reported for DSM IV axis I and II disorders (Mavissakalian 1990; Swartz et al. 1990) and among DSM IV axis II disorders (Zimmerman &

Coryell 1990; Moran 1999a). Such classificatory systems may be insensitive to the heterogeneity within diagnostic groups (Dolan, Evans & Norton 1995; Roth & Fonagy 1996; Kerr 1999) and the spectrum of severity within the category of PD (Cawthra & Gibb 1998). The British Psychological Society (1999) asserts that the reliability of diagnosis using the DSM and ICD classifications is poor, the high levels of comorbidity of personality disorders make discrimination difficult and that diagnosis has little predictive validity in terms of providing information about likely treatment outcome or in terms of indicating the appropriate treatment type. Moran (1999b, p. 13) argues:

‘Of all the mental disorders, the classification of personality disorders is probably the least satisfactory, borrowing elements from psychoanalysis (borderline and narcissistic), phenomenology (schizoid & anankastic), genetics (schizotypal) and behavioural psychology (anxious/avoidant). It is therefore hardly surprising that descriptions overlap and mixed categories of personality disorders are the rule rather than the exception’ (Moran 1999b, p. 13).

Tyrer (2001, p. 81) comments, ‘most attempts to diagnose personality disorder in a few words seem laughingly inadequate, a two-dimensional parody of something we all know to be exceedingly complex’.

Numerous authors have argued for a dimensional approach to classification (Eysenck 1947; Smith 1978; Widiger & Frances 1985; Livesley 1986, 1991; Blackburn 1988; Widiger 1991; Stone 1993; Livesley et al. 1994; Strack & Lorr 1994; Clark et al. 1997; McHoskey, Worzel & Szyarto 1998), purporting that personality disorders should be considered along dimensions that reflect extreme variants of normal personality, lying on a continuum with normality, rather than categories (present versus absent) representing distinct disorders that qualitatively set them apart from normal personality. Such an approach would do away with arbitrary thresholds, remove some of the heterogeneity that arises from categorical approaches, and limit the loss of information associated with categorical judgments. In the words of Tyrer (2001, p. 82), ‘Dimensions, not categories’ has become the war cry of the reformists and their case is a powerful one’.

Despite criticisms of the categorical approach to classification of personality pathology, practitioners continue to rely on the simplified and prototypical definitions

of disordered personality. Millon and Davis (2000, p. 3) state: 'the system [DSM IV] is widely considered the official classification system or taxonomy for use by mental health professionals'. Corey (1996) refers to Diagnostic and Statistical Manual of Mental Disorders (DSM IV, APA 1994) as the bible for guiding practitioners in making diagnostic assessments and further comments that clinicians who work in community mental health agencies, private practice and other human service settings are generally expected to assess client problems within the framework of the DSM IV.

C.2.2 The Epidemiological Context of Personality Disorders

Regarding the prevalence of these disorders, despite the enormous variation that exists between subtypes, de Girolamo and Dotto (2000) suggest that between 10 and 13% of individuals in the community have a personality disorder. Research cited recently by Alwin et al. (2006, p. 10) suggests that, in primary care, five to eight per cent of patients have personality disorder as their main clinical diagnosis, with estimates rising to 29-33% when all clinical diagnoses, not just the primary diagnosis, are considered. Prevalence rates increase if patients within the mental health and forensic systems are considered: 36-67% in psychiatric populations, 50-78% of prison population (Pidd et al. 2005); 30-40% psychiatric out-patients, 40-50% of psychiatric in-patients, and 50-78% of adult prisoners (Alwin et al. 2006). Personality disorders are more common in younger age groups (Zimmerman & Coryell 1989) and are equally distributed between males and females, although the sex ratio varies for the different types of PD, antisocial personality disorder being more commonly diagnosed in males and borderline personality disorder more common in females (American Psychiatric Association 1994). However, such epidemiological data needs to be interpreted with caution as studies use varying diagnostic standards, PDs have a fluctuating course, and are highly comorbid with each other and with axis I clinical syndromes.

C.2.3 The Aetiological and Therapeutic Context of Personality Disorders

There is little agreement as to what the aetiological factors in personality disorders are. As with most mental disorders, no single factor explains their development, and multiple factors (biological, psychological and social) all play a role. Aetiological

theories emphasising nature include genetic factors, chromosomal abnormalities, cerebral pathology, and neurotransmitter depletion (i.e. serotonin) (Cloninger et al. 1993; Zanarini 1993; Zuckerman 1995; Paris 1996; Blair & Frith 2000; Hoptman 2003). Those theories stressing nurture consist of psychodynamic formulations of incomplete or faulty transitions in the early stages of child development, poor attachment/bonding or early separation between infant and parent, inadequacies in social learning, modelling antisocial behaviour from parents, adversities such as family dysfunction, and traumatic experiences in early life e.g. physical and sexual abuse (Adler 1985; Herman 1992; Kernberg 1996; Paris 1996; Fonagy 1998; Johnson et al. 1999; Perry 2002).

A variety of treatment approaches (including psychodynamic therapy, cognitive behavioural models, therapeutic community treatment, pharmacotherapy, physical interventions) have arisen driven by these different aetiological theories and defended by varying degrees and types of evidence. A brief summary of each treatment approach together with research detailing treatment effectiveness shall now be introduced before providing a general discussion of methodological limitations. The decision to address methodological issues in a more global way in a separate section as opposed to alongside individual studies has been made on account of the sheer volume of literature and the unfortunate limitations of space presented by this thesis.

C.2.3.1 Cognitive Behavioural Models

There are four different approaches to therapy that have been included here under the rubric of cognitive behavioural models: cognitive therapy (Beck et al. 1990); schema focused cognitive therapy (Young 1999); dialectical behaviour therapy (Linehan 1993); and cognitive analytic therapy (Ryle 1997a, 1997b). Each, of course, have their distinctive features, however all share the central tenets of cognitive behavioural approaches in being collaborative, time limited, goal directed, problem solving therapies that focus on teaching clients specific skills to improve current functioning. This is in contrast to, for example, the insight oriented psychodynamic approach.

Cognitive therapy of personality disorders as described by Beck et al. (1990) focuses on working at the dual levels of the symptom structure (manifest problem) and

underlying schemas (inferred structures). Schemas are understood as directing rule-guided behaviour, including maladaptive behaviour of PD individuals. Beck et al. (1990) outline maladaptive schema stemming from childhood (i.e. abandonment and loss, unlovability, excessive dependence, subjugation, mistrust, inadequate self discipline, fear of losing emotional control, guilt, emotional deprivation). Therapy focuses on reconstructing, modifying or reinterpreting schemas, training clients in self-help and self-monitoring skills, and developing crisis intervention strategies. Similarly, schema focused cognitive therapy as described by Young (1999) concentrates on identifying and modifying 'early maladaptive schemas' thought to underlie PD and have their origins in adverse childhood experiences. Schemas are defined as 'broad pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree' (Young et al. 2003, p. 7). Schemas cover themes around five principal domains: disconnection and rejection; impaired autonomy and performance; impaired limits; other directedness; and over-vigilance and inhibition. Therapy consists of identifying and activating core schemas (e.g. through use of imagery), and modifying them using cognitive reconstruction, behavioural and experiential techniques.

Dialectical behaviour therapy (DBT), a manualised therapy developed by Linehan (1993), is based on the principle that borderline personality disorder is essentially the result of deficits in interpersonal and self-regulatory skills and that these skills can be taught in therapy (Winston 2000). The approach posits that those with borderline personality disorder have reduced interpersonal abilities, emotion-regulation, tolerance of distress and abilities to control themselves (Warren et al. 2003). The biopsychosocial theory underpinning the approach emphasises that dysfunctional behaviour stems from the interaction of environmental factors with biological abnormalities and that such factors obstruct the ability of the individual to use the interpersonal skills they have. The aim of the therapy is first and foremost to control self-harm characteristics of individuals with borderline personality disorder and, following this, to promote change in the emotional dysregulation that is judged to be the core of the disorder (Robins 2003). Treatment consists of individual and group sessions incorporating a combination of behavioural procedures of skills training, exposure based procedures, cognitive modification, contingency management and

problem solving with validation, mindful practices, reciprocity and a focus on the patient therapist relationship (Koerner & Linehan 2000). The dialectical aspect of the therapy refers to the balancing of acceptance with change, throughout the therapy.

Ryle (1997a, 1997b) developed an aetiological model of borderline personality disorder based on the concept of multiple 'self-states', defined as partially dissociated states between which the client switches abruptly. Inadequate parenting is thought to result in inability to integrate these 'self states', leading to rapid shifts between them. Each 'self state' is linked to specific moods, behaviours and symptoms and is associated with corresponding 'interpersonal roles'. The shifts between 'self states' and their associated 'interpersonal roles' are seen as a cause of the instability and emotional dyscontrol that individuals with borderline personality disorder display. Cognitive analytic therapy (CAT) (Ryle 1997a, 1997b, 2004), an integration of cognitive and psychoanalytic ideas, is a collaborative approach between client and therapist, which aims to identify 'self states' and 'interpersonal roles' and assist the individual in making links between early experience and current behaviour.

Cognitive behaviour therapy has been shown to be an effective intervention in the treatment of many mental health problems (Roth & Fonagy 2004) and it therefore comes as no surprise that numerous attempts have been made to evidence base its utility in those individuals diagnosed with personality disorder⁽¹²⁾. It can however be somewhat difficult to interpret the research literature and draw conclusions regarding the general effectiveness of the cognitive behavioural approach to the treatment of personality disorder due to the variety of approaches subsumed under this heading and a lack of clarity and specificity in describing the form of cognitive behaviour therapy applied in individual studies. For example, Davidson and Tyrer (1996) evaluated the effectiveness of 'Beck's cognitive therapy' adapted for personality disorder in 12 borderline and antisocial personality disordered clients using single case methodology and demonstrated an improvement in target symptoms (self-harm and self-destructive behaviours). Brown et al. (2004) describe an open trial of 'cognitive therapy' where 32 clients with borderline personality disorder showed significant improvements in suicidal ideation, hopelessness, depression, borderline symptoms and dysfunctional beliefs, after weekly sessions for a period of one year and at 18 months follow up. Randomised controlled trials by Evans et al. (1999), Tyrer et al. (2003a, 2003b) and

Weinberg et al. (2006) have demonstrated improvements in rate of suicide acts, frequency of self harming, self rated depressive symptoms following application of 'a mixed cognitive therapy and dialectical behaviour therapy protocol (manual assisted cognitive behaviour therapy - MACT)'. A recent year-long randomised controlled trial by Davidson et al. (2006b), showed added benefit of 'cognitive behaviour therapy', as compared to treatment as usual, on positive symptom distress index, state anxiety, dysfunctional beliefs and the quantity of suicidal acts at 2 year follow up in 106 individuals meeting diagnostic criteria for borderline personality disorder. What is clear is that descriptions of cognitive behaviour therapy in the above studies (ranging from 'Beckian cognitive therapy', to 'cognitive therapy', to 'a mixed cognitive therapy and dialectical behaviour therapy protocol', to 'cognitive behaviour therapy') are probably describing very different treatment approaches and it is therefore unclear which elements make the treatment approach effective.

In contrast, research studies investigating schema focused therapy (Young 1999) and dialectical behaviour therapy (Linehan 1993) approaches, developed partly as an attempt to expand and add to traditional cognitive behaviour therapy, appear more overt and specific in labelling their descriptions of treatment.

Although schema therapy is a relatively new form of treatment for personality disorder there is emerging evidence that it can be effective (Alwin et al. 2006, p. 39). Nordahl and Nysaeter (2005), in a single case series for six patients with a primary diagnosis of borderline personality disorder, reported clinically meaningful improvement in five of the six patients with three of the six not fulfilling criteria for the disorder at end of treatment. Giesen-Bloo et al. (2006) conducted a multisite randomised controlled trial spanning three years comparing schema therapy with psychodynamically based transference focused psychotherapy in patients with borderline personality disorder⁽¹³⁾. Comparisons were made on measures of cost effectiveness, borderline criteria and quality of life at one, two and three year treatment periods. Results demonstrated a superiority of schema focused therapy over transference focused psychotherapy on all measures.

Davidson (2002) describes DBT as one of the most promising interventions for patients with borderline personality disorder. Indeed, DBT in comparison to treatment as usual

has been shown to be effective in reducing severe dysfunctional behaviours that are targeted for intervention (e.g. self harm / self mutilating behaviours, parasuicidal behaviours, self damaging impulsive acts), reducing psychiatric hospitalisation, increasing treatment retention, and improving social and global functioning (Linehan et al. 1991; Linehan et al. 1993; Linehan et al. 1994; Linehan et al. 1999; Turner 2000; Koons et al. 2001; Rathus et al. 2002; Verheul et al. 2003; Bohus et al. 2004; Simpson et al. 2004; van den Bosch et al. 2005; McQuillan et al. 2005; Fleischhaker et al. 2006; Linehan et al. 2006). However, Bateman and Tyrer (2004a, p. 384) question whether the popularity of DBT is justified and comment on 'the widespread adoption of dialectical behaviour therapy being a tribute to the energy and charisma of its founder, Marsha Linehan, and to the attractiveness of the treatment, with its combination of acceptance and change, skills training, excellent manualisation, and a climate of opinion that is willing and able to embrace this multifaceted approach'. Bateman and Tyrer (2004a) and Warren et al. (2003) express concern over the effectiveness of the therapy as a treatment for the personality disorder itself due to methodological limitations of effectiveness studies⁽¹²⁾, in particular achievements are mainly confined to self harm episodes (Bateman & Tyrer 2002) and the evidence for longer-term (over one year post-treatment follow-up) improvement shows poor maintenance of changes in parasuicidal behaviours (Warren et al. 2003). In addition, it is not clear which elements of dialectical behaviour therapy (psychotherapy, skills training, telephone consultation, therapist consultation team) make this treatment method effective (Bateman & Tyrer 2004a). Recent studies by van den Bosch et al. (2005) and Linehan et al. (2006) have attempted to address one of these methodological difficulties by examining whether treatment results were sustained over follow up. Both studies demonstrated that treatment gains were indeed sustained, in the case of van den Bosch et al. (2005) at six months post treatment and Linehan et al. (2006) at twelve months post treatment. However recent reviews conducted by Binks et al. (2006) and Brazier et al. (2006) maintain that the quality of studies remains poor and findings should be interpreted with caution owing to differences in patient characteristics, comparison groups and outcome measures.

As regards the efficacy of CAT, Bateman and Tyrer (2002) and Davison (2002) comment that, although many are enthusiastic about the effectiveness of this approach in the treatment of PD, the approach remains to be supported by research evidence.

There have been case studies which describe the utility of CAT with personality disorder (Ryle & Beard 1993; Pollock & Kear-Colwell 1994; Ryle 1995; Pollock & Belshaw 1998, Kerr 1999), however, controlled trials, the gold standard for judging therapeutic effectiveness, are absent to date. A small prospective, pre- and post-design study explored the six and 18-month outcomes for a group of patients with borderline personality disorder (Ryle & Golyunkina 2000). Patients were categorised as 'improved' or not on the basis of whether they continued to meet criteria for borderline personality disorder at follow up. Based on this outcome measure, fifty per cent of patients were improved and fifty per cent unimproved.

(12) For information on methodological limitations, please refer to C.2.4 Methodological Issues.

(13) For information on transference focused psychotherapy, please refer to C.2.3.2 Psychodynamic Models.

C.2.3.2 Psychodynamic Models

A psychodynamic approach to personality disorder emphasises personality structure and development (Warren et al. 2003). Therapy is insight oriented and aims to understand the way in which the past influences the present with the use of interpretation. Treatment focuses on the therapeutic alliance between patient and therapist, the individual's emotional life, and defences (Bateman & Tyrer 2002). Therapy uses the relationship between patient and therapist (issues of transference) as a way of understanding how the internal world of the individual affects their relationships (Bateman & Tyrer 2002). Addressing how the patient thinks, feels, and acts through the vehicle of the therapeutic relationship provides them with an understanding of themselves and their interpersonal relationships (Warren et al. 2003). An increase in insight allows for the development of increased self-control and empathic understanding of themselves and others. There are many different forms of psychodynamic therapy ranging from individual or group oriented, time limited or not, adapted to a variety of settings, but there are two specific types which deserve particular mention here on account of their recent popularity and manualisation, namely Mentalization-Based Treatment (Bateman & Fonagy 2004) and Transference Focused Psychotherapy (Clarkin et al. 1999; Yeomans, Clarkin & Kerberg 2002; Clarkin, Yeomans & Kerberg 2006).

Mentalization-based treatment (Bateman & Fonagy 2004; Fonagy & Bateman 2006) focuses on increasing the reflective or mentalizing capacity of the patient in the context of group and individual therapy. Mentalization entails making sense of the actions of oneself and others on the basis of intentional mental states such as desires, feelings and beliefs. It involves the recognition that what is in the mind is indeed in the mind and reflects knowledge of one's own and others' mental states as mental states. Bateman and Fonagy (2004) hypothesise that this capacity is enfeebled in borderline patients, and so group and individual therapy actively focuses on developing these patients' understanding and recognition of the feelings they evoke in others and the feelings evoked in them by others.

The roots of Transference Focused Psychotherapy (Clarkin et al. 1999; Yeomans et al. 2002) are in object relations theory (Kernberg 1967). Personality disorders are believed to result from disruptions in the normal organisation of internalised object relations. Individuals with personality disorders have internalised object representations that are split into either 'all good' or 'all bad' self and other representations. The therapeutic emphasis is to work with the transference in the 'here and now' by identifying the internalised objects and the linking affect (either idealised 'all good' or devalued 'all bad') that are enacted in the transference during the session and work systematically to bring these to the patient's awareness. In this process, the part objects become integrated (the 'good' and 'bad' are no longer split) and the individual develops the capacity to experience relationships and themselves in a more integrated, balanced way. Transference is believed to be the key to understanding and change in the patient, since it is believed that the patient's internal world of object representations unfolds and is 'lived' in the transference.

Randomised and non-randomised controlled studies of psychodynamic psychotherapy (Winston et al. 1991; Piper, Rosie, Azim, et al. 1993; Winston, Laikin, Pollack, et al. 1994) have shown improvement on a variety of outcome measures (e.g. self report measures of depression, anxiety, general symptom distress, interpersonal function social adjustment, frequency of self-harming acts, hospital admissions) ⁽¹⁴⁾.

Support for Mentalization-Based Therapy comes from a randomised study examining the effectiveness of a psychoanalytically oriented partial hospitalisation programme

with standard psychiatric care for patients with borderline personality disorder (Bateman & Fonagy 1999). On all outcome measures there was significantly greater improvement in those allocated to psychotherapy. The improvements in symptoms and function were delayed by several months but were greatest by the end of treatment (18 months). In a follow-up study gains were maintained after a further 18 months (Bateman & Fonagy 2001). As yet the active components of therapy remain unclear, especially because it was not possible to show that mentalization had increased in the patients who showed the most gains. The results however are promising and an evaluation of a mentalization based treatment programme for individuals with borderline personality disorder is currently underway in the Netherlands headed by Professor R. Verheul ⁽¹⁵⁾.

Transference-Focused Psychotherapy has given promising results (Bateman & Tyrer 2004a). In a cohort study (Clarkin et al. 2001), 23 female patients with borderline personality disorder were assessed at baseline and at the end of 12 months of treatment by means of diagnostic instruments, measures of suicidality, ratings of self-injurious behaviour and measures of medical and psychiatric service use. Compared with the year prior to treatment, the number of patients who made suicide attempts and the medical risk and severity of medical condition following self-injurious behaviour significantly decreased. In addition, patients during the treatment year had significantly fewer hospital admissions as well as number and days of psychiatric hospitalisation compared with the year before. Conference reports of a comparison study between patients treated with transference focused psychotherapy and a matched untreated control group confirm the benefits of treatment (Clarkin 2002). A recent randomised controlled trial conducted by Clarkin et al. (2007) examined three year-long outpatient treatments for borderline personality disorder: transference-focused psychotherapy, dialectical behaviour therapy and dynamic supportive treatment. Results revealed that all three treatment groups showed significant positive change in depression, anxiety, global functioning and social adjustment. Both transference focused therapy and DBT were associated with improvement in suicidality. Both transference focused therapy and supportive treatment were associated with improvement in anger and impulsivity. Only transference was significantly predictive of change in irritability and verbal and direct assault. The authors concluded that

transference focused therapy is associated with greater change than DBT or supportive treatment.

(14) For information on methodological limitations, please refer to C.2.4. Methodological Issues.

(15) Further information available at: <http://www.vispd.nl/projects.htm>. Last accessed: 27 November 2006.

C.2.3.3 The Therapeutic Community Model

A therapeutic community (TC) may be defined as an intensive form of treatment in which the environmental setting becomes the core therapy and the primary agent of change, where behaviour can be challenged and modified, essentially through group interaction and interpersonal understanding (Bateman & Tyrer 2004a). On account of their uniqueness, representing a treatment modality as much as a specific treatment method itself (Kennard 1998), TC treatment is considered here under a separate section, despite the fact that they commonly incorporate within the formal daily programme some of the therapies mentioned above (in particular psychodynamic group therapy). TCs are designed as cohesive communities all of whose members (staff and patients) have a significant involvement in decision-making and practicalities of the day-to-day running of the community. They include democratic and concept types, the former including members of the community as decision makers, the latter being more hierarchical in nature. They originated in the UK during World War II in psychiatric hospitals and represented a move away from an authoritarian doctor-patient model of treatment to a more democratic style (Jones 1952).

Effectiveness studies of TC treatment have demonstrated favourable outcomes across a variety of measures: psychological and behavioural changes during treatment; reduction of violent incidents in treatment settings; reductions in utilisation of psychiatric services (especially acute inpatient admissions); significant improvements following treatment in life history variables (e.g. recidivism, rehospitalisation); reductions in core symptomatology and features of PD (Dolan et al. 1996; Dolan et al. 1997; Chiesa & Fonagy 2000; Chiesa & Fonagy 2003; Davis & Campling 2003; Chiesa et al. 2004; Chiesa et al. 2006)⁽¹⁶⁾. An early review by Dolan and Coid (1993) concluded that TC treatment showed the most promising results of any treatment

modality for psychopathy and antisocial personality disorder. In a more recent review conducted by Warren et al. (2003), the authors concluded that the TC model had been shown to be effective in producing long term symptomatic and behavioural improvements and currently offered the most promising evidence for treatment of PD clients. However, both Dolan and Coid (1993) and Warren et al. (2003) noted the dearth of controlled research studies into TC treatment.

(16) For information on methodological limitations, please refer to C.2.4. Methodological Issues.

C.2.3.4 Biological Models

C.2.3.4.1 Pharmacotherapy

Several lines of argument support the notion that pharmacotherapy might have a place in the treatment of personality disorders (Tyrer & Bateman 2004): the sub-syndromal or spectrum argument; and the biological argument. The sub-syndromal or spectrum argument purports that personality disorders can be considered as part of a spectrum in which they are envisaged as one component on a continuum of mental disorders (Siever & Davis 1991). For example, schizotypal and paranoid personality disorders (Cluster A) are a sub-syndrome of schizophrenia; anxious/fearful personality disorder (Cluster C) to the common anxiety disorders such as phobic and generalised anxiety disorders. This argument has some face validity and is supported by the frequent associations (comorbidity) of each mental disorder with its personality counterpart (Tyrer et al. 1997). The biological argument suggests that personality disorders are deemed to reflect underlying biologically determined temperaments, purportedly linked to neurobiological predispositions and vulnerabilities. This is supported indirectly by evidence that personality traits, characteristics or dimensions have high rates of heritability of around 50% (Livesley et al. 1993; Jang et al. 1996).

Neurobiological research on personality disorder suggests that impulsiveness, self-harm and outwardly directed aggression are associated with dysfunction within the serotonergic system (Linnoila & Virkkunen 1992). Based on the sub-syndromal and biological arguments, pharmacological agents typically used to treat mental disorders and neurobiological abnormalities may be useful in the treatment of personality disorder.

Pharmacological treatment has indeed shown some promise in the treatment of individual symptoms associated with personality disorder. Authors such as Bateman & Tyrer (2002), Davison (2002), Fagin (2004) and Paris (2005) discuss research advocating different pharmacological agents to treat different symptoms of PD, such as lithium in the treatment of aggressive and assaultive behaviour; anticonvulsants in treating mood instability, irritability and impulsivity; antipsychotics in treating the psychotic symptoms sometimes experienced by patients with borderline and schizotypal personality disorder; selective serotonin reuptake inhibitor (SSRI) antidepressants in the treating anxious symptoms. However, Paris (2005) points out that although several drugs have been shown to alleviate symptoms, they do not produce remission of PD and there is no evidence of the effectiveness of drug treatment for PD per se. Paris (2005) asserts that failure to understand this point has led to polypharmacy regimens, on the assumption that multiple drugs are needed to target all aspects of the disorder. In longitudinal follow-up studies of patients with borderline personality disorder, over 75% had experienced polypharmacy (Zanarini et al. 2003). Tyrer and Bateman (2004) suggest that this probably represents clinical desperation rather than evidence-based prescribing. Zanarini et al. (2001) express concern over the prescribing of multiple pharmacological agents with all their attendant side effects in the absence of evidence from clinical trials supporting the efficacy of such combinations.

Despite many reservations, it is clear that medication will continue to be used in the treatment of personality disorder and that it has the potential to be an important intervention. This has been formally acknowledged by the American Psychiatric Association (2001) who advocate pharmacotherapy as an adjunctive (rather than primary treatment) for personality disorder.

C.2.3.4.2 Physical Interventions

Research studies investigating physical treatments for PD are sparse and there is little evidence that any form of physical treatment can successfully treat personality disorder (Warren et al. 2003). One uncontrolled study (Blais et al. 1998) of electroconvulsive therapy (ECT) for major depressive disorder suggested that some

co-morbid personality disorders (avoidant, histrionic and schizotypal) may be ameliorated by ECT treatment. However, other evidence from a case series study suggests that PD is a predictor of poor response to ECT (Sareen et al. 2000). Warren et al. (2003) suggest that physical treatments should only be used in desperate circumstances and when all other approaches have been exhausted.

C.2.4 Methodological Issues

A number of studies into the effectiveness of different therapies have been discussed above but, as already alluded to, the research that exists is shrouded by methodological imperfections. The quality of the evidence for treatment of personality disorder is poor and consequently the literature that exists is difficult to interpret and draw any firm conclusions from, a fact that has been commented upon almost universally by authors (Dolan & Coid 1993; Roth & Fonagy 1996; Bateman & Fonagy 2000; Bateman & Tyrer 2002; Warren et al. 2003; Bateman & Tyrer 2004a; Alwin et al. 2006; Davidson et al. 2006a).

Heterogeneous samples have included different diagnoses (types) of PD. There has been an overrepresentation of borderline personality disorder diagnoses and authors such as Tyrer (1999), Higgitt & Fonagy (1992), and Davison (2002) suggest that borderline personality disorder may differ fundamentally from the rest of the personality disorder spectrum. Different diagnostic instruments/criteria have been used across studies. Confusion is engendered by use of terminology such as 'psychopathy' and 'severe personality disorder'. European texts use the term 'psychopathy' to refer to all PDs whereas in the UK it more often means the subtype of antisocial PD. Farnham and James (2001, p. 1926) have referred to 'dangerous and severe personality disorder' as 'a neologism that has no legal or medical status'. Both 'psychopathy' and 'severe personality disorder' are widely used by clinicians in the forensic arena, whereas the psychiatric and psychological literature relies on DSM and ICD systems of classification. There has been a lack of consideration of the high comorbidity between axis I & axis II disorders (Tyrer et al. 1997), which may either exaggerate or obscure treatment effects. As mentioned earlier in the discussion of effectiveness studies for DBT, treatment has been poorly described and there have been differences in treatment setting, modality and duration, specificity of

intervention, and limited follow-up. Problems in research design include uncontrolled studies, lack of randomisation, small sample sizes, and high or unreported attrition rates. Huge variation has existed in outcome measures: behavioural features (criminal activity, recidivism rates, self harm, mutilation, suicidality); cognitions (coping beliefs); mood (depression, anxiety); social function (employment, relationships); rates and duration of psychiatric hospitalisation. Few studies have assessed change in personality disorder status following treatment. Few studies have identified or controlled for possible effects of concomitant treatments e.g. psychological therapy in addition to medication/pharmacotherapy.

In an early review of treatment effectiveness, Dolan and Coid (1993) suggested that the lack of evidence of treatment efficacy stems from the researchers themselves and that the inadequate design of most outcome studies provides little convincing evidence that PD either can or cannot be treated effectively. More recently, Bateman and Tyrer (2004a, p. 379) acknowledge the 'formidable difficulties' of meeting the requirements for establishing effective treatment (e.g. randomised controlled trials), and highlight the resultant tendency for researchers to abandon them or only partially fulfil them.

Despite this methodological gloom, what becomes apparent in reading recent literature is a significant shift from the view that PD is untreatable and a current climate of optimism. Bateman and Tyrer (2004a, p. 386) state 'for the first time in the history of personality disorder, people are regarding the condition as potentially treatable'. Perhaps the government's current preoccupation with PDs has drawn our attention to the issue⁽¹⁷⁾. Perhaps the allocation of resources to fund research and improve service provision (NIMHE 2003a), and the recent proliferation of reviews into treatment effectiveness (e.g. Bateman & Fonagy 2000; Bateman & Tyrer 2002; Leichsenring & Leibing 2003; Warren et al. 2003; Bateman & Tyrer 2004a; Alwin et al. 2006) have provided an impetus for good quality future research. Perhaps recent therapy and management guidelines (e.g. Bateman & Tyrer 2002; Davison 2002; NIMHE 2003; Bateman & Tyrer 2004b; Fagin 2004) have engendered hope where previously there was none. It will be some time before these initiatives consolidate to provide a clear and full picture of the optimum spectrum of services for PD required for the future, however the outlook is far from bleak.

(17) For further information, please refer to C.2.5. The Political Context of Personality Disorder.

C.2.5 The Political Context of Personality Disorder

Over eight years ago the UK Government announced its intention to reform the Mental Health Act (1983) in England and Wales. The proposals grew out of public outcry over brutal murders committed by individuals diagnosed with personality disorder. Having been deemed untreatable under the Mental Health Act (1983), the authorities had no power to detain these individuals. One notorious example was the case of Michael Stone diagnosed with severe antisocial personality disorder and convicted in 1998 of double murder and attempted murder. The then Health Secretary, Alan Milburn (2000), is famously quoted as saying:

'At present neither the law nor the services are geared to cope with the risks posed by dangerous people with severe personality disorder. As a consequence there has been a gap in the protection mental health laws should afford the public – a gap we will now close.' ⁽¹⁸⁾.

Since this time, the management of individuals with PD has been the subject of great debate in the UK. Legislative and parliamentary deliberations began in 1998 and have resulted in the publication of numerous documents including those composed and commissioned by the government and those penned by academics, journalists and mental health professionals in response to legislative moves. The chronology of this process is outlined in Table C.3. below.

(18) Available at: <http://www.guardian.co.uk/society/2000/dec/20/socialcare.mentalhealth>. Accessed: 26 November 2007.

Table C3: Chronology of Mental Health Act Reforms

| | |
|--------------------|--|
| September 1998 | Government announces its intention to reform the Mental Health Act 1983. |
| October 1998 | Expert committee established, chaired by Geneva Richardson (generally referred to as Scoping or Richardson Committee). |
| January 1999 | Expert Committee report 'Review of the Mental Health Act 1983: Report of the Expert Committee' published (Richardson Report) (Department of Health 1999a). |
| July 1999 | Consultation paper 'Managing Dangerous People with Severe Personality Disorder' published (Home Office 1999). Paper sets out Government's proposals for tackling the challenge to public safety presented by the very small minority of people with severe personality disorder, who because of their disorder pose a high risk of serious offending. Proposals aim to ensure that dangerous people with severe personality disorder are kept in detention for as long as they pose a high risk to others; and to provide high quality services for them to enable them to deal with the consequences of their disorder, reduce their risk to others and so work towards successful re-integration into the community. |
| November 1999 | Green Paper 'Reform of the Mental Health Act 1983: Proposals for Consultation' published (Department of Health 1999b). |
| November 2000 | Summary of over 1000 responses received on Green Paper consultation made public. |
| December 2000 | White Paper 'Reforming the Mental Health Act' published. (Department of Health 2000). |
| June 2002 | 'Draft Mental Health Bill' published for consultation. (Department of Health 2002). |
| 16 September 2002 | Consultation ends with over 1700 formal responses and over 200 official letters received. |
| June 2003-May 2004 | Meetings with stakeholders on a range of issues to 'road test' the provisions of the Bill. |
| September 2004 | The responses from the 2002 consultation exercise led to a refinement of the bill and a Revised Draft Mental Health Bill was published in 8 September 2004 (Department of Health 2004). Pre-legislative scrutiny began. |

| | |
|----------------------------|---|
| October 2004-February 2005 | Revised Draft Mental Health Bill subject to prelegislative scrutiny by a Joint Committee of the House of Commons and House of Lords required to report by the end of March 2005. |
| March 2005 | Report from parliamentary committee published (Joint Committee on the Draft Mental Health Bill 2005), response to which was published in July 2005 (Department of Health 2005). |
| 23 March 2006 | Government announce decision to abandon its plans to pursue a new act and instead decide to amend the 1983 Mental Health Act. |
| 16 November 2006 | Mental Health Bill 2006 introduced to House of Lords (Department of Health 2006). The Bill amends the 1983 Mental Health Act. |
| 28 November 2006 | The Mental Health Bill 2006 received its Second Reading in the House of Lords. |
| 8 January 2007 | The Mental Health Bill 2006 was considered by Committee of the House of Lords on 8, 10, 15, 17 January 2007. |
| 19 February 2007 | The Mental Health Bill 2006 began its report stage in the House of Lords. At report stage House of Lords make six key changes to the Bill. |
| 7 March 2007 | The Mental Health Bill 2006 received its First Reading in House of Commons having been amended to reflect changes made to the Bill during its passage through the House of Lords. |
| 16 April 2007 | The Mental Health Bill 2006 received its Second Reading in House of Commons. |
| 24 April – 16 May 2007 | House of Commons Committee Stage of the Mental Health Bill 2006. |
| 18-19 June 2007 | Changes to Mental Health Bill 2006 debated and voted on in parliament. Bill goes to report stage. |
| 4 July 2007 | Mental Health Bill 2006 finished passage through parliament. |
| 19 July 2007 | Mental Health Act 2007 received Royal Assent. |
| October 2008 | Deadline for final implementation of amendments. |

The process of reform culminated in the Mental Health Act 2007 passing through parliament on 4 July 2007 and receiving Royal Assent on 19 July 2007. The new Act purports to strike a balance between safeguarding the rights of individual patients and protecting patients from harming themselves or others. In comparison with the Mental Health Act 1983, the Mental Health Act 2007 proposes: a generic and inclusive definition of mental disorder enabling the compulsion of individuals with all forms of personality disorder in the same way as those with mental illness; the abolition of the so-called 'treatability test' to enable detention of individuals with personality disorder currently considered untreatable; criteria for compulsory treatment in patients (whether treatable or not) who are in substantial risk of causing serious harm to others; and provisions enabling compulsory treatment in community settings, in keeping with the era of deinstitutionalisation.

Since inception, however, the reforms have been highly contentious, engendering massive disquiet and receiving challenging criticisms from a vast audience. The Mental Health Alliance (an 80-member coalition of service user and carer groups, voluntary organisations and charities, professional bodies, and service providers, including MIND, the Sainsbury Centre for Mental Health, the Royal Colleges of Psychiatry and Nursing, SANE, the Mental Health Foundation, and the British Psychological Society) and numerous other authors expressed extreme anxieties about the reforms in terms of ethics, practicality and effectiveness. The intention to preventively detain people suffering from personality disorder who are considered to pose a serious risk to others was strongly opposed and contested on the grounds of ethics and impeachment breach of civil liberties. The underlying motivations were criticised in light of beneficence (in whose interests do the proposals serve, the public or the patients?) and autonomy (the right to liberty under Article 5 of the Human Rights Act 1998, Department for Constitutional Affairs 2006).

Concern was expressed over the widening of the criteria for detention resulting in a large proportion of false positives with individuals being inappropriately detained. The academic literature (e.g. Feeney 2003; Buchanan & Leese 2001) has discussed the issue of dangerousness, the problem of prediction and the lack of evidence of a link between

dangerousness and personality disorder. Moran (2002) and Castillo (2003) questioned the ethics of imposing treatment in the absence of good evidence to show that treatment actually works (Bateman & Fonagy 2000). Castillo (2003) expressed concern that people who need help may be driven underground, away from services, that measures for compulsory treatment may alienate service users and make it less likely they would seek the care and treatment they needed for fear of being unjustifiably detained. Moran (2002, p. 9) commented on 'further marginalisation of an already disadvantaged section of society'. Other campaigners feared that an emphasis on managing risk would reinforce the public misconception that mentally ill people are dangerous, increase stigma, discrimination, prejudice, ignorance and fear. Reforms were criticised as being badly out of step with the Government agenda to tackle social exclusion – the proposals running counter to Standard 1 of the National Service Framework, that 'health and social services should combat discrimination against individuals and groups with mental health problems and promote their social inclusion' (Department of Health 1999, p.14). Other authors expressed anxieties in respect of professional roles, drawing unwelcome parallels with measures of social control. Farnham and James (2001, p. 1926) commented on proposals requiring, 'an explicit change in the role of the doctor from treating the sick to social control'. The Royal College of Psychiatrists labelled proposals 'a Public Order Bill' that is 'ethically corrupt' and 'morally indefensible' (cited in: Goodchild & Brown 2002). Eastman (1999, p. 549) discussed the hybridisation of punishment and health care with 'law that allows preventive detention of even the unconvicted'.

Concern over resource issues needed to implement the bill were expressed in the press 'the mental health bill may be a crowd-pleaser, but it will not help as much as well-directed funding' (Moller, 2002) and academic texts 'will sufficient investment be forthcoming?' (Castillo 2003, p. 162). Professionals worried that ramifications of the reforms would overload already under-staffed and overstretched services and stressed the need for new laws to be backed by extra staff and more resources. So controversial were the proposals that, in May 2007, five organisations (i.e. the British Psychological Society, the College of Occupational Therapists, the Royal College of Nursing, Unison, the Mental Health Nurses Association), representing 85% of the NHS mental health staff

(Carvel 2007), suspended their membership of the Mental Health Alliance over disagreement regarding the key issue of whether only psychiatrists should retain exclusive rights to section people under mental health legislation.

The final arrival of the Act remains controversial and has been greeted with mixed emotions – apprehension, disappointment, gratitude and relief. Brindle (2007) writing for *The Guardian* newspaper states:

‘...The result is only something approaching respectability. There are still battles to be won. The legislation may be passed, but there will be another scrap over the all-important code of practice that will give it practical effect. Decisions on some of the trickiest points of detail in the bill have been deferred... These include: the precise definition of “treatment” in respect of personality disorder; how community treatment orders will be applied and to whom; and clarification that an individual will not be detained compulsorily simply because of their behaviour as distinct from any illness.’ (Brindle 2007).

The Mental Health Alliance (2007) gave final verdict on the Mental Health Act 2007: ‘The new Mental Health Act will go down in history as a missed opportunity for legislation fit for the twenty-first century’.

C.2.6 The Natural History of the Present Research

In 2001 a research study investigating the experiences of community mental health team professionals in working with clients diagnosed with personality disorder using grounded theory methods was conducted by the present researcher. The origins of this study can be traced back to: the researcher’s clinical experiences in working with this client group (immensely challenging and characterised by intense fluctuations of emotions and concern for one’s own mental health); highly emotive conversations with colleagues concerning the stresses and strains placed upon professionals working with these clients; and explorations of pertinent literature suggesting negative prognosis, potential treatment difficulty, and stormy and crisis-laden therapy (e.g. Henderson 1951; Main 1957; Chiesa Iacoponi & Morris 1996; Cawthra & Gibb 1998; Hinshelwood 1999; Ryle & Golyunkina 2000; Winston 2000). This early study is mentioned here as it was at this time that the

seed for the present study was planted. In working with semi structured interview transcripts, the researcher was astounded by the language used by participants to convey their experiences. Descriptors and metaphors used were particularly vivid, generating powerful imagery:

'With a PD... It is just a constant battle with aspects of their behaviour'
(Support Worker, CMHT, 2001).

'I would say all of the people who we work with are battle hardened underneath it all. Christ almighty this does affect you this work. I have suffered a kind of works injury. I've become battle hardened to survive'
(Approved Social Worker, CMHT, 2001).

'It's like having a row with someone working with a PD'
(Psychologist, CMHT, 2001).

Such sentiments were echoed in the academic literature and cultural writings, texts being highly emotive, pessimistic and, more disturbingly, often pejorative:

*'They [PDs] establish a sort of malignant and inappropriate dependence on clinical services, without any noticeable improvement of their psychopathology taking place'.
(Chiesa, Iaconi & Morris 1996, p. 502).*

*'He slew 1000 Philistines with the jawbone of an ass, but biblical hero Samson may have been just a victim of a medical condition, which made him pick fights and cause wanton vandalism. Scientists believe the character traits attributed to Samson in the Book of Judges have all the hallmarks of antisocial personality disorder. Academic Eric Altschuler told New Scientist magazine that Samson's exploits exhibited 6 out of the 7 tell-tale signs of the condition. These included impulsive behaviour in picking fights with passing Philistine armies, going against social norms by burning philistine fields, being deceitful in not telling his parents he obtained honey from a lion's carcass, bullying other children and torturing animals as a boy. He showed disregard for his own safety by telling his mistress Delilah the secret of his strength.'
(Author unknown. 'Why, why, why did Delilah like him?', London Metro Newspaper, February 15 2001)*

'At every level of psychiatric services from the outpatient clinic to the forensic services, PD patients are an acknowledged problem. Their behaviour is difficult,

obnoxious, threatening, and they are hard to manage in institutional settings. It is not easy (indeed sometimes impossible) to engage them in psychiatric treatment over a sustained period of time. Even if one is successful, the outcome of treatment is uncertain. When at large in the community they cause problems for others through their antisocial and irresponsible conduct. Their incessant and contradictory demands upon health service resources (e.g. through repetitive suicidal gestures like overdoses) evoke negative reactions from all professions. Some psychiatric staff reject them completely, seeing them as 'psychological vampires' fully responsible for their behaviour, and appropriate cases for punishment rather than treatment. Yet if held in prison their behaviour remains disordered. Even in that setting they are difficult to manage, and though recognisably mentally disturbed their transfer to psychiatric care is, in most cases, impossible. Generally speaking they are people no one wants'.
(Bowers 2002, p. 2).

The researcher began to question why participants and writers were choosing such vivid, dramatic and powerful language to depict these individuals and communicate their experiences and whether such language was, in fact, shaping or constructing a culture that served to demonise personality disorders. If this was the case surely the implications of such language could have far reaching consequences for the lives of individuals labelled with a diagnosis of personality disorder.

Impelled by a sense of fascination for language, a sense of injustice at the seemingly blatant stigmatisation of individuals with PD, a sense of urgency considering the topical nature of the subject in terms of mental health act legislation, the present study was born.

C.2.7 Research Aims

The present study aimed to explore the discourse around personality disorder and reveal its nature, functions and implications.

C.3 Methodology

C.3.1 Social Constructionism and Discourse Analysis as a Research Framework

Traditionally within the discipline of psychology, 'knowledge' arises from the results of studies conducted using a positivist framework. From this epistemological position it is assumed that the truth is out there waiting to be found, that the nature of the world can be revealed by the scientific method of observation, by testing of hypotheses, controlling and manipulating variables, and uncovering truth, reality or fact. Such a philosophy of knowledge dominated the discipline until the 1970s when psychologists, influenced by social constructionist thinking, began to challenge such notions. The origins of social constructionism are placed within the works of twentieth century philosophers, communications theorists, historians, and sociologists (e.g. Wittgenstein 1953; Austin 1962; Foucault 1972), but the seminal writings of Gergen (1973) and later Potter and Wetherell (1987) are credited with bringing such theorising to the field of psychology.

Social constructionist thinking involves a radical epistemological shift away from traditional positivist notions. Social constructionists argue that our knowledge about the world is constructed in interaction and that what we regard as truth, our current accepted ways of understanding the world, is not a product of objective observation of the world, but of the social processes and interactions in which people are constantly engaged with each other (Burr 1995). Social constructionism stresses the problems with knowing 'reality as it is', denies that knowledge is a direct perception of reality, and argues that versions of knowledge are fabricated through interactions between people in the course of social life. In other words, we, as a culture or society, construct our own versions of reality between us (Burr 1995).

Viewing interactions between people as actively producing knowledge, as constructing the world, highlights the salience of language. As Potter and Wetherell (1987, p. 9) state, 'the study of language is particularly vital to social psychology because it simply is the most basic and pervasive form of interaction between people'. Within constructionist

approaches, language becomes more than simply a way of expressing ourselves. Such approaches 'question the notion that language simply and unproblematically refers to 'real' entities lying somehow outside of language itself' (Dickerson 1998, p. 213). Language is no longer viewed as a passive vehicle for thoughts and emotions, but as a form of action and is seen to construct reality, not simply reflect it. Such sentiment is echoed in the writings of constructionist authors such as Potter and Wetherell (1987, p. 21), 'talk is not merely about actions, events and situations, it is also a potent and constitutive part of those actions, events and situations' and Burr (1995, p. 7), 'when people talk to each other, the world gets constructed'. Dickerson (1998, p. 213) talks of constructionism challenging 'the idea that language is or can be merely a 'window on the world', a neutral medium which can allow us unproblematically to see the 'real' determinate experiences and activities lurking behind it'. Taking the metaphor further, he states 'language could be seen as sharing certain features of a stained glass window whose colours and shapes give a meaningful form to the light which flows through it' and comments on this resonating with Fowler's (1991, p. 10) conceptualisation of language: 'language is not a clear window but a refracting, structuring medium' (Dickerson 1998, p. 213).

Discourse analysis is a particular research method, underpinned by the epistemological position of social constructionism, which prioritises the constructive role of language in building versions of the world and views language as 'worthy of analysis in its own right' (Dickerson 1998, p. 212). The method challenges us to understand language not as revealing hidden essences, but rather as the very medium through which we build up (or construct) our social realities and, therefore, 'puts to work the rather abstract philosophical ideas of social constructionism' (Dickerson 1998, p. 213). Language is conceptualised as constitutive of experience rather than representative or reflective and the linguistic categories we use to 'describe' reality are not reflections of intrinsic and defining features of entities, but actually bring into being the objects they describe (Willig 1999). Discourse analytic researchers are sensitive to the constructive and functional aspects of language in use and pay particular attention both to what versions of the world are produced and to what sorts of implications or functions they may have.

Discourse analysis literally means the analysis of `discourse`, which is variously defined as talk, language, text, communication, spoken and written language. Such a simplistic definition, however, fails to do justice to the plethora of approaches falling under the discourse analytic umbrella. Wetherell, Taylor and Yates (2001, p. i) allude to this plethora in defining discourse analysis as a `set of methods and theories for investigating language in use and language in social contexts`. Similarly, Antaki, Billig, Edwards and Potter (2003) comment on the recent proliferation of forms of discourse analysis, and Burman and Parker (1993) on the considerable variety of discourse analytic methods available. The numerous discourse analytic approaches which have evolved may be distinguished on the basis of their historical roots and disciplinary locations, the research questions they aim to address, their focus and emphasis, the sorts of knowledge they claim to make, and the kinds of procedural techniques they employ. All approaches, however, share `a rejection of the idea that language is simply a neutral means of reflecting or describing the world and a conviction of the central importance of discourse in constructing social life` (Gill 1996, p. 141).

Versions of discourse analysis have been applied in a range of disciplines in the social sciences and humanities, including cultural and media studies, sociology, linguistics, education studies and psychology. In choosing an appropriate method for the present study, exploration was limited to those specific approaches utilised within the field of psychology where, in recent years, discourse analysis has become an increasingly popular research tool (Potter & Wetherell 1987; Edwards & Potter 1992; Parker 1992; Burman & Parker 1993; Burr 1995). Within this field researchers typically distinguish between two main types of discourse analysis (Burr 1995; Parker 1997; Willig 2001), namely Foucauldian Discourse Analysis and Discursive Psychology.

Discursive Psychology has its roots in ethnomethodology (Garfinkel 1967) and conversation analysis (Sacks 1992) and is interested in the negotiation of meaning in local interaction in everyday contexts. It focuses upon the performative qualities of discourse, that is, what people are doing with their talk or writing, what they are trying to achieve, and how they use language in order to negotiate and manage social interactions

so as to achieve interpersonal objectives. Discursive psychology therefore focuses on discourse practices, on the action orientation of talking and writing, and the study of what talk and writing is being used to do. Examples of such work include: Billig (1987, 1991); Potter and Wetherell (1987); Edwards and Potter (1992). In contrast, Foucauldian discourse analysis was inspired by the writings of Michel Foucault who explored the 'role of language in the constitution of social and psychological life' (Willig 2001, p. 91). The approach seeks to explore the role of discourse in the constitution of subjectivity, selfhood and power relations by focusing upon discourse resources, as opposed to discourse practices. Foucauldian discourse analysts are interested in 'what kind of objects and subjects are constructed through discourses and what kinds of ways-of-being these objects and subjects make available to people' (Willig 2001, p. 91). Examples of Foucauldian discourse analytic work include: Walkerdine (1987); Weedon (1987); Hollway (1989); Parker (1992); Parker et al. (1995).

Considering the difference in focus of these two discourse analytic approaches, Foucauldian Discourse Analysis was initially selected as the most appropriate approach for the present study. In line with the research aims, such an approach would allow the researcher to identify dominant constructions of the object 'personality disorder' and consider how such constructions positioned individuals with personality disorder and with what consequences.

C.3.2 The Location of Suitable Texts for Analysis

A number of considerations played a role in the location and selection of suitable texts for analysis in the present study. Methodological considerations required a research site to provide texts or talk as data. Practical considerations required ready access to textual data within the timeframes and resource constraints of DPsych research. In addition, the particular research questions and their theoretical assumptions imposed certain requirements. As the researcher's interest lay in identifying constructions of personality disorder, texts not only needed to be clearly focused on the object of the research i.e. personality disorder, but also to provide variability in order for the broad range of

constructions to be identified. In reflecting on the research context and development of the research question, it was also important that texts be temporally matched.

Such considerations led to the decision to analyse a sample of contemporary professional, cultural and political texts, more specifically Hansard debates, newspaper articles and academic journal articles. The researcher believed that such texts would involve a broad spectrum of social actors (e.g. politicians, journalists, clinicians, academics) and would therefore provide access to the variety of discursive constructions of the object present within society. An advantage of this type of data was the accessibility, volume and range of pre-existing, publicly available texts which lent themselves to the application of the discourse analytic methods. In addition, as such texts exist within the public domain, ethical permission was not required.

A decision was made at the outset of the study regarding the number of data items to include in each data category. This decision was based upon the predicted length of the data samples and the time constraints of the research. As transcripts of Hansard debates and academic articles were predicted to be lengthier than press articles, a decision was made to analyse only six Hansard debates and six academic articles, in contrast to the 12 broadsheet and 12 tabloid press articles analysed.

Archival data were collected from the five year time period (i.e. 1999-2003) immediately preceding the data collection phase of the research study. The researcher believed this time period would provide rich material for analysis as it captured recent legislative moves regarding individuals with personality disorder and the surge in academic and journalistic writings. Similarly, in keeping with legislative moves tracked by the UK Parliament Hansard debates, journalistic and academic data was limited to the British context. Predefining a data period and national context at the outset was driven by the research question regarding mapping a particular discursive economy at a particular time and, in addition, served to make data set more manageable.

Cultural texts in the form of archival press articles were sampled through accessing websites of those British newspapers perceived by the researcher to be widely read (i.e. *The Sun*, *The Daily Mail*, *The Mirror*, *The Guardian*, *The Independent*, *The Telegraph*, *The Times*). Key words were entered into site search engines and pertinent material was downloaded. Key words included both direct reference to the object of study (i.e. 'personality disorder') and the more lateral references 'Michael Stone', 'psychopath', 'Mental Health Act', 'Mental Health Bill'. Ever mindful of the need for discourse analytic work to explore both similarities and differences in the way objects are constructed, the process of narrowing down the data set entailed the researcher reading all downloaded press articles (total number = 300) and endeavouring to choose pertinent and interesting materials whilst at the same time ensuring variability of data.

Two parallel sampling strategies were adopted in locating professional texts in the form of academic journal articles suitable for analysis. Firstly, access was gained to the online bibliographic databases PsycINFO and Medline which provide citations, references and abstracts for journal articles, books, book chapters, and research papers in psychology and psychological aspects of related disciplines (e.g. medicine, psychiatry, nursing, sociology, health). Search terms utilised in locating press articles were entered into search engines. Searches were limited to journal articles published in English language and to peer reviewed journals in the time period specified. Secondly, potential journal articles were noted and acquired during the course of the literature search conducted as part of the initial phase of the research. In narrowing down the numerous academic articles located as a result of the two sampling strategies, a decision was made to consider only editorials, as opposed to review articles or research papers. The rationale for this was that editorials are similar in form, are widely read, are more likely to discuss controversies or challenges in the field, and, as such, were perceived by the researcher to be a good way of identifying contemporary and dominant discursive constructions of the object of study. In practical terms, editorials are also often shorter than review or research articles and therefore more manageable in terms of data analysis. In addition, the researcher was mindful of variability, and chose papers published in a variety of journals so as not to get an artificial disciplinary consensus.

Political texts in the form of Hansard debates were accessed using a single sampling strategy. The United Kingdom Parliament website was accessed which provides the Official Report (Hansard), the edited verbatim report of proceedings in both the House of Commons and the House of Lords, from 1988 onwards. As in sampling strategies for the cultural and professional data sets discussed above, relevant key words were entered into the site search engine to access relevant texts. Once again, the researcher endeavoured to choose pertinent and interesting materials, whilst at the same time ensuring variability of data.

C.3.3 Data Handling and Preparation Prior to Analysis

Prior to analysis the researcher engaged in the process of coding the material as 'an analytic preliminary' (Potter 2004, p. 216) in order to make the data more manageable and allow for the tracing of analytic interpretations ⁽¹⁹⁾. As each data sample already existed in written form, no transcription was necessary. For the purposes of analysis, the data set was subdivided into four groups and each group was coded with letters: Hansard debates (H), academic journal articles (A), tabloid press articles (NT), and broadsheet press articles (NB). Each data sample was given an arbitrary numerical value (e.g. the newspaper article appearing in *The Sun* Newspaper on 21 December 2000 entitled 'Nuts to be caged for life by docs' by David Wooding was designated the code NT9). Texts were then divided into sentences, each of which was coded with a numerical value.

(19) In Appendix C1 the reader will find a list of abbreviated data references (e.g. NT12) and an explicit statement of what they refer to (e.g. The Sun 05.07.01, 'Psychopath', Neil Syson).

C.3.4 Analytic Procedure

Many authors have expressed concern over the feasibility of accurately describing or articulating the analytic procedure followed in discourse analytic studies. For example, Widdecombe (1993) argued that the skills of discourse analysis do not lend themselves to

procedural description. In attempting to specify the practice of discourse analysis, Gill (1996, p. 143) stated:

'one walks a tightrope between, on the one hand, what one might call the 'recipe book' approach to doing research, which involves laying out procedures step by step, and, on the other hand, the complete mystification of the process. While the attraction of the methodical recipe is easy to understand, somewhere between 'transcription' and 'writing up', the essence of doing discourse analysis seems to slip away; ever elusive, it is never quite captured by descriptions of coding schemes, hypotheses and analytical schemas'.

Gill (1996, p. 143)

This recipe metaphor is also utilised in the somewhat humorous comments of Potter (2004, p. 204), 'doing discourse analysis has an important element of craft skill, it is sometimes more like sexing a chicken than following the recipe for a mild chicken Rogan Josh'. Despite such pessimism, numerous authors have attempted to develop procedural guidelines for the analysis of discourse. Examples from Discursive Psychology include Potter and Wetherell (1987) and Billig (1997) and, from Foucauldian Discourse Analysis, Kendall and Wickham (1999), Parker (1992), and Willig (2001).

In the spirit of methodological transparency and creation of analytic impetus, a decision was made by the researcher to adopt the procedural guidelines outlined by Willig (2001) to guide analysis. Willig (2001, p. 109) sets out six stages in the Foucauldian approach to analysis of discourse which 'allow the researcher to map some of the discursive resources used in the text and the subject positions they contain, and to explore their implications for subjectivity and practice'. The first stage is concerned with the identification of discursive constructions and the different ways in which the discursive object (in this case 'personality disorder') is constructed through language. The second stage focuses on the differences between constructions of the discursive object and aims to locate the various discursive constructions of the object within wider discourses. Stage three is concerned with the action orientation of the text and aims to elucidate what the various constructions of the discursive object are capable of achieving within the text. The fourth stage focuses upon the subject positions, discursive locations from which to speak or act,

offered by discursive constructions and discourses identified in earlier stages. Stage five is concerned with the relationship between discourse and practice and explores the ways in which discursive constructions and the subject positions contained within them open up or close down opportunities for action. The final stage explores the relationship between discourse and subjectivity and traces the consequences of taking up various subject positions for the participant's subjective experience.

Two analytic tools were designed prior to the onset of analysis to guide the researcher through the stages outlined by Willig (2001). The first consisted of a checklist of key questions to ask the material whilst doing analysis (See Table C4 below). The second analytic tool consisted of more elaborate notes to assist analysis ⁽²⁰⁾.

(20) See Appendix C2 in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

Table C4: Analytic Tool: Key Questions for Analytic Reading

| Key Questions | Corresponding Analytic Stage (Willig 2001) |
|--|--|
| How is PD constructed through language? What type of object is being constructed? | Discursive Constructions |
| What discourses are drawn upon? | Discourses |
| What do the constructions of PD achieve? What is gained from constructing PD in this way at this point in the text? What is its function? What is the speaker / writer doing? | Action Orientation |
| What subject positions are made available by that construction? | Positionings |
| What possibilities for action are mapped by constructions of PD? What can be said and done from within different discourses? | Practice |
| What can be felt, thought, experienced from various subject positions? | Subjectivity |
| <p><u>Additional Questions</u></p> <p>What is absent? What could the speaker / writer have said that would have been different? What is left unsaid? What is the evidence?</p> | |

Data analysis then progressed sequentially, with the aid of these tools, through eight distinct phases ⁽²¹⁾.

This systematic process of data analysis is described as follows ⁽²²⁾:

Phase 1: Familiarisation

Data analysis began with reading and re-reading of material.

Total number of data samples = 36 ⁽²³⁾.

Phase 2: Analytic Notes

Each original data sample was annotated with detailed analytic notes. Every word in data samples was examined with the series of questions outlined in the aforementioned analytic tools ⁽²⁴⁾. Exhaustive analytic notes commented on key discursive constructions identified, discourses mobilised, action orientation of text, subject positions made available by constructions, and implications for practice and subjectivity. The researcher was mindful of searching for exceptions, differences, contradictions, contrasts, and absences.

Total number of analytic note files = 36 ⁽²⁵⁾.

Phase 3: Analytic Summary of Data Samples

As a means of condensing analytic notes, analytic summaries for each data sample were produced. The analytic summaries were structured into sections for discursive constructions, discourses, action orientation, positionings, practice, subjectivity and additional thoughts/information. Raw data and corresponding analytic notes (with line references) were included as evidence of analytic insights under each heading.

Preliminary labels for constructions and discourses were included as subheadings for constructions and discourses (e.g. 'PD as threat/danger', 'discourse of morality').

Analytic summaries were given a reference corresponding to the data sample in question (e.g. AnSum H1 was a condensed form of AnNote H1).

Total number of analytic summaries for data samples = 36⁽²⁶⁾.

Phase 4: Analytic Summary for Data Source

Analytic summaries for each data sample were then merged to form analytic summaries for each data source. The resulting 4 analytic summaries for data source were termed cumulative analytic summaries and followed the same format as the analytic summaries for data samples mentioned in Phase 3 above.

Total number of analytic summaries for data source = 4⁽²⁷⁾.

Phase 5: Cumulative List of Constructions & Discourses for Data Source

Cumulative lists of constructions and discourses for each data source were then compiled by referring to the cumulative analytic summaries (analytic summaries for data source). Constructions and discourses were coded with letters and arbitrary numbers (e.g. CH1 refers to a construction evident in Hansard data, DNT10 refers to a discourse identified in tabloid press data). In addition, original data sample codes (e.g. N23) were included alongside coded construction and discourse labels as evidence and to ensure that it was possible to track origin.

Total number of cumulative lists of constructions & discourses for data source = 4⁽²⁸⁾.

Academic data evidenced 134 constructions & 69 discourses.

Hansard data evidenced 51 constructions & 17 discourses.

Tabloid press data evidenced 162 constructions & 58 discourses.

Broadsheet press data evidenced 129 constructions & 47 discourses.

Phase 6: Combined List of Constructions all Data

The 4 cumulative lists of constructions and discourses produced in Phase 5 were then combined to make a single exhaustive list of constructions for the entire data set.

In this phase, the original 4 data groups (i.e. academic, Hansard, tabloid press & broadsheet press) were collapsed to form a single data set. At the outset of the analysis, data from different sources appeared superficially quite different, however, throughout the process of analysis it transpired that the discourses underpinning texts and the constructions contained within were in fact very similar. The same discourses / constructions were being manifested by journalists in media texts, politicians in Hansard debates and academics in journal articles.

Phase 6 involved similar constructions being grouped and merged under single construction labels (now denoted by CF1, CF2 etc...) and duplicates being eradicated. Coded reference to cumulative lists of constructions & discourses for data source were included (e.g. CA9) as were original data sample codes (e.g. N9).

Total number of combined list of constructions = 1⁽²⁹⁾. Total number constructions = 136.

Phase 7: Condensed List of Constructions

The combined list of constructions for all data was then narrowed down to produce a condensed list of constructions for all data. This process involved grouping similar constructions and applying an appropriate label.

Total number of condensed list of constructions = 1⁽³⁰⁾. 136 constructions from Phase 6 were reduced to a total number of 52 constructions.

Phase 8: Analytic Themes

The final phase may be considered as an extension of the process in Phase 7 above. The data set was further reduced through the grouping of final constructions under overarching analytic theme labels. At this phase, 4 final constructions were discarded from the analysis.

136 constructions from Phase 6 were reduced to 8 analytic themes⁽³¹⁾.

The analytic themes identified in Phase 8 form the basis of section C.4. Analysis of Themes.

(21) The term 'phase' is used here in order to differentiate from the 'stages' outlined by Willig (2001).

(22) A diagrammatic representation of the process is provided in Appendix C3, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(23) See Appendix C4 for coded data sample, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(24) See Table C4. See Appendix C2, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(25) See Appendices C5, C6, C7, and C8 for examples of analytic notes from each data source, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(26) See Appendix C9 for an example of one analytic summary for data sample, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(27) See Appendix C10 for an example of one analytic summary for data source, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(28) See Appendices C11, C12, C13, & C14 for cumulative lists of constructions and discourses for data sources, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(29) See Appendix C15 for combined list of constructions and discourses, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(30) See Appendix C16 for condensed list of constructions, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

(31) See Appendix C17 for list of analytic themes, construction groupings and discarded constructions therein, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

C.3.5 Reflecting upon the Evolution of the Analytic Procedure

In the first section of this methodology chapter, a distinction was drawn between two traditions of discourse analysis in psychology, namely Discursive Psychology and Foucauldian Discourse Analysis. At the outset of this research, the researcher identified with the Foucauldian strand of discourse analysis and began the data analysis phase with the intention of adopting this approach (as described by Willig 2001) to the analysis of data. As the analysis progressed, however, the researcher found herself being drawn towards analytic concepts and insights embedded within other approaches. While Burman and Parker (1993) warn against blurring approaches which subscribe to specific and different philosophical frameworks, researchers such Potter and Wetherell (1995) and Wetherell (1998) do, in fact, argue that different approaches are complementary and that any analysis of discourse should involve insights from each.

Broadly speaking a Foucauldian approach was adopted in the present study, however cross-fertilisation did occur and analytic concepts and insights were borrowed from other methodological camps. The range of textual materials analysed, from conversational Hansard debates to authoritative academic articles through to dramatic and entertaining media extracts, necessitated a broader exploration of methodological literature than was originally anticipated. The variety of data drew the researcher towards the writings of Fairclough and his analyses of media and political texts (Fairclough 1995, 2000), to Potter and Wetherell's discursive focus on discourse practices (Potter & Wetherell 1987), and to Wilkinson and Kitzinger's feminist theory (Wilkinson & Kitzinger 1996)⁽³²⁾. The researcher felt such writings were able to offer something specific to the type of text in question. In this sense, the final analysis was, in fact, contextual and driven by the need to be sensitive to the different kinds of data (Harper 1999).

(32) Evidence of such influence can be found in C.4. Analysis of Themes.

C.3.6 Evaluating Discourse Analytic Work

The importance of developing evaluative criteria for discourse analytic work has been emphasised by many researchers (e.g. Henwood & Pidgeon 1992; Potter 1996; Coyle 2006) and numerous criteria have been posited (e.g. Potter & Wetherell 1987; Henwood & Pidgeon 1992, 1994; Stiles 1993; Potter 1996; Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh 1997). Although thorough discussion of such issues is reserved for the conclusion section of this thesis ⁽³³⁾, the researcher felt a cursory mention was warranted in the methodological chapter. The criterion of transparency was forefront in the mind of the researcher at all stages of the research process, but has particular relevance to the methodological section for a number of reasons. Such a criterion serves to validate not only the aforementioned coding scheme for data and analytic insights, but also the externalisation of, and indeed justification for, the sequential progression through 8 distinct phases of data analysis. In addition, the creation of an 'audit trail' (Lincoln & Guba 1985, p. 319-321) of the research process acted as a powerful analytic tool and the significance of its role in guiding and informing the analytic procedure described above cannot be overstated ⁽³⁴⁾.

(33) See C.5. Synthesis, Evaluation & Concluding Remarks.

(34) See Appendix C18 for an example of monthly log notes and Appendix C19 for supervision meeting notes, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

C.4 Analysis of Themes

C.4.1 Introduction to Analysis ⁽³⁵⁾

This section is divided into eight analytic themes as identified in Phase 8 of analytic procedure:

- Analytic Theme 1: Threat and Danger
- Analytic Theme 2: Control and Detention
- Analytic Theme 3: Criminal
- Analytic Theme 4: Problem
- Analytic Theme 5: Labelling & Ascription of Attributes
- Analytic Theme 6: Illness
- Analytic Theme 7: Victim
- Analytic Theme 8: The Other

Constructions of personality disorder (PD) that emerged through data analysis are included under each theme, strategies by which they are achieved are articulated, and examples from raw data are included as illustrations. Segments of raw data that are included as examples are placed in single quotation marks and followed by a bracketed letter and number which refer to the original transcript ⁽³⁶⁾. Within examples, certain turns of phrase or words are underlined in an attempt to draw the reader's attention to what the researcher believes to be salient illustrations of a particular strategy of construction at work. In addition to exemplifying constructions of 'personality disorder' that emerged through data analysis, the researcher considers the subject positions made available by constructions and hypothesises the possible effects and consequences such positionings may have for individuals.

The analytic themes were devised for the sake of clarity and structure and are not independent of one another. As such, samples of raw data and strategies of construction may be included under more than one analytic theme. Moreover, the raw data presented

is used to exemplify constructions and there are, of course, many other possible examples from the raw data which have not been included.

(35) See C.3. Methodology for further information on analytic procedure.

(36) See C.3.3. Data Handling and Preparation Prior to Analysis, for further information on coding of material. See also Appendix C1 for list of abbreviated data references and an explicit statement of what they refer to, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

C.4.2 Analytic Theme 1: Threat and Danger

Individuals with personality disorder are constructed as dangerous individuals who present a threat to a number of groups, e.g. to the public, to society, to the community. They are constructed as violent, indiscriminate, uncontrollable and predatory.

Throughout the texts, individuals with personality disorder are given a variety of overt labels: 'dangerous psychopaths' (N23); 'dangerous man' (N14); 'dangerous people' (N15); 'dangerous people with' (A4); 'danger men' (N16); 'dangerous, severely personality disordered people' (H1); 'dangerous personality disordered individuals' (H1); 'dangerous people in the community' (H1), 'dangerous individuals' (A6). This frequent collocation of personality disorder with danger explicitly constructs these individuals as a threat. In fact, many of the press headlines and journal article titles themselves introduce the theme of PD as a threat and danger by incorporating within them the term 'dangerous' e.g. '“Personality disorder”, dangerous behaviour and public safety: a role for psychologists?' (A1), '“Dangerousness” and dangerous law (A2), Dangerous people with severe personality disorder. British proposals for managing them are glaringly wrong – and unethical' (A4), 'Anger at plan for indefinite detention of people with dangerous mental disorders' (N16), 'How do you decide who is socially dangerous?' (N19), 'Dangerous psychopaths may be held indefinitely' (N23).

Individuals with personality disorder are referred to by their actions alone e.g. 'nailbomber' (N7), 'killer' (A5), 'psycho killers' (N13), 'cold-hearted detached killer' (N21), 'cold blooded executioner' (N12) which serves to depersonalise or dehumanise

those individuals, reducing them to one dimension, constructing them only by their violent (and indiscriminate) threatening actions. Simple textual features like emphasising certain words through capitalisation serves to heighten the sense of alarm e.g. 'A BRUTAL killer' (N10).

The nature and abundance of graphic language used in the data samples increases the dramatic effect. It generates powerful imagery, and serves to construct PD as violent and dangerous. The theme of danger is reinforced by describing events using graphic language e.g. 'horrific hammer attacks' (N23), 'stabbed... to death' (N1), 'knifed' (N1), 'savage' (N6), 'terrorised' (N7), 'terror' (N7), 'attack' (N3), 'strangle' (N18). Such descriptions conjure images of PD as threatening and sensationalise the violent nature of the events. In his analysis of media discourse, Fairclough (1995, p. 160) discusses the 'great temptation for journalists with a story of this sort is to play up its sensational potential, the violent, horrific and wanton nature of the attack'. A particularly vivid and gory description is provided in an article from *The Sun* newspaper: 'Gran skewered to bed by killer' (N10). In addition to the graphic nature of the language, is the abundance of such terms. For example, in one press article alone an individual's actions are referred to by the verbs 'killed', 'stabbed', and 'knifed' (N1). Employing many different verbs to describe the same action event serves to exploit the story's sensational potential.

The amount of detail provided in accounts serves to dramatise the text and emphasise danger. In one article from *The Sun* newspaper the reporter states: 'Tony Gamble, 28, delivered a final knife blow through Rene Swanwick's neck and shoulder... Mrs Swanick, 86, was found with a knife piercing the right of her neck and coming out on the left side of her shoulder' (N10). Here, overt mention of the weapon and inclusion of the detail of injuries highlights the violence and brutality of the attack and emphasises the threat posed by such individuals. Similarly, in newspaper articles from *The Telegraph*, *The Daily Mail* and *The Independent* respectively, details of weapons used help to develop a text suffused with danger and violence: 'The court was told that Ruddle, 46, who killed a neighbour in Glasgow with a Kalashnikov in 1991, kept sexually explicit letters from the woman, who taught at the state hospital, disguised as lawyers'

correspondence' (N17); 'In one attack, they heard, he had used a hammer, and in another, a knife' (N3); 'Stone 41, a heroin addict diagnosed with an untreatable personality disorder murdered Lin Russell and her 6 year old daughter, Megan, with a hammer as they walked home through the Kent countryside' (N16).

People with PD are constructed as a threat / danger by both overt and covert manoeuvres of opposing them with a vulnerable victim. Overt reference to victims in the text is a powerful way of constructing PD as dangerous and threatening e.g. 'Some of the property had the victim's blood on it' (N10), 'Huge search for victims drew blank' (N5). Through providing a counterpoint of groups that society may perceive as vulnerable or helpless (e.g. stereotyped vulnerable groups such as the elderly, children, women, the unwell), an article from *The Times* newspaper highlights the danger presented by individuals with personality disorder e.g. 'Dr Shipman killed all types of people, but they were overwhelmingly female and predominantly the elderly and sick, but not terminally ill' (N21).

Authors such as Fairclough (1989) and Parker (1992) encourage the discourse analyst to attend not only to what is said in a text, but also to what is not said. By focusing on absences, the unsaid, or what the speaker could have said that would have been different, we can find further evidence of the construction of PD as a threat / danger. For example, one broadsheet newspaper article in *The Times* newspaper states, 'Josie Russell, now 15, was seriously injured in the attacks' (N23). Within this statement, Josie Russell, despite having survived the attacks, is positioned as a victim as opposed to a survivor. Had the statement read 'Josie Russell, despite attacks was able to fend off her assailant', Josie's position as a victim, along with the construction of threat and danger, would have been minimised.

By referring to victims as 'youngster' (N1), 'boy' (N1), 'little girl' (N3), 'youngsters' (N5), 'two young children' (N5), 'children' (A6), 'young girl' (N8) 'child' (N3) and citing their young age (e.g. '12 year old boy' (N1), 'six year old' (N9), 'five-year-old Victoria' (N5), '14 year old' (N3)), the texts mobilise a discourse of childhood, youth,

and innocence which serves to highlight the victim's vulnerability. Further examples of mobilisation of this discourse of childhood include: 'extract from a Harry Potter book' (N3); 'she played in the garden with her pet rabbit' (N3); 'he befriended the boy at the Phoenix Gardens playground in Covent Garden' (N1).

In one article in *The Sun* newspaper, the victim is referred to as 'elderly widow' and 'gran' (N10). This, again, uses age to highlight the victim's vulnerability. In the same article, the perpetrator's age is mentioned i.e. 'Tony Gamble, 28, delivered a final knife blow through Rene Swanwick's neck and shoulder'. This highlights his youth and contrasts it with the aforementioned 'elderly' victim emphasising her vulnerability and the threat of PD. Similar contrasts in age are provided in press articles from *The Daily Mail* newspaper i.e. '12 year old boy' (victim) and '52 year old jobless drifter' (PD) (N1), and '56-year-old shot teenage burglar' (N2).

When talking of victims, the text includes personal details and dramatises the accounts by describing events in the lives of ordinary people. As such, the text draws upon a conversational discourse of everyday life and victims are constructed 'as ordinary persons, as co-members of the world of common experience' (Fairclough 1995, p. 137). By referring to victims by first name, the author constructs familiarity, and the reader feels as though they are on first name terms with the victim, as if they know them personally. In an example taken from a newspaper article (*The Sun*), the victim is personalised by including detail of her marital status, living arrangements, her late husband's occupation, and even her pet's name: 'Mrs Swanwick lived alone with her cat Emily in West Bridgford, Notts, following the death of her husband, a World War II RAF pilot' (N10). By rooting the story in ordinary everyday life and experience, the reader is encouraged to draw parallels with their own lives and the lives of the victims. As such, the text positions us, the reader, as potential victims – "it could happen to me". Similarly, dramatising texts with quotes serves the same function in bringing the story to a more personal level, encouraging personal affect and empathy in the reader e.g. 'I did once ask what she would think if the verdict was not guilty and she said maybe she wouldn't want

to walk home on her own' (N3), 'Many years after his crimes, I asked him: "what about situations when your victims were pleading with you: 'no, please don't kill me'?' (N6).

In contrast to the way the victim is constructed, when talking of PD, individuals are depersonalised. They are referred to by surname only and little detail or personal information is provided. This contrast is apparent in the following examples taken from press articles: 'She suffered appalling head injuries in drug-crazed Stone's vicious attack with a claw hammer as Mrs Russell walked her daughters home from a school swimming gala in Chillenden, Kent on a sunny afternoon in July 1996' (N3); 'Widowed mother-of-three Eunice Yabsley, a local restaurant owner, was having an affair with Allen and lived with him for 12 years after he murdered his family' (N5); 'Stone killed Lin, 45, and Megan, 6, in July 1996 as they returned from a school swimming gala' (N23). In these examples, individuals with PD are referred to by last name only, whereas details such as the victim's first names, family position, title, occupation, ages and life events are included. By including contextual and personal information about the victims, constructing their innocence, the unjustified nature of the crime is emphasised, further highlighting the danger and unpredictability of PD.

Constructing PD as threat / danger positions the public (and the reader) as potential victims who are vulnerable, powerless and unable to protect themselves. As such, they have no possibilities for action, nothing can be said or done and they are dependent or reliant upon a higher body, an authority, to protect them. The position of authority is the only location within this discursive construction from which action can be taken. The discursive construction of danger / threat and its constituent positions therefore serves to justify any measures or action that the authorities (e.g. government) deem appropriate, measures such as control and detention. Constructing PD as a threat / danger to the public may serve to reshape the obligations of professionals, to warrant changes in their role, to encourage departure from usual conduct. Professionals may depart from actions involving consensual ways of working with individuals to less consensual options such as detention, perhaps justified by 'appeal to utilitarianism' (Semin & Manstead 1983, p. 91-

92). People positioning themselves as potential victims might be expected to feel relief or gratitude that a higher body is able to act in their interests.

Through the use of emotive language connoting fear and danger, the reader is given little choice but to feel this way. Terms like 'horrific' (N9), 'horrified' (N1), 'terrified' (N13), assume the reader too feels these emotions. A narrative of fear is built up which may provide a warrant for extreme action and inoculate against any potential challenges.

An important strategy for constructing PD as danger / threat within the texts is the use of contrast. For example, the strategy of minimising then maximising threat within the same sentence serves to emphasise threat by contrast: 'There are few people involved, but the public dangers are quite significant' (H2); 'The current system does nothing to protect those patients and it certainly fails to protect the public if a small minority of dangerous people with mental disorders in those circumstances go on to harm or even kill others or themselves' (H6). Such contrasts also serve a disclaiming function. Potter and Wetherell (1987) state that disclaimers attempt to ward off anticipated negative attributions in advance of an act or statement. People use disclaimers when they are about to do or say something which is likely to be interpreted as objectionable or offensive. In the examples cited here, the speaker, aware that what they are about to suggest may sound oppressive, (i.e. compulsory detention of individuals with PD), attempts to prevent the listener interpreting the talk in this manner.

Evoking certain imagery and mobilising contrasting discourses are also used to magnify danger and threat. For example, in an article from *The Independent* newspaper, the reporter states 'Stone, 41, a heroin addict diagnosed with an untreatable personality disorder, murdered Lin Russell and her six year old daughter, Megan, with a hammer as they walked home through the Kent countryside' (N16). Here, by contrasting the peaceful 'countryside' with the violent act of murder, the threat of PD is emphasised. In an article from *The Times* newspaper, the contrasting discourses of respectability ('Dr') and violence ('killed') are mobilised: 'Dr Shipman killed all types of people, but they were overwhelmingly female and predominantly the elderly and sick, but not terminally ill'

(N21). In articles from *The Daily Mail* and *The Times* newspapers, the contrasting discourses of childhood innocence and violence are employed: 'Why was Satanist freed to kill Diego? A satanist stabbed a 12-year-old boy to death six weeks after being freed on bail on a charge of stalking the youngster. Edward Crowley knifed Diego Pineiro 30 times in front of horrified onlookers ...He was living on benefits and sleeping rough behind the Savoy Hotel when he befriended the boy at the Phoenix Gardens playground in Covent Garden. The pair accompanied each other to amusement arcades, cinemas and the swimming pool ...A message written in capitals in typewriter correction fluid was found on a playground roundabout...The boy's cries could be heard as Crowley stabbed him repeatedly with a 6in kitchen knife' (N1). 'Stone killed Lin, 45, and Megan, 6, in July 1996 as they returned from a school swimming gala' (N23).

By contrasting the descriptors used, danger and threat are emphasised. An interesting example of this is provided in an article from *The Mirror* newspaper e.g. 'Nazi nailbomber David Copeland, who terrorised immigrant and gay communities, has been beaten up in Broadmoor by a fellow patient' (N7). In this example, the individual with personality disorder is described as 'Nazi nailbomber' and his actions as 'terrorised', however his attacker is referred to as a 'fellow patient' and his action described as 'beaten up'. The attacker is not referred to damningly like 'Nazi nailbomber' or 'terrorised', but more neutrally or mildly which mitigates the actions of attacker and emphasises the threat posed by people with PD. In an article from *The Times* newspaper, the reporter sets up an overt contrast of descriptors i.e. 'The two most important conclusions reached about the Shipman case over the past two weeks are the Home Secretary's announcement that he would never be released and Dame Janet Smith's conclusion that, despite his reputation as a kindly Dr Cameron-type figure devoted to his patients, he was a cold-hearted, detached killer' (N21).

Many different strategies are used to emphasise the threat posed by individuals with PD. For example, including adjectives, such as 'significant', 'serious', 'high' in the examples below, serves to maximise danger and the threat posed e.g. 'Fourthly, there will be new criteria giving clear authority for the detention of patients who pose a

significant risk of serious harm to others as a result of a mental disorder' (H3), 'present a high risk of harm to other people' (H3). Other texts refer to 'that attack' (N7) and 'history of sadistic sexual violence' (N12) encouraging the reader to deduce that such attacks have been numerous and that there is a high likelihood of future attacks. As such, danger is magnified and individuals with PD are constructed as an uncontrollable threat. The discursive construction of 'PD as threat' to different groups (e.g. society, the public, the community), as opposed to threat to individuals, could be seen as spreading or universalising threat, e.g. 'for the protection of the individuals concerned, their families and the wider community' (H3), 'the danger that those very difficult people pose to the community at large' (H1). Failing to specify a victim, through mention of the vague 'others', heightens the sense of unfocused danger and PD are constructed as an indiscriminate threat e.g. 'to pose a threat to the safety of others' (A2). Potter and Wetherell (1987, p. 76) state, 'justifications... claim certain actions are in fact good, sensible or at least permissible in the circumstance'. The emphasis placed upon threat posed by individuals with PD may serve as a justification for extreme measures such as control and detention.

Counterfactuals, such as those provided in the examples below, paint a bleak picture of the likely consequences of failing to act. They construct people with PD as an increasing threat and disclaim negative attributions of advocating measures of control or detention e.g. 'I know that there is concern, and that there will be controversy, but I say in all candour that unless we do something we shall see more of the problems in our constituencies of which we are only too painfully aware' (H6), 'Although the number is small, unless appropriate treatment and management are available there is a grave danger of precisely the problems that the hon. Gentleman mentioned in his speech' (H6), 'She has tried to distance herself from him and has had counselling for post-traumatic stress disorder, but feels it is only a matter of time before something happens again' (N18).

One broadsheet newspaper article (*The Telegraph* newspaper) includes a powerful metaphor constructing a helpless vulnerable victim counterpoint and, in so doing, highlights the threat of PD e.g. '"I am like a tethered lamb," she said yesterday' (N18).

Another broadsheet newspaper article (*The Times* newspaper) employs a temporal dimension by highlighting the chronology of diagnosis and violent act and succeeds in constructing PD as a time bomb, a crime waiting to happen, a constant threat to the community e.g. 'Michael Stone had a severe personality disorder diagnosed years before he killed Lin and Megan Russell, but he could not be detained under the Mental Health Act because of a legal loophole' (N23).

The declarative nature of the statements adds weight to the construction of PD as danger / threat by not allowing the audience to construct the object differently. Statements are categorical, assertive, claimlike, authoritative, and factual in their presentation not allowing anyone to disagree or question the information. There is little room for doubt and ambiguity. As such, the reader is forced to share the construction of PD as a danger and threat and concur that the only legitimate option is control and detention of such individuals. Examples such as those listed below declare individuals with PD a risk and provide no qualification or hedging: 'The people... are a risk not only to the wider community--and, especially to their families, who inevitably bear the brunt when things go wrong--but to themselves' (H3); 'the risk they pose to others' (H4); 'those with a severe personality disorder who pose a risk to others or to themselves' (H4). In an example from a Hansard debate in the House of Commons 15 February 1999, use of the auxiliary verb 'will' renders the statement categorical, 'despite the fact that future events are contingent on many things and therefore uncertain' (Fairclough 1995, p. 4). Again there is 'no qualification or hedging, no probably or maybe' (Fairclough 1995, p. 4) e.g. 'there are very dangerous, personality disordered people about who, if they are not detained, will go out and commit further offences' (H1). In one House of Lords Hansard debate, by declaring 'the level of risk' rather than stating the indeterminate 'whether they are a risk', people with PD are constructed as a threat e.g. 'The consultation paper that led up to the White Paper and the proposal for legislation outlined the need for a systematic approach to the determination of whether an individual has a severe personality disorder and the level of risk that is posed to others' (H4). In another Hansard debate, the inclusion of 'full well' negates the effect of 'could' and renders the statement, and the construction of PD as a threat, a factual assertion e.g. 'people in official

positions...know full well that they could pose a risk to others as well as themselves' (H6). Similarly, the use of assertive adverbs (e.g. 'certainly') and adjectives (e.g. 'obvious') forces the reader to share the speaker's or writer's constructions, versions of events and arguments e.g. 'The current system does nothing to protect those patients and it certainly fails to protect the public if a small minority of dangerous people with mental disorders in those circumstances go on to harm or even kill others or themselves' (H6), 'The admirable summing up by Dame Janet makes it obvious why it would never be safe to let him out' (N21). Attribution of statements to experts or authoritative sources is a key part of the rhetoric of factuality (Fairclough, 1995) and, again, the reader is allowed little room to think otherwise e.g. 'Last March, he was freed on bail despite the opinion of a psychiatrist that he was a danger' (N1). Likewise, placing certain pieces of text into inverted commas or speech marks may be 'understood by readers to mean that there is some authority for the story, perhaps even a quotable source' (Truss 2003, p. 149) e.g. 'The key word in the new term DSPD is "dangerous"' (A2), 'The public is terrified of 'psycho killers', the government is anxious to reassure them - but does this make for good law or sensible spending?' (N13). Both these strategies of attributing statements to authoritative sources and including inverted commas are used in an example from one broadsheet article (*The Times* newspaper) e.g. 'Dame Janet concluded, and it seems a very reasonable conclusion, that Dr Shipman was a deeply sinister man who could have had "a need to kill"' (N21).

Many discourses are drawn upon within the texts and serve to construct individuals with PD as a danger and threat. By evoking a discourse of horror fiction, people with PD are constructed as sinister, menacing and threatening and fear may be evoked e.g. 'There was this awful Hitchcockian moment when I saw him in the shadows coming towards the house' (N18). In an article from *The Daily Mail* newspaper, an individual with PD is referred to as a 'Satanist' (N1). In another press article, an individual with PD is described as 'a deeply sinister man' (N21) and yet another talks of 'the sheer evil of' (N5). Such examples illustrate how drawing upon a religious discourse serves to construct PD as evil, malevolent, menacing and threatening. The deployment of such a value laden discourse may serve to justify extreme measures of treatment of such

individuals under the guise of righteousness. Instances of the mobilisation of a discourse of nature construct people with PD as animalistic, uncontrollable, and violent and may be seen as a tool for justifying control measures (e.g. 'savage attack' (N3)). The verb 'kill' is often used in texts and, in contrast to possible alternatives such as 'murder', this verb draws upon a discourse of nature to construct PD as violent and inhuman, like animals. In an article from *The Times* newspaper, the reporter states 'a deeply sinister man who could have had "a need to kill"' (N21), constructing PD as uncontrollable and predatory. This predator construction is also apparent in one tabloid article through use of the verb 'stalking' (N1). In an article from *The Guardian* newspaper, in suggesting that both Saddam Hussein and Osama Bin Laden suffer from personality disorder, the reporter states 'Saddam Hussein will not give up his weapons and will lash out with everything he has if cornered' (N14). Here, people with a diagnosis of PD are constructed as an uncontrollable threat ('lash out with everything he has') and inhuman, like an animal ('if cornered'). By stating 'He remained at large for nearly a year suffering from an untreatable personality disorder as the police hunt continued' (N3), PD are constructed as an uncontrollable threat ('at large') that need to be hunted down like an animal ('hunt'). Similarly, in *The Independent* newspaper 'Danger men who slipped through the net' (N16), individuals with PD are constructed as a dangerous animal that needs to be caught ('slipped through the net'). The declarative newspaper headline 'Nuts to be caged for life by docs' (N9) constructs people with a diagnosis of PD as inhuman, animalistic and needing to be controlled ('caged').

C.4.3 Analytic Theme 2: Control and Detention

Having constructed individuals with PD as dangerous and threatening⁽³⁷⁾, the texts focus on the need for action to be taken against the threat posed. Control and detention are presented as the only legitimate options in order to ensure the safety of the general public. Individuals with PD are constructed as objects of management, manipulation and control that require the discipline, supervision, monitoring and regulation afforded by detention. This is done through the prolific mobilisation of an official authoritarian discourse of control and management. Terms such as: 'checked or supervised' (H2); 'conditions

imposed` (H1); `measures` (H1); `managing` (A4); `powers` (A3); `handle` (H2); `order` (H5); `dealt with` (H1); `govern` (H6); `force` (N9); `sanctions` (H2); `programmes` (A1); `regime` (A1); `held indefinitely` (N23); `detained` (N17); `restrained` (H1); `detention` (N13); `compulsion` (H3); `institutions` (H2); `units` (A1); `procedures` (A1); `management` (A6); `strategy` (N13); `kept` (A3); `manage` (A5); `dealing with` (N19), connote force, control, power, and management. People with PD are further constructed as powerless objects of control, who are acted upon, by the use of passive verbs e.g. `person subject to` (H4), `to direct those` (H3), `they will be held` (H3), `was freed` (N1), `was led away` (N3), `who are allowed to` (N9), `those who are sent` (H4), `are undergoing` (A2).

Declarative statements construct people with PD as objects that need to be detained e.g. `I am glad that my hon. Friend supports the changes and recognises that some of these people have to be detained` (H1), `Why has it taken so long to appreciate that a new indeterminate sentence is absolutely vital?` (H2). In one House of Commons Hansard debate, the speaker states `once in detention` (H1) as opposed to a possible `if in detention` or `if detention is necessary` and so constructs the act as necessary. In such statements, the primacy given to the option of detention and the significant exclusion of other possibilities further strengthens the construction. One House of Lords Hansard debate talks of `detention and treatment` (H2) rather than `detention or treatment` constructing individuals with PD as objects that need to be detained. The same construction is achieved in one tabloid article (*The Sun* newspaper) through use of the auxiliary verb `will` which `renders the statement categorical despite the fact that future events are dependent on many things and therefore uncertain` (Fairclough 1995, p. 4) e.g. `DANGEROUS mental patients will be locked up for life under new laws to protect the public` (N9). In such statements, there is `no qualification or hedging, no probably or maybe` (Fairclough 1995, p. 4).

Through constructing outrage at the current situation, individuals with PD are constructed as objects that need to be detained or removed from the community. This is done through use of the adverb `only` (e.g. `under the current provisions of the

Mental Health Acts, only some of those severely disordered people can be detained, and then only if the "treatment is likely to alleviate or prevent a deterioration of their condition" (H1), 'Currently in the UK, people with personality disorder can only be detained in hospital under the category of psychopathic disorder if they are thought to be treatable' (A3)). In a statement from a House of Commons Hansard debate, the auxiliary verb 'cannot' serves the same function e.g. 'Many cannot be compulsorily detained in hospital because they can be defined as untreatable under the current law' (H3), implies that people with PD ought to have been detained and so naturalises detention. Such outrage is also constructed through use of the peremptory verb 'demand' (e.g. 'Yesterday, as Crowley was jailed for life for murder, Diego's distraught mother demanded to know why the 52-year-old jobless drifter had been granted bail') and such sentiment is reinforced through dramatisation of the text with a direct quote (e.g. 'Outside, 49-year-old Mrs Fernandez said: 'How could he have taken my son away? If I ever met him I would kill him. 'Can you imagine putting this dangerous man out on to the streets and letting him get so close to my son?' (N1). Press articles utilise the phrase 'at large' in describing individuals with PD and communicating the need for imprisonment, restraint or detention e.g. 'He remained at large for nearly a year suffering from an untreatable personality disorder as the police hunt continued' (N3), 'He was at large because his illness was untreatable and therefore he could not be legally detained. (N15)

The rhetorical question provided in the headline of one tabloid press article (*The Daily Mail* newspaper) links a lack of detention of individuals with PD with the act of murder and encourages the reader to surmise that in order to prevent such eventualities detention is the only option e.g. 'Why was Satanist freed to kill Diego?' (N1). The same strategy is used in one broadsheet press article (*The Telegraph* newspaper) where the lack of detention is linked with danger e.g. 'It also emerged that Ruddle, who walked free from Carstairs after a sheriff ruled that because his personality disorder was untreatable he could not be detained, kept whisky despite fears that access to drugs and alcohol could cause a paranoid schizophrenic relapse' (N17).

The fact that individuals with PD may not be detained is attributed to a 'loophole', an oversight or mistake (e.g. 'As the law stands, only those with treatable disorders can be detained under the Mental Health Act - although Home Secretary Jack Straw has already promised to close this loophole' (N1), 'His release led to moves to block the legal loophole' (N17), 'The compulsory measures aim to close a loophole that allows people with severe personality disorders to avoid detention' (N16)) and verbs such as 'close' (N1, N16) and 'block' (N17) stress the need for this to be rectified.

Use of auxiliary verb 'should' mobilises a discourse of obligation and constructs those who fail to act, who fail to detain individuals with PD or to remove them from the community, as somehow neglectful. The audience is placed under moral obligation to take such action or allow others to do so e.g. 'Those who are sick should be taken out of the community' (H1), 'there should be new legal powers for the indeterminate but reviewable detention of dangerous personality disordered individuals' (H1), 'Dangerous people should not be allowed to walk around...' (N15).

The adjectives 'right' and 'wrong' mobilise a discourse of morality and construct the necessity for detention of individuals with PD e.g. 'It cannot be right to have dangerous people in the community...' (H1), 'it is right to detain people who have severe personality disorders...' (H1), 'why on earth is it wrong to detain people who are regarded as untreatable...' (H1). Detention is justified by suggesting that failing to do so would be to mistreat the individuals concerned e.g. 'Some of the offenders themselves have begged for the security of detention, because they do not trust themselves not to commit the most serious offences', 'we owe it to those offenders to provide incarceration' (H1). Extreme action may be morally legitimised as justifiable through such an 'appeal to values' (Semin & Manstead 1983, p. 91-92).

Detention is endorsed through emotive expressions of gratitude, appreciation and relief which encourage the reader to concur, e.g. 'Oh, good, said Josie, as jury jails Stone for second time' (N3), 'the vast majority of whom are, thankfully, detained' (H1). In one broadsheet press article, 'calls for' together with mobilisation of an authoritarian

discourse ('powers') constructs detention as necessary i.e. 'His terrible crime led to calls for powers to detain untreatable "psychopaths"' (N15). The vague 'calls for', lacking in agency, constructs consensus and encourages the reader to form the same opinion.

In an article from *The Guardian* newspaper, the use of the verb 'enable' implies that such an act of detention is required e.g. 'If it becomes law, it would enable the compulsory detention and treatment of people once called psychopaths, and now termed as having a dangerous and severe personality disorder' (N13). In the headline of one tabloid article (*The Mirror* newspaper), the use of the verb 'gets', as opposed to a possible 'given', constructs individuals as deserving of detention, as having somehow earned it i.e. 'Man who killed family in 1975 gets life' (N5). Inclusion of the adverb 'already', meaning before a particular or expected time, in an excerpt from an academic article (Clinical Psychology Forum) constructs individuals with PD as requiring detention, i.e. 'The proposals are based on the premise that the DSPD population is identifiable and small (estimated at just over 2000 people, most of whom are already detained in prison, hospital, secure units or special hospitals)' (A1).

Within this analytic theme, many strategies are used to divert potential criticism or disagreement from those arguing against the construction of PD as an object of control and detention. Authoritarian discourse is toned down by use of euphemisms. For example, the euphemisms 'positive', 'fellow citizens', and 'undertakes' are used, whilst drawing on authoritarian discourse ('units', 'regime', 'managed', 'confined'), in order to moderate the sentiment e.g. 'The new units should provide a positive regime based on education, psychological input and rehabilitation' (H2), 'However, we are making it wider than that because we are saying that in some circumstances, with care, caution and safeguards, it may be that some of our fellow citizens will have to be managed by having their liberty taken away, even though they have committed no crime' (H2), 'anyone who is committed under the system undertakes more than the normal medical examination under the Mental Health Acts, but seriously consider where such a person will be confined' (H1). Moderation is also achieved in the following statement from one House of Commons Hansard debate through inclusion

of the determiner 'some' which would give grounds for defence if this account was challenged e.g. 'I am glad that my hon. Friend supports the changes and recognises that some of these people have to be detained' (H1). Potential disagreement or criticism is acknowledged and pre-empted by overt mention of the justification of the action of detention e.g. 'I hope to set at rest any suggestion that one is simply locking up people without proper justification' (H2), 'There is ample justification in a public protection context and in the fact that many people who have serious disorders are simply not treated' (H2). Another contribution to a Hansard debate talks of 'regular, quasi-judicial reviews of the justification for detention continuing' (H1) which serves a useful function in allowing extreme or controversial actions to take place since justification for such actions will be periodically reviewed or monitored.

In one House of Commons Hansard debate, the necessity for detention is overtly stated with personal conviction and authoritative endorsement, however acknowledging the seriousness of the action and suggesting future canvassing of opinion and careful consideration prior to action serves to ward off potential criticism: 'I have outlined for the House what the Government believe is needed, but, because of the complexity of this area, and the seriousness of creating the kind of detention powers that I have described, it will be important for us to consult more widely. This will enable us to ensure both that we have not overlooked any options and that the action we take is effective and measured, commands broad support and is compatible with our obligations under the European convention' (H1). Another statement from the same Hansard debate uses the word 'process' implying well defined, well thought out stages; 'robust' implying faultlessness; and 'system', containing many components, implying failsafe e.g. 'we will ensure that the process of ordering detention involves a robust system of checks' (H1). The statement overall suggests that all angles have been covered and that detention is the only option.

(37) See C.4.2. *Analytic Theme 1: Threat and Danger*.

C.4.4 Analytic Theme 3: Criminal

Individuals with personality disorder are constructed not only as criminals, but as serious recidivistic criminals incapable of reform.

By mobilising a discourse of law and order, individuals with PD are constructed as criminals. Overt labels refer to them as 'offenders' (H1, H2, A5), 'those convicted' (H2), 'the accused' (H2), 'inmates' (N12), and the more colloquial 'crook' (N3). Judicial terminology talks of 'conviction' (H1), 'courts' (H1, H3, A3), 'sentence' (H2), 'jury' (N3, N7), 'the hearing' (N2), 'verdict' (N3), 'magistrates' (N1), 'criminal proceedings' (N3), 'plea' (N7), 'trial' (N10), 'case' (N18). One Hansard debate (H1) mobilises a discourse of criminality to construct individuals with PD as criminals with a propensity towards violence. Individuals are referred to as 'those who are capable of committing acts of a serious sexual or violent nature' (H1), but could have been described merely as 'those who are dangerous and violent'. An article from *The Mirror* newspaper draws upon an official discourse of law enforcement e.g. 'Senior detectives revived the investigation after Sergeant Peter Wycliffe-Jones, based at Kingsbridge near Salcombe, carried out research in his own time' (N5). The citation of experts in this example adds credibility to the account. The fact that the expert here 'carried out research in his own time' demonstrates his personal commitment and conviction to the cause which may lead the reader to concur with his opinion. Both official ('custody') and antiquated ('police constable') discourses of law enforcement are mobilised in one House of Lords Hansard debate 'If I walk along the street, see someone who is behaving oddly and think that he may have a personality disorder, am I to go up to the nearest police constable and say, "Take him into custody and have him looked into"?' (H2).

Having constructed individuals with PD as criminals, texts go on to construct them as serious and recidivist criminals incapable of reform. This is achieved through use of adjectives describing the individuals (e.g. 'one of the worst maniacs in our prisons' N12), their actions (e.g. 'they may commit serious crimes' H1, 'one of the most horrific crimes

ever committed' N3, 'convicted of a serious violent or sexual offence' A3), and their fate (e.g. 'jailed for life' N1, 'transfer to a top-security prison' N12). An interesting statement from one House of Commons Hansard debate suggests that the individuals themselves share this construction e.g. 'Some of the offenders themselves have begged for the security of detention, because they do not trust themselves not to commit the most serious offences... They may themselves have warned prison staff of their certainty of recommitting serious offences on their release' (H1). In this example, use of the declarative 'certainty', as opposed to a hypothetical 'possibility', strengthens the construction. An article from *The Mirror* newspaper constructs individuals as serious criminals through quantification, 'Copeland was given six life sentences at the Old Bailey' (N7). In this example, naming the court adds to the construction as it draws upon a shared knowledge that trials at the Old Bailey are reserved for serious cases.

By providing a chronological list or string of crimes committed, one tabloid article (*The Mirror* newspaper) succeeds in constructing individuals with PD as serious criminals, incapable of reform e.g. 'Born Anthony John Angel, the clerk had faked suicide in 1967 and changed his identity while being probed over cash missing from wage packets. And in the early 70s he was jailed for three years for setting fire to postbags while running a delivery service during a mail strike. In 2000 he was given a six-month suspended sentence for stealing £8,000 from Abbotsley golf club near St Neots, Cambs' (N5). In discussing the function of such lists Fairclough (2000, p. 28) states, 'what items are included in or excluded from the list matters less than their cumulative effect'. The cumulative effect here is to construct PD as serious criminals, incapable of reform.

The declarative nature of statements constructs individuals with PD as incapable of reform. For example in one House of Commons Hansard debate the statement 'unless and until they can be convicted of a further offence' (H1) instead of a possible 'unless or until' highlights the inevitability of further crime. This inevitability is echoed in other Hansard debates in declarative statements regarding 'further offences' e.g. 'there are very dangerous, personality disordered people about who, if they are not

detained, will go out and commit further offences (H1), 'the prevention of further offences is the most important consideration (H2), and academic articles' mention of reoffending e.g. 'To date, interventions of different duration, format, intensity and theoretical approach have failed to reduce reoffending risk' (A1). The adjective 'incurrible' used in one academic article in the Journal of Mental Health constructs individuals as beyond correction, reform or alteration e.g. 'a persistent incurrible pattern in the conduct of individuals' (A6).

As criminals, individuals are viewed as culpable, responsible and blameworthy for their actions. Their lawlessness and criminal behaviour are perceived as a result of their choices and are not acceptable according to social rules of a lawful society. The social action appropriate to such wilful and wrongful behaviour is correctional (e.g. discipline, punishment) and may be justified by 'appeal to principle of retribution' (Semin & Manstead 1983, p. 91-92). Constructing individuals as serious recidivist criminals incapable of reform serves to warrant extreme forms of correction e.g. imprisonment. Being constructed and positioned as a criminal therefore affords individuals with PD no rights to speak or act. By drawing on a discourse of law and order, and the power and authority held within such a discourse, the text legitimates its version of the events.

C.4.5 Analytic Theme 4: Problem

Individuals with PD are constructed as a problem through overt references to the 'problem' e.g. 'the nature of the problem' (H1), 'the problems posed by 'dangerous people with severe personality disorder' (A3), 'the social problem created by dangerous individuals' (A6). The construction is also achieved through use of synonyms of this noun e.g. 'the issue of dangerous people with a severe personality disorder' (H3), 'the difficulty' (H6), 'the dilemma posed by the "socially dangerous"' (N19), 'dealt with the matter when' (H6); and provision of the antonym 'solution' e.g. 'this is an incredibly difficult area in which to come to the right solution' (H1), 'the UK government has announced a proposed 'solution' to the problems posed by 'dangerous people with severe personality disorder' (A3). Emotive adjectives serve to

exaggerate the magnitude or severity of the problem posed by individuals with PD e.g. 'a deeply worrying social problem' (H2), 'an extremely grave problem' (H1).

The adjective 'difficult' constructs individuals with PD as a problem e.g. 'I have some concerns about that difficult area' (H6), 'There is no question but that this is a very difficult matter, and that we have a gap in provision precisely because it is so difficult (H1). In one broadsheet press article (*The Guardian* newspaper) use of adjective 'awkward' serves the same function e.g. 'A collection of his profiles of terrorists, rogue heads of state and other awkward leaders are to be published this month under the title Know Thy Enemy by the US Air Force Counter-Proliferation Centre, as a primer for decision-makers' (N14). In academic articles authors not only use the adjective 'difficult', but further strengthen the construction by mentioning the need for support and assistance in working with these individuals e.g. 'Professionals working with people described as 'personality disordered' require guidance and support to do a difficult job to the best of their ability. Moreover, local services should have policies which make clear the rules of engagement with clients with a diagnosis of PD and the types of staff training and support required to work with this difficult group of people (A6).

The verb - preposition combination 'deal with' is common across data sources and constructs individuals with PD as a problem requiring action e.g. 'in dealing with what the paper calls the "dangerous severely personality disordered." (A4), 'to deal with people suffering from personality disorders' (H2). Other synonymous verbs serve the same purpose e.g. 'to handle this matter' (H2), 'Neither the law nor services are currently geared to cope with' (H3), 'able to resolve the issue' (H5).

Through mobilising a classical mythical discourse, people with PD are constructed as a complicated and intricate problem requiring decisive action. One academic article in the British Medical Journal draws upon an ancient Greek legend, through reference to 'the Gordian knot' (A4).

Extract from academic text:

'The paper avoids descending into the apparently unending debate over what is, or is not, a personality disorder and to what extent personality disorders are treatable and attempts to cut through the Gordian knot with what presumably are intended as straightforward and practical proposals for action' (A4).

According to the legend, the first person to untie the Gordian knot (a complicated knot tied by king Gordius of Phrygia) would gain the empire of Asia. Many travellers had failed to unravel the knot, but Alexander of Macedonia solved the problem by cutting the knot with his sword and then went on to win all Asia.

The construction of PD as a complicated and intricate problem is also represented in the following metaphor from a House of Commons Hansard debate e.g. 'I thank the Home Secretary for finding what seems to be a sensible way through a tangled web and also his officials, for the way in which they have dealt with individual cases' (H1).

In addition to being constructed as a complex or difficult problem, individuals with PD are constructed as a longstanding problem by including a temporal dimension e.g. 'We have had psychiatric treatment for 80 years and the problem does not seem to be getting better' (N19), 'The dilemma posed by the "socially dangerous" has been around for hundreds of years' (H2).

The posing of rhetorical questions constructs individuals with PD as a problem to be resolved, as something about which a decision needs to be made and action taken e.g. 'what are those of us in decision-making positions to do?' (H6), 'How do we balance the rights of patients against the rights of the public?' (N15). The construction is reinforced in one House of Lords Hansard debate through use of the phrase 'get round the fact' constructing PD as an obstacle or problem e.g. 'Who will decide which patients can be detained and for how long, and how do we get round the fact that

there is no suitable definition of severe personality disorder?' (H6). In the same Hansard debate another rhetorical question constructs individuals with PD as an insurmountable problem through expressions of defeat e.g. 'Should we throw up our hands and say that there is nothing we can do?' (H6). An additional dimension of this strategy of posing a rhetorical question is to place the reader in a position to have to solve a problem. However, owing to the aforementioned complexity of the problem, such rhetorical questions are unanswerable and therefore serve to disempower the reader so justifying the need for extreme action to be taken by others.

Questions such as that posed in the title of one academic article in Clinical Psychology Forum, i.e. "Personality disorder", dangerous behaviour and public safety: a role for psychologists? (A1), immediately opens up the subject for debate and constructs PD as an object of contention, controversy, or disagreement. An academic article in the Journal of Mental Health refers to individuals with PD as 'contested patients' and 'the contested field about PD' (A6). Other texts make overt reference to the 'debate' and 'controversy' e.g. 'The management of personality disorders is currently the subject of great debate in England and Wales' (A3), 'The hon. Gentleman is right: there is controversy' (H6). An example from one House of Commons Hansard debate, i.e. 'I know that there is concern, and that there will be controversy, but I say in all candour that unless we do something we shall see more of the problems in our constituencies of which we are only too painfully aware' (H6), operates as a disclaimer. By pre-empting 'controversy' the speaker disclaims possible negative attributions consequent on the suggestion that individuals with PD should be detained.

The strategy of constructing disagreement within different communities further constructs individuals with PD as an object of contention or controversy e.g. 'substantial ambiguity in the professional evidence and views available to them about PD' (A6), 'The only clear agreement which exists about PD is' (A6), 'There is certainly not a set view in clinical circles' (H6), 'His criticism started a war of words on radio and television and in the print media, including the professional literature' (A5). In one academic article in the Journal of American Academy of Psychiatry and

the Law, overt reference is made to the 'debate' and a list of numerous participants is also included 'In this DSPD debate, politicians, lawyers, professionals, family members of both victims and patients, and human rights activists, are all key players' (A5). This detail strengthens the construction of PD as an object of contention. In one broadsheet article (*The Times* newspaper), the additional strategies of citation of experts ('historians and doctors') and employing a temporal dimension ('more than fifty years after...still') stress the difficulty of the task e.g. 'More than fifty years after Hitler's death, historians and doctors are still debating whether he had any well-defined personality disorders or a psychiatric disease' (N20).

Constructing the 'problem' as complex and with a long history serves as justification for taking extreme action despite remaining uncertainties. Paradoxically by acknowledging how difficult the problem is, how we could wait forever for a consensual opinion on a solution, any form of immediate action, however extreme, becomes legitimised.

C.4.6 Analytic Theme 5: Labelling and Ascription of Attributes

Individuals with personality disorder are constructed as objects of labelling through overt references to 'the term personality disorder' (A3), 'the label of PD' (A6), and 'a neologism' (A2). In addition, the use of synonymous passive verbs constructs these individuals as objects to be labelled, described and categorised e.g. 'are labelled as' (A1), 'described as' (A6), 'categorised as' (A5), 'be recorded with' (A6), 'commonly known as psychopaths' (N13), 'people once called psychopaths, and now termed' (N13), 'termed' (A3), 'be given a category' (N24), 'what we call personality disorder' (H4), 'was branded a psychopath' (N5). By designating overt labels, as in the case of the single word headline in one tabloid newspaper (*The Sun* newspaper) i.e. Psychopath (N12) individuals with PD are constructed as an object to be labelled from the outset. An example from a broadsheet newspaper (*The Times* newspaper) demonstrates the search for a label to apply to individuals with PD e.g. 'As with Hitler, there is a suggestion that even if he is not schizophrenic, and therefore by

definition psychotic, he may be suffering from schizotypal personality disorder' (N20). In addition to drawing on a technical discourse of diagnosis, use of the word 'even' preceding a clause of supposition or hypothesis 'if' emphasises that, whether or not the condition in it is fulfilled, the statement in the main clause remains valid. In other words, individuals with PD still need to be labelled. Providing a string or list of labels adds weight to the construction of PD as an object of labelling or, in the words of Fairclough (2000, p. 28), 'what items are included in or excluded from the list matters less than their cumulative effect'. In a statement from a broadsheet article (*The Telegraph* newspaper), numerous technical diagnostic labels are used e.g. 'Lady Kilbracken believed, however, that he is schizophrenic – there are periods where he behaves quite normally and suffers from some form of personality disorder, as well as alcoholism' (N18). Drawing on a discourse of everyday life, one tabloid article (*The Mirror* newspaper) designates a list of labels, e.g. 'John Allen, 67 –bigamist, conman and womaniser – was...' (N5).

Constructing PD as an object of labelling, an object to be described, categorised, or pigeonholed, serves to undermine an individual's autonomy. The verb 'labelling' applied to individuals, with its connotations of restriction, serves to close down, or certainly limit, possibilities for feelings, thoughts, actions and experience. A lack of autonomy positions individuals as dependent and powerless, as lacking agency, and acts as justification for their fate being decided by others. Another interesting point as regards agency is highlighted in academic texts where active verbs in conjunction with the noun 'label' construct PD as an object of labelling, but give agency to the individuals with personality disorder e.g. 'who attract the label' (A1), 'people unfortunate enough to have attracted the label "personality disorder"' (A1), 'elicit that label' (A6). This attribution of agency suggests that individuals with PD somehow invite this construction or possess some property that pulls or draws it towards themselves, they are constructed as somehow to blame. This attribution of agency serves to justify what could be perceived as harsh or extreme treatment measures.

The evaluative nature of overt labels, the adjectives chosen to describe individuals, the direct attribution of character traits to individuals, and the phraseology used to describe their actions serve to construct individuals as possessing certain personal qualities. Such strategies construct individuals with personality disorder as: cold, not revealing or affected by emotion, (e.g. 'showed a diminished emotional resonance about the plight of others' (A6), 'he was a cold-hearted, detached killer' (N21)); remorseless (e.g. 'a remorseless individual with no concern for others' (N17), 'without conscience, indifferent to the suffering he caused to others, had neither guilt, nor compassion and has expressed no regret' (N21)); and egotistical (e.g. 'Barry George was gradually laid bare as a deeply dishonest egotist who' (N24)).

Overt labels such as those provided in one tabloid article (*The Mirror* newspaper) construct individuals with PD as duplicitous, deceitful, and dishonest (e.g. 'A heartless cheat who', 'John Allen, 67 - bigamist, conman and womaniser - was', 'who fell for the fraudster.' (N5)). This construction is also achieved through the direct attribution of character traits (e.g. 'an extraordinary record of dishonesty' (N5)), and the phraseology used to describe their actions (e.g. 'Killer Allen couldn't stop lying' (N5), 'faked suicide in 1967 and changed his identity' (N5)). Use of the verb 'claimed' rather than, for example, 'stated' questions truthfulness and constructs individuals with personality disorder as deceitful, dishonest (e.g. 'George claimed to be going blind at his Old Bailey trial, a "condition" that quickly cleared up' (N12)), as does the mobilisation of a discourse of deception (e.g. 'Although 'wearing a mask of sanity, this concealed a remorseless individual' (N17)).

People with PD are constructed as possessing intelligence and charm (e.g. 'was impressed by his charm and intelligence' (N18), 'was intelligent and a smooth talker' (N17)), as chivalrous (e.g. "He always thought of all those little things a woman likes so much...When we were together in London we often went to the theatre in the West End, always with a box of chocolates for me, and he never forgot to have the drinks already ordered for the interval"(N5)), but also as using these attributes to manipulate situations to their advantage (e.g. 'who had to be observed very carefully because of his charming

and manipulative manner' (N17), 'used his superficial charm to give him greater opportunity to gain access to his would-be victims' (N21), 'he exaggerated symptoms because he felt the "sick role" protected him' (N12)). Formulations of manipulative behaviour may have the discursive effect of providing a rationale for the extreme treatment options.

Such negative evaluative labels encourage the reader to build up a negative critical view of PD and serves to justify extreme measures such as control and detention by 'appealing to the principle of retribution' (Semin & Manstead 1983, p. 91-92). In other words, individuals may be regarded as deserving of coercive or harsh treatment because of their unfavourable actions ('appealing to the principle of reciprocity', Semin & Manstead 1983, p. 91-92) or qualities ('appealing to the principle of derogation', Semin & Manstead 1983, p. 91-92).

Individuals with personality disorder are constructed as a homogenous group. In academic texts, they are referred to by acronym alone (e.g. 'centres for DSPD are' (A2), 'sums set aside for DSPD would' (A2)). In Hansard debates individuals with PD are referred to as 'groups of people with severe personality disorders' (H5), 'the small minority of dangerous mentally disordered people' (H6) 'the small cohort of patients' (H6). Similarly, academic texts talk of 'a particular group of risky people: those with a dangerous and severe personality disorder' (A5), 'individuals with DSPD constitute a group of patients whom' (A5), 'this difficult group of people' (A6). Academic texts also refer to 'the DSPD population' (A1), 'the personality-disordered' (A2).

By constructing individuals with personality disorder as a homogenous group or population, they are deindividualised and qualities attributed become generalised to all individuals with personality disorder. An example of this occurs in declarative statements such as those made in one broadsheet article (*The Times* newspaper) e.g. 'People with a schizoid personality are indifferent to normal social considerations and what others think of them. They are emotionally restricted and happy to exist without close relationships. They do not display great anger or joy, are indifferent to praise and are cold and aloof. They are goal-orientated' (N20). Constructing individuals with PD as a homogenous group serves to undermine or deny their

autonomy and restrict their opportunities for action and experience.

By discussing individuals with PD in relation to other groups or individuals the reader is encouraged to draw parallels between the two. The following passage from an academic article in the Journal of Mental Health illustrates how people with PD are constructed in relation to politicians and how negative attributes such as egocentricity and dishonesty, commonly ascribed to politicians, become a defining construction of individuals with PD as well.

Extract from academic article A6:

'Also, within current western democracies what of politicians themselves? The sub-cultural norms of party politics and government entail egocentric careerism, recurring insincerity and impression-management ('spin'). We have now come to expect politicians to be untrustworthy and their activities (such as press conferences and party conferences) to be 'stage-managed'. New accounts of sexual or financial corruption ('sleaze') create little surprise, let alone shock, in the electorate. Given this picture, are many of our elected politicians suffering from some version of dramatic PD? Can their brazen actions be readily distinguished from those 'suffering' from ASP or histrionic personality disorder? Are PD patients failed politicians? The fact that these questions can be posed so readily demonstrates the blurred line between PD and normality' (A6).

In Hansard debates individuals with personality disorder are discussed in relation to sex offenders. For example, within the debate held in the House of Commons on Monday 15 February 1999, participants oscillated between discussion of individuals with personality disorder and sex offenders. The debate is entitled 'severe personality disorders', and frequent mention is made of 'severely personality disordered individuals', however within the debate references are also made to 'convicted sex offenders', 'life sentences for sex offenders', 'known sex offender', 'the sex offender review', 'sex offender order' (H1). Such a proximity effect constructs PD as sharing qualities with sex offenders. Sex offenders, as society's villains, are universally constructed as amoral, deviant, and being grouped with such individuals, means individuals with personality disorder are constructed in the same way.

Similarly, constructing individuals with PD in relation to the political figures such as Osama bin Laden, Adolf Hitler and other notorious figures such as the Yorkshire Ripper Peter Sutcliffe may encourage sentiments of repugnance, loathing and fear in the reader as such figures, certainly within the UK, are perceived as ruthless and cruel. Grouping them with individuals with personality disorders renders the latter tainted with the same characteristics.

Examples:

'This particular brand of personality disorder exhibits itself in an extreme lack of empathy for others, paranoia, the absence of conscience and a readiness to use violence to achieve goals. Post believes Bin Laden is suffering from the same malady' (N14)

'As with Hitler, there is a suggestion that even if he is not schizophrenic, and therefore by definition psychotic, he may be suffering from schizotypal personality disorder' (N20)

'Secure mental hospital Broadmoor, which houses Yorkshire Ripper Peter Sutcliffe, is expected to take him' (N12).

By constructing individuals with PD in relation to other groups or individuals, the ways of being and opportunities for action for each become the same. The merging of the two groups means that the forms of treatment or discipline appropriate for one group become possible for another group. For example, current constructions of sex offenders mentioned earlier (i.e. villainous, amoral, deviant) serve to justify punitive measures of detention or removal of these individuals from the community. It could be argued that as individuals with PD are constructed in relation to or the same as sex offenders, they should be dealt with in same way.

C.4.7 Analytic Theme 6: Illness

Personality disorder is constructed as an illness through the mobilisation of a medical discourse. The overt use of medical terminology (e.g. 'diagnosis' (H2), 'treating' (H4), 'prognosis' (N4), 'cured' (A4), 'symptoms' (N20), the inclusion of technical diagnostic categories (e.g. 'had a paranoid personality disorder' (N2), 'assessed as having a histrionic personality disorder' (N12)) and use of the acronym 'DSPD' (H6) succeed in mobilising a specialist medical discourse and construct PD as an illness. One jargonistic example from an academic text (British Medical Journal) reads like an actual excerpt from medical case notes or a psychiatric report e.g. 'antisocial and self damaging behaviours are at least in part a product of abiding character traits such as impulsivity and suspiciousness combined with abnormalities of mental state, including instability of mood and dissociative symptoms' (A4). Across data sources frequent references are made to the 'patient' (e.g. N14) and individuals are described as 'suffering from' (N20), 'having' (N12), 'displaying clear signs of' (H3) personality disorder. A lay medical discourse is deployed in talking of 'people... who are desperately sick' (H1) and 'he is unwell' (N18).

This medical discourse contains within it the positions of those who offer treatment through their medical knowledge (e.g. medics, health service professionals) and of the less knowledgeable non-medics and patients who receive their care. Through this discourse, individuals with PD are positioned as patients, as suffering from an illness for which they are not to blame. As patients, they deserve help and have the right to receive medical care and treatment (e.g. 'care they need' H3, 'treated and cared for' H3, 'looked after and treated' H4). Individuals positioned as the less knowledgeable non-medics have no rights to take action or make decisions about the care of these individuals, but have the right to expect correct decisions to be made and action to be taken on their behalf. Medics through their superior knowledge are obligated to make such decisions and take action. People drawing upon this discourse, and positioning themselves as non-medics / laypersons might be expected to feel sympathy for patients suffering from an illness. Such a feeling may be influenced by the

humanisation of individuals (e.g. 'people suffering from' H1) encouraging us to draw parallels with our own lives. Those positioning themselves as medics might feel responsible for their care.

When the construction of PD as illness accompanies mention of dangerous or threatening acts (e.g. 'Michael Stone had a severe personality disorder diagnosed years before he killed Lin and Megan Russell' N23), the position of a patient may remove the aspect of responsibility as their actions are attributable to their 'illness', and by implication they are not responsible or blameworthy. Actions are pathologised and excused by labelling individuals as ill or diseased ⁽³⁸⁾. The individuals themselves are victims of illness and the social action appropriate to this is medical treatment. The deployment of a medical discourse helps to construct dangerous or threatening acts in such a way as to warrant medical intervention. Responsibility lies with the agency charged with their care. In this instance, people positioning themselves as non medics may feel anger towards the agency that failed to adequately care for these individuals and could have prevented the events (in this case, the murders). Those positioning themselves as medics / health service professionals might feel guilty for the apparent failings of their profession. Equally they might feel angered and feel that they are wrongly held accountable for the events. Those positioning themselves as patients might feel the agency responsible have failed to look after them, that they are victims of the system.

One could argue that positioning people with PD as patients affords individuals more rights than for example positioning them as criminals (i.e. the rights to receive care and treatment as opposed to punishment and correction). However, the paternalism implicit in a medical discourse may, in fact, serve to justify coercive measures, such as involuntary hospitalisation, under the guise of treatment. Similarly, in contrast to the humanised suffering patient position discussed above, at times people with a diagnosis of PD are dehumanised and constructed only as an illness, an objective clinical category, a diagnosis ('for DSPD' A2, 'those with the diagnosis' A6). The act of dehumanising individuals precludes an empathic response in the reader and may serve to gather support for more coercive measures of treatment. The deployment of an archaic psychiatric

discourse (e.g. 'was mad' N4, 'the madhouse' N8, 'asylum' N8) conjures images of an historic era where coercive treatments, such as detention, were universally advocated and employed for those suffering from mental illness. The mobilisation of such a discourse may serve to justify the current need for such extreme treatment measures for individuals with personality disorders.

The use of quotation marks and the citation of experts were discussed earlier under 'Analytic Theme 1: Threat and Danger' as strategies for encouraging the reader to share the speaker's or writer's constructions, versions of events and arguments. Here, such strategies serve to amplify the authority and expertise implicit in a medical discourse and the reader is forced to share the author's constructions of PD as illness e.g. '...people who have been diagnosed as having "severe personality disorder"' (A1), 'Philip Joseph, a consultant forensic psychiatrist who examined Martin for six hours after his conviction, told the court the farmer had a 'paranoid personality disorder' and was depressed in the run-up to the shooting' (N2), 'Had Diana been suffering Borderline Personality Disorder it would, experts say, have rendered her incapable of being able to cope with the responsibilities of motherhood, let alone royal duties' (N4). Similarly, the power implicit in a medical discourse is reinforced by mobilising a complementary scientific discourse. For example, one contribution to a House of Commons Hansard debate deploys a discourse of scientific legitimacy e.g. 'recognised severe personality disorder' (H1) and other texts draw on an authoritative discourse of scientific method and statistics e.g. 'evidence' (H5), 'proof' (N2), 'experimental ... cohort of patients ...proportion' (H6).

Having constructed PD as an illness, texts range from pessimism through confusion to optimism regarding the issue of treatability. Examples from both Hansard debates and academic texts construct PD as an untreatable illness. Declarative statements refer to individuals with PD as 'the untreatable' (A2), 'people who are not treatable' (H1), and those who 'cannot be treated' (H3). A more subtle strategy for constructing PD as an untreatable illness is that of providing a sentence adverb, expressing the speaker's view of the likelihood of the state of affairs denoted by the sentence (Trask 2000) e.g. 'there is a continuing debate about what treatments, if any, are effective in

dealing with such severe personality disorder' (H1). Here, the inclusion of 'if any' alludes to expected failure regarding treatment. Constructing PD as untreatable may serve to justify extreme actions such as detention as other, less extreme, treatment efforts may be perceived as futile. On the other hand, futility or hopelessness may lead to a withdrawal or reluctance of professionals to treat individuals with PD and the individuals may be neglected or disregarded, and may receive no care or service.

Other Hansard texts construct PD as an object of confusion or contention among the medical community regarding treatability. This is done through the concurrent deployment of a medical discourse and the construction of disagreement e.g. 'One cannot find unanimity of clinical perception about precisely what the disorder is, or whether it is treatable' (H2), 'One psychiatrist will regard an individual as untreatable while another will be prepared to accept the same person for treatment' (H2). Constructing PD as an object of confusion or contention, among even experts, may create feelings of apathy regarding treatment efforts and serve to justify inaction. Alternatively, constructing disagreement or dubiousness about treatment efficacy may lead to feelings of unease and therefore reliance on extreme, or 'tried and tested', actions such as control and detention. Optimism is expressed through constructing PD as an illness awaiting the discovery of an effective form of treatment e.g. 'It is as wrong in psychiatric medicine to regard treatability as something that is fixed in time, as it is in any other sort of medicine, whether oncology or another specialty' (H1), 'As the science develops --the science not only of psychiatry, but of clinical psychology and many other disciplines--a condition that we previously regarded as wholly untreatable may become treatable' (H1). The use of a medical and scientific discourse to express optimism, allows the speaker to construct hope by which the audience may be reassured that efforts are being made by the medical profession to develop appropriate treatment methods. The utilisation of a positive and optimistic discourse of scientific success and progress, the rhetoric of increasing knowledge and scientific advancement, serves to justify any action suggested by these experts and defends such action from possible challenges.

Although PD is constructed as an illness and individuals are thus positioned as patients, a distinction is drawn between them and other patients. For example, one headline from a broadsheet newspaper (*The Times* newspaper) reads 'No symptoms of ordinary madness; Medical briefing' (N20). By drawing on official/technical ('symptoms...medical briefing') and lay ('madness') medical discourses, PD is constructed as an illness. However, the negation explicit in this statement constructs PD as different to 'ordinary madness'; as extraordinary; as different to other 'madness' patients. Similarly, individuals with PD are constructed as different to other patients through references to the 'patient' and 'subjects' in contrast to 'normal clients' (i.e. 'Everything is in place except his patient... He still has a few normal clients who turn up in person at his pleasant home in the wooded outskirts of Washington, but many of his subjects are referred to him by the US government' N14).

Not only are PD constructed as different other patients, but also as less deserving or less worthy. They are constructed as competing with other patients for attention, assistance and resources. The strategy of providing a counterpoint, of opposing PD with a more 'worthy' patient group, is used to construct PD as less deserving patients e.g. 'It is hard not to conclude that the large sums set aside for DSPD would better be targeted at improving health care for those already legitimately detained, suffering from illnesses for which proven treatments exist' (A2), 'But the growing emphasis on "dangerousness" is curtailing primary care trusts' development of services for people with low-risk mental health problems' (N13). In the following example, the additional strategy of citing an expert and including a direct quotation adds authority and weight to the argument e.g. 'Matt Muijen, director of the Sainsbury centre for mental health, said many inner-city NHS trusts were struggling to deal with a small number of extremely disturbed clients, diverting services from helping people at the onset of a mental illness before they reach crisis. "The disparity in investment hits you in the face," he said' (N13).

The use of the adverb 'regrettably' in one House of Lords Hansard debate constructs PD as less deserving of attention e.g. 'Although the Statement makes it clear that such people

are small in number compared to the large number of people with a treatable mental condition, the whole balance of the Statement is, I think, regrettably skewed towards this subject and away from others of at least equal importance' (H4). The qualification 'I think' offered in this example has the effect of introducing tentativeness which may be useful since any challenge can be met with the response that only a tentative hypothesis was being proposed. In one tabloid article (*The Mirror* newspaper), use of the discourse marker / sentence connector 'but' rather than a possible 'and' expresses disagreement and outrage whereby people with a diagnosis of PD are constructed as less deserving, as needing to be treated differently e.g. 'But he was diagnosed with a personality disorder and went to Broadmoor. There he is allowed a TV and CD player and has access to a gym' (N7).

Another example of the construction of individuals with a diagnosis of PD as less deserving is provided in the headline of a broadsheet newspaper article (*The Guardian* newspaper) where the journalist uses sarcasm / irony to construct PD as less deserving than individuals suffering from other 'illnesses'. The example reads: 'Come back when you're really sick. The public is terrified of 'psycho killers', the government is anxious to reassure them - but does this make for good law or sensible spending?' (N13). The first sentence in this example reads as an imperative sentence, where, through the mobilisation of a lay conversational medical discourse (i.e. 'sick'), PD is constructed as an illness. The sentence is referring to generic patients being turned away by health authorities in favour of individuals with PD who are regarded as more ill, more deserving. The use of 'really', an extreme case formulation, questions the authenticity of the generic patient. The authorities (perhaps the government, health professionals) are addressing and telling the public that they are not worth looking at, not ill enough, and that there are others more deserving and in need. However, the journalist's sarcasm negates the literal meaning of this statement. Although this statement literally constructs people with a diagnosis of PD as more deserving than other patients, the sarcasm within it constructs PD as the opposite, as less deserving. Through sarcasm the journalist claims co-membership with the reader / public, and positions them as wronged, unfairly treated by the authorities and PD as less deserving than the generic patient. This same strategy (i.e. sarcasm / irony) is exemplified

again later in the same article 'So if you walk around with a hammer you get an all-singing, all-dancing new unit and high- cost intensive care' (N13). PD are constructed as less deserving and other patients as neglected.

Drawing a distinction between individuals with PD and other 'patients', constructing them as different to or less deserving than other patients, may serve to deny individuals the rights commonly attributed to the 'patient' position. By constructing individuals with PD as less deserving they may lose the aforementioned rights of patients to receive care and treatment and coercive actions such as detention and control may be legitimised.

(38) This attribution of responsibility or blame is in stark contrast to that discussed in Analytic Theme 3: Criminal.

C.4.8 Analytic Theme 7: Victim

Individuals with personality disorder are constructed as victims through depictions of mistreatment and neglect at the hands of both medical and forensic services e.g. 'system has failed people with personality disorders' (H2), 'rejecting people with personality disorder from services (A5), 'written off or dumped in institutions without hope' (H2), 'a group that has received shamefully little attention from health services' (A2). The use of the verb 'threatened' (e.g. 'threatened with detention' (H4), 'threatened with compulsory treatment' (H6)) suggests imminent harm, danger, or pain for the individual. Individuals are constructed as suffering (e.g. 'people who suffer from such disorders' (H1), 'those who undoubtedly suffer' (H1), 'he suffered these moods' (N21)); as distressed (e.g. 'distressed and disturbed individuals' (A4), 'their distress' (N4)); as vulnerable and frightened (e.g. 'his mental problems, it was said, combined to create a frightened man' (N2)); all of which contribute to the construction of PD as a victim.

Individuals with PD are constructed as victims of injustice e.g. 'There were and may still be people who entered a custodial regime for what we would regard as no proper

reason and what should then have been identified as no proper reason` (H2), `Even now, there are patients in Broadmoor who have never injured anyone` (N15), ` the nightmare scenario of finding in 25 years' time that someone has been wrongfully detained from the beginning? (H1). One tabloid article from *The Daily Mail* newspaper reports on the appeal case for Tony Martin, convicted of murder for shooting a burglar in 2000, and constructs PD as a victim of injustice by highlighting legal incompetence e.g. `The case put forward by the defence at the original trial had only ended up helping the prosecutionHis lawyers had also appeared to misunderstand the evidence of their ballistics expert` (N2).

Drawing on a discourse of morality, personality disorder is constructed as a value judgment thereby constructing individuals with personality disorder as victims of labelling e.g. `The distinctive moral character of the diagnosis` (A6) , ` the term is a device for attaching the scientific prestige associated with health with what are essentially judgements of value` (A3). This construction is also achieved through use of adjectives e.g. `people unfortunate enough to have attracted the label "personality disorder"' (A1). In discussion of the late Princess Diana, an article in *The Mirror* newspaper, refers to the act of labelling her with PD as `bad taste and insensitive... irresponsible and cruel` (N4), and the label itself as `an incredibly damning one` (N4). This constructs her as a victim of labelling and implies that such a label is derogatory and insulting, tarnishes her reputation and judges her value. In another press article (*The Guardian* newspaper), by drawing the reader's attention to the chronology of an individual being labelled and subsequently detained, the reader infers causality between the two events and constructs PD as a victim of labelling e.g. `One severely depressed woman acquired a "public danger" label after admitting to her psychiatrist that she fantasised about kicking over pushchairs on the street; she is now in a maximum security hospital` (N15).

Individuals with PD are constructed as victimised, as selectively punished or ill treated, e.g. `the further marginalisation of an already disadvantaged section of society` (A6). In one broadsheet article (*The Guardian* newspaper), the verb `stripped`

suggests that the individuals have been mistreated or deprived and the adverb 'simply' reiterates the unjustness e.g. 'As a specialist mental health lawyer, I represent patients who have been stripped of many rights simply because they are ill' (N15). This construction is also achieved through mobilising a discourse of comparison, where individuals with PD are constructed as unfairly treated in comparison to other individuals e.g. 'even those with severe symptoms wait 18 months for treatment – three months longer than the maximum waiting time for physical illness' (N13), 'a relatively ignored group of mentally disordered people' (A4), 'Has anyone asked them what they [individuals with personality disorders] think, especially at a time when other sections of mental health policy emphasises the involvement of the "consumer" whenever possible?' (A5).

The mobilisation of an ethical discourse encourages the reader to draw upon moral principles or values and constructs individuals with PD as potentially wronged (e.g. 'Discussion of the ethical dilemmas that these proposals present for health professionals is absent, presumably because they are ethically and professionally indefensible' (A4), 'The suggestion that someone should be incarcerated without limit of time, having committed no offence at all and not being incarcerated for treatment because, ex hypothesi, there is none, seems to raise a very difficult question' (H4), 'Can we really detain someone because we think it more likely than not that in future that person will commit some act of violence...?' (H4).

Through deployment of a discourse of human rights, individuals with PD are constructed as victims, as being denied the rights to which human beings are entitled, for example the right to liberty (e.g. 'Preventive detention in any setting is wrong and contrary to the spirit of freedom and liberty' (A5), 'those of us who are worried that too many civil liberties will be lost in the name of public protection' (H6), 'will violate the human rights of those concerned' (H5)).

In an extract from one broadsheet article (*The Guardian* newspaper), a number of strategies operate. It reads 'According to mental health campaigners the draft bill, while

succeeding in its primary aim, threatens the civil liberties of the mentally ill and fails to improve the care of the vast majority of patients' (N13). This statement draws upon a discourse of human rights ('civil liberties') and uses the verb 'threatens', suggestive of harm, to construct PD as victim. The citation of experts and attribution of statements to authoritative sources ('according to mental health campaigners') makes the argument more credible, as does the mobilisation of a discourse of statistics ('vast majority') which draws upon a 'cautious and authoritative discourse of science and other academic disciplines' (Fairclough 1995, p. 131). However, the statement is mitigated by 'according to' which serves to question truthfulness and the foreground 'while succeeding in its primary aim' which may act to disclaim anticipated negative attributions (Potter & Wetherell 1987) linked with measures of detention advocated in the draft bill.

By mobilising a historical discourse and discussing individuals with PD in relation to other groups or individuals who have been mistreated, victimised or oppressed, the reader is encouraged to draw parallels between the two and construct PD as similarly treated e.g. 'Although I recognise that there is a problem here, has my right hon. Friend looked at some of the precedents: internment without trial in Northern Ireland was justified on exactly the same basis—that people who had committed no offence should be kept out of the public domain without a trial? In the Soviet Union, that practice was widely followed because it can be easily abused' (H1). Another example from a House of Lords Hansard debate discusses individuals with PD in relation to the 'witches of Salem', those individuals tortured and executed in Massachusetts USA in 1692 having been accused of witchcraft e.g. 'one does not want the "witches of Salem" tendency' (H2). The same debate also draws parallels between the treatment of individuals with PD and the historical persecution of women e.g. 'I think back to all those women who spent lifetimes in asylums often because they had simply had an illegitimate child' (H2). Both Hansard and academic texts mobilise a historical discourse through mention of Draco the seventh century BC Athenian lawgiver whose laws were notorious for their severity, the death penalty being prescribed for trivial offences. As such PD are constructed as victims of a harsh punitive regime, e.g. 'I hope that all hon. Members will recognise the desperate need for resources and for

improving the morale of people working in the mental health service, and for those things to be done before powers that are too draconian are taken in legislation' (H6), 'The new proposals were so draconian that I seriously thought they would go away with time' (A5).

Academic and tabloid texts mobilise a literary discourse. A statement from one academic article in the *Lancet* reads, 'It now threatens to assume an Orwellian air, as the socially undesirable risk indefinite incarceration in psychiatric (or pseudopsychiatric) institutions' (A2). The use of the adjective 'Orwellian' characterises the novels of George Orwell (d1950) depicting the way in which people are manipulated and controlled by an authoritarian state (Orwell 1961). This adjective, in combination with the alarmist verbs 'threatens' and 'risk', construct individuals with PD as victims. Another academic article from the *Journal of American Academy of Psychiatry and the Law* provides a similar example: 'Suddenly, I am rudely awakened, sweating, and weighed down by the same intense dysphoria experienced by poor Alex in Anthony Burgess' (and famously in Stanley Kubrick's 1971 film treatment) 'A Clockwork Orange'. His dream of cure merged with the reality of the so-called treatment and it was no less abhorrent' (A5). Here the individual with PD is constructed in relation to the character Alex, victimised through use of the adjective 'poor'. One tabloid article (*The Daily Mail* newspaper) constructs the individual with PD in relation to the fictional character Miss Havisham e.g. 'He only reacted to shake his head when claims were made about the ramshackle state of the garden at the dilapidated Bleak House where he lived alone with a huge collection of teddy bears.... He then compared Bleak House to the home of Miss Havisham in the Charles Dickens novel 'Great Expectations' and said he had become 'fossilised in time' (N2). Miss Havisham, having been abandoned at the alter, chooses to withdraw from society. As a victim of betrayal, she lives a bitter, sorrowful and pitiful existence.

Through the use of emotive terms within declarative statements, in Fairclough's terms 'the vernacular language of affect' (Fairclough 2000, p. 7), the reader is told how they should be feeling e.g. 'It is worrying that the Secretary of State uses language such as, "If

people refuse treatment, they will be compulsorily detained." (H6), 'It is damaging and disappointing that the Government stand poised to implement the much-needed updating of the Mental Health Act 1983 with what could be considered repressive legislation, and to lock up people with untreatable personality disorders indefinitely' (H6), 'Martin's life sentence at Norwich Crown Court last year was greeted with fury by law-and-order campaigners who backed the right of property owners to defend their own home' (N2). Such examples illustrate how the reader may be encouraged to feel worry, concern, disappointment, and anger at the way individuals with PD are treated.

Statements from academic articles construct the government as a wrongdoer and so position individuals with PD as victims. This is achieved through questioning the sincerity of the government's actions, highlighting their hypocrisy, and the lack of justification for their behaviour e.g. 'if these proposals were really about providing care and treatment for the personality disordered' (A4), 'At the very time that the home office was pursuing a policy of preventative detention for some dangerous people with a diagnosis of PD who may have committed no crime, it refused to ban Tyson's matches in Manchester and Glasgow' (A6), 'That is no excuse for detention for those with personality disorder, or for compulsory treatment, but it is an argument for better follow-up, more support for those patients and ensuring that they remain in touch' (H6).

The evocation of a psychological discourse serves to construct individuals with PD as victims through the attribution of causality to adverse events e.g. 'People who suffer from personality disorders.... have often experienced trauma in their lives' (H6), 'Emotional abuse was an overriding factor in Andrew's personality disorder: he just wasn't being heard' (N22), 'If Diana was demanding, prone to dark moods and indulged in self-pity and bouts of gloom, it was because her husband's behaviour instigated it' (N4). Individual's actions result from traumatic or abusive experiences at the hands of others. This succeeds in absolving individuals of responsibility or blame. As discussed under 'Analytic Theme 6: Illness' this may serve to warrant less severe treatment options (e.g. care and treatment versus punishment and correction).

The contrast provided in one tabloid article (*The Daily Mail* newspaper), i.e. 'He was living on benefits and sleeping rough behind the Savoy Hotel when he befriended the boy at the Phoenix Gardens playground in Covent Garden' (N1), constructs individuals with PD as underprivileged and disadvantaged. Within 'Analytic Theme 1 – Threat', the contrast between the inclusion of contextual and personal information about victims and depersonalising dehumanising individuals with PD (the perpetrators) was discussed as highlighting the danger and threat posed by PD. Within this theme, people with PD are constructed as victims and we can see the same strategy, although reversed, in operation. The texts include personal details, draw upon a conversational discourse of everyday life and individuals with PD are constructed as ordinary persons, as co-members of the world of common experience. The use of pronouns encourages the reader to draw parallels with their own lives and the lives of individuals with PD e.g. 'I am sure that my right hon. Friend will agree that it is very difficult—perhaps it is the most difficult thing of all--to prove that one is not dangerous'(H1), 'If Diana: The Story Of A Princess does anything at all it is to remind us how a torturous relationship can colour everything we do, make us act irrationally and out of character' (N4), 'Any woman who has lived with rejection, suffered a broken heart, spent nights crying into their pillow in frustration, anger and bitterness can relate to Diana' (N4), 'And we felt her pain' (N4). In an article from *The Daily Mail* newspaper, whilst constructing as victim of injustice through legal incompetence, the individual with PD is referred to as 'the farmer' and so draws on a discourse of everyday life to construct PD by occupation, to normalise or humanise him, to construct his ordinariness. The same article goes on to state, 'Bachelor Martin – who was convicted 18 months ago of the murder of 16-year-old Barras – maintains he fired his pump-action Winchester shotgun three times in panic at his isolated home when confronted by two burglars' (N2). The inclusion of 'Bachelor' and 'isolated home' constructs PD as vulnerable and alone. By stating 'Winchester shotgun' as opposed to just 'gun', the reader views the weapon as a farming gun used for self protection and the individual is constructed as a victim. Similarly, 'three times in panic', and later in the same article 'on the stairs when he opened fire into the night', constructs the individual's action as self defence motivated by fear as opposed

to intent to harm. Constructing PD as ordinary and unassuming contributes to the construction of PD as vulnerable victim e.g. 'He just wants to live in the country and get on with his life as a farmer' (N2), 'a 'man who goes through life still considering himself as a boy of ten' (N2). Highlighting the individual's youth, innocence, and vulnerability e.g. 'young boy', and describing the individuals suffering e.g. 'terror' further strengthen this construction e.g. 'The court also heard startling medical claims that Martin suffered from sexual abuse as a young boy which led to problems with forming relationships with women and a terror of intruders' (N2).

Within the analytic theme 'victim', various discourses (e.g. ethical, human rights, historical, literary) are drawn upon to claim that extreme actions (e.g. detention), warranted by constructions within other analytic themes, damages the quality of life of individuals with PD and is unethical. In contrast to other analytic themes (e.g. Analytic Theme 1: Threat and Danger, Analytic Theme 3: Criminal), here, the authorities (e.g. medical, forensic, government, legal systems) are vilified and positioned as the offender / perpetrator. Embedded within this is an implicit appeal to the public / reader as witness. This is the only analytic theme which positions the public / reader in a potentially active role. Analytic themes such as 'Illness' and 'Criminal' absolve the public / reader of this responsibility, this power to act by giving this agency to authority. Constructed as victims, individuals with PD are in the position of requiring someone to act on their behalf, and the public / reader is empowered to do so. Individuals positioned as witnesses have the right to take action or make decisions about the care of these individuals.

C.4.9 Analytic Theme 8: The Other

The strategy of distancing, of fostering polarisation, constructs individuals with PD as separate and different to a variety of groups. By providing a counterpoint, by opposing individuals with PD with 'the public' they are constructed as 'the other' e.g. 'a group of dangerous, severely personality disordered individuals from whom the public at present are not properly protected' (H1), 'people who have been diagnosed

as having “severe personality disorder” and whose dangerous behaviour is believed to pose an unacceptable risk to the public` (A1). Through the mobilisation of a financial discourse in one broadsheet article (*The Guardian* newspaper), individuals with PD are set in opposition to the `the public` and so constructed as `the other`, e.g. `How do we balance the rights of patients against the rights of the public?` (N15). Pronouns such as `those` and `them` refer to people other than the speaker or people addressed and succeed in constructing PD as `the other` e.g. `those very difficult people` (H1), `those with a severe personality disorder` (H3), `And where no daft do-gooders can let them run riot` (N8), `Ministers want to close a loophole that allows them to refuse medical attention` (N11).

By opposing individuals with PD with other groups of individuals, people with PD are constructed as different. For example, people with PD are constructed as distanced from other criminals, as serious criminals e.g. `propensity of such people to commit the most serious sexual and violent acts` (H1). They are constructed as different to other patients and prisoners, as requiring different or additional treatment e.g. `many of those people will not be treatable in the normal sense` (H1), `ensure that anyone who is committed under the system undertakes more than the normal medical examination` (H1), `offer "bespoke" therapy and incarceration for people who are known to be severely disruptive` (N19).

Individuals with PD are constructed as lacking or deficient (e.g. `personality disorder exhibits itself in an extreme lack of empathy for others... the absence of conscience` (N14), `They are devoid of remorse` (N20)), and incapable (e.g. `Had Diana been suffering Borderline Personality Disorder it would, experts say, have rendered her incapable of being able to cope with the responsibilities of motherhood, let alone royal duties` (N4), `And the cold-blooded executioner –who shot Jill, 37, dead on her doorstep – feels no remorse and is incapable of loving anyone but himself` (N12)). They are constructed as flawed, impaired or damaged (e.g. `She wanted to discover exactly what was wrong with Patrick` (N18), `My Lords, will it be a valid ground of appeal that the personality defect is not treatable?` (H5)). Individuals are constructed

as abnormal through overt references (e.g. 'on the basis of abnormal personality' (A5)), through mobilising a medical discourse (e.g. 'people with long term dysfunction' (A6)), and through drawing distinction between them and the 'average person' (e.g. 'As a result, said Mr Joseph, Martin did not react to events in the same way as the 'average person' and had an 'abnormality of the mind' (N2)). They are overtly labelled as deviant (e.g. 'to deal with this "new" group of deviant persons' (A5)). It may be argued that referring to individuals with whom the reader and author are unacquainted by first name only communicates disrespect, is impolite and discourteous, and so constructs them as inferior (e.g. 'Saddam, tell me about your mum' ... insights into Saddam's state of mind' N14).

Individuals with PD are constructed as outsiders, as voluntarily living on the outskirts of society (e.g. 'Yesterday, as Crowley was jailed for life for murder, Diego's distraught mother demanded to know why the 52-year-old jobless drifter had been granted bail' (N1), 'He was living on benefits and sleeping rough behind the Savoy Hotel when he befriended the boy at the Phoenix Gardens playground in Covent Garden' (N1), 'He added: 'Mr Martin viewed his home as a safe refuge from the outside world' N2), and as outcast by society (e.g. 'It now threatens to assume an Orwellian air, as the socially undesirable risk indefinite incarceration in psychiatric (or pseudopsychiatric) institutions' (A2)).

The construction of 'PD as the other' contains the binary subject positions of the 'other' and the 'not-other'. The position of the 'other' is defined by the dominant group and applies to those outside of, or subordinate to, the dominant, 'not-other' group. In theorising on representing the 'other', Wilkinson and Kitzinger (1996, p. 12) state, 'Others by definition are oppressed and marginalised by the dominant culture'. Constructing individuals with PD as 'the other' may, therefore, serve to justify oppression and marginalisation by 'not-others', by the dominant group of individuals without PD. Occupying the position of 'the other', individuals with PD are not accorded the rights and respect of the dominant, 'not-other' position. They occupy an unequal position whereby they may be subjugated and silenced, attributed a negative value, and

their views delegitimised. Implicit also in the construction of 'the other', is the notion of power. Carabine (1996, p. 168) states, the 'Other is generally a socially significant negative positioning within hierarchical power relations'. Being constructed and positioned as 'the other' therefore renders individuals with PD powerless to exert any influence over any measures or action that the dominant, not-other group may sanction.

C.5 Synthesis, Evaluation and Concluding Remarks

'The (discourse) analyst is engaged in elaborating the, perhaps unintended, consequences of the language that was used, tracing the ripples that linguistic material creates in the pool of meaning into which it is tossed'
(Coyle 2006, p. 366).

The epistemological orientation of this work is social constructionist and the research method employed a form of Foucauldian discourse analysis. Through the examination of a variety of pre-existing professional, cultural and political texts taken from a pre-defined time period, the research succeeded in identifying dominant constructions of the object 'personality disorder' at a particular moment in history. The constructions and discourses exemplified were shown to prescribe particular positions for individuals with personality disorder, which were, more often than not, limiting and served to close down opportunities for action and experience for these individuals.

Constructing PD as 'criminal', as 'threat and danger, as 'object of control' served to justify punitive correctional measures such as control and detention. Constructing PD as 'untreatable illness' warranted coercive treatment options such as involuntary hospitalisation. Even constructions that opposed extreme measures of detention or hospitalisation, such as PD as 'illness' and 'victim', limited individuals' possibilities for action through granting agency elsewhere. Constructing PD as 'the other' denied individuals the rights and respect of individuals without PD and forced them to occupy an unequal position whereby they may be subjugated, silenced, and

delegitimised. Constructing PD as 'object of labelling' and 'problem' denied individuals autonomy, agency and power to exert influence over their lives.

Having exemplified the emergent constructions and mobilisation of discourses in the data, having identified subject positions and considered opportunities for action and experience (C.4. Analysis of Themes), what remains is further speculation on the relationship between discourse and social and psychological life, on the power of language to influence what can be felt, thought and experienced by individuals diagnosed with PD. In this chapter, I will argue that language has far reaching consequences for the lives of individuals with PD. As a practicing psychologist working with individuals diagnosed with personality disorder, my interest lies in exploring the power of language to influence the individual's own mental health and the care they receive at the hands of mental health professionals and policy makers. I will argue that the largely disempowering constructions exemplified in this study both reflect, and contribute to, the stigmatisation, discrimination, rejection and exclusion experienced by people with personality disorder and can have a profoundly damaging effect on their mental health and their care. Following this I shall, more optimistically, focus on the unexpected presence of the 'victim' analytic theme and suggest that the location of this counter-discourse is heartening and offers hope for change in the way individuals with personality disorder are constructed and treated. I argue that the theme 'victim' allows us to envisage an alternative scenario which is infinitely preferable to that created by the dominant disparaging account and that this is a scenario we must foster. Lastly, I shall reflect on the research process and evaluate the quality of this piece of research.

C.5.1 Disparaging Constructions, Disempowering Subject Positions and Limited Opportunities: A Disheartening Picture

There is an abundance of research literature evidencing negative and stigmatising portrayals of individuals with mental illness in the press and the media has long associated mental health with violence (e.g. Wahl 1995; Philo 1996; Sayce 2000),

so it is perhaps unsurprising that disparaging constructions of personality disorder (and the disempowering subject positions and limited opportunities for action therein) were ever-present in the current research's press data sample. However, the fact that their presence was to some extent expected makes the potential ramifications no less disturbing.

Let us consider the fact that the culture reflected and shaped by such discursive manoeuvres is also shared by individuals with PD. Imagine ourselves with a diagnosis of personality disorder picking up a newspaper littered with discursive manoeuvres constructing us as a 'threat and danger', as a 'criminal', as an 'object of control', as 'untreatable', as 'the other', as a 'problem', as an 'object of labelling' and advocating measures such as control, detention, involuntary hospitalisation. How might we feel?

- Might we feel hurt and anger at being portrayed in this way?
- Might we begin to internalise such images, to self stigmatise, to conceive of ourselves in the same unfavourable and demeaning ways that others appear to?
- As an 'object of labelling', might we feel stigmatised, misunderstood and persecuted?
- As a 'problem', might we feel we are a burden, undeserving of care?
- As a 'criminal', might we fear incarceration, detention?
- As an 'object of control', might we feel vulnerable, powerless and threatened?
- As an 'untreatable illness', might we feel hopeless, forever flawed, and alienated from the medical system with no prospect of care, treatment or recovery?
- As 'the other', might we feel ostracised, marginalised, isolated, lonely and alienated?
- As a 'danger/threat', might we fear our own actions?
- Might we worry that the person who is aware of our diagnosis begins to treat us differently? Might we conceal or deny our difficulties from friends and family fearing their withdrawal, rejection?

- Might we distance ourselves from others, isolating us from valuable social and emotional support?
- Might fear of coercive treatment and detention make us distrustful of mental health professionals and prevent us from approaching services for help?

In positioning ourselves as an individual with PD and considering such questions we begin to appreciate the latent power of language to influence the internal world of those diagnosed with personality disorder. Personality disorder itself adversely affects aspects of the individual's life, such as his/her close relationships, ability to trust or relate to people, feelings of satisfaction with life, and desired educational, work and other achievements (Byrt & Woods 2006). The disorder can be integrally associated with low self-esteem and a distorted sense of self and individuals may often suffer the profound effects of emotional trauma, neglect, physical, sexual and emotional abuse in their earlier years (Bennett 2003; Castillo 2003). Add to this the pain and distress when confronted by media messages that people such as yourself are flawed, disapproved of, disliked, dangerous, and feared and surely one's life becomes even more difficult to bear?

So what of political and academic texts? What was unexpected in the present research, and indeed particularly unwelcome bearing in mind the researcher's professional affiliation, was the echoing of pejorative constructions of personality disorder in academic and political texts. Any naïve hope at the outset of the research that academics, practitioners and politicians may be more empathic to the suffering and needs of individuals with personality disorder was quashed by the disturbing presence of such constructions in academic writings and political conversations. What is deeply worrying is the fact that politicians and academics/professionals are powerful actors in the lives of individuals diagnosed with personality disorder. Not only does mental health care legislation result from political deliberations in the House of Commons and House of Lords, but treatment philosophy, availability and delivery are dictated by professionals who either write academic articles such as those analysed or certainly use them to guide and inform clinical work.

Let us speculate upon the ramifications of such individuals taking up powerful positions embedded within the constructions identified in this research. Think of those politicians tasked with debating legislation for individuals with PD. Think of those professionals designing services for individuals with PD. Think of those commissioners allocating financial resources and purchasing services for this client group. Think of those professionals formulating care and treatment plans. Think of those professionals in one to one sessions with clients diagnosed with personality disorder and of those offering consultation or supervision to other professionals working with this client group? How might their decisions, therapeutic effectiveness, willingness to engage with and care for individuals with personality disorder be influenced?

- Might they reject people from services in the belief that they are untreatable?
- Might they be reluctant or refuse to engage therapeutically, provide treatment and other interventions assuming that individuals will not respond to these?
- Might they be concerned that their resources are too scarce or unsuited to manage a group of patients who are unlikely to benefit from treatment?
- Might they argue or campaign for legislative moves or services to confine individuals based on the threat and danger they pose, based on what they might do?
- Might they fear being held responsible for their patients' dangerous or criminal behaviour?
- Might they fear for the safety of other clients who may be traumatised or harmed by their presence?
- Might they lack confidence, feel overwhelmed, deskilled, untrained to work with individuals with such a complex diagnosis?
- Might stigmatisation and moral evaluation impact upon their ability to develop a non-judgemental, accepting, and empathic approach to caring for individuals with this diagnosis?
- Might they consider them illegitimate users of health service resources and reject them in the belief they are the responsibility of criminal justice system?

As discussed, constructions identified in the present research served to justify extreme action, coercive treatment options such as involuntary hospitalisation, punitive correctional measures such as control and detention, and to warrant changes in professional role or departure from usual conduct. The authority (professionals, politicians, law enforcement) were positioned as the powerful actors in all but one of the analytic themes (the exception being analytic theme `victim` to be discussed in following section), so it is entirely possible in speculating on the ramifications of constructions identified that professionals / politicians, should they take up the powerful positions, have a profound and adverse effect on the care received by individuals with PD.

Indeed recent service user research (Castillo 2003; Haigh 2006) indicates that individuals diagnosed with personality disorder face many difficulties in accessing care and report unsatisfactory and upsetting experiences of contact with mental health services. Service users provide vivid and moving accounts of the distress and difficulties they face in accessing care reporting experiences of rejection and refusal by services to provide treatment, lack of validation of their experience, negative labelling, being dismissed as untreatable, having poor access to information about their condition and the available treatments and services, being excluded from services (Castillo 2003; Haigh 2006). Such literature adds weight to the argument that constructions are influential in terms of how professionals act in relation to clients with diagnoses of personality disorder.

C.5.2 Unexpected Constructions, Space for Resistance and a Period of Transition: Grounds for Optimism

Having acknowledged the overwhelming presence of pejorative constructions of personality disorder in the data, having speculated upon the adverse consequences of positionings, the outlook for individuals with this diagnosis certainly appears bleak. Certainly the presence of disparaging constructions across data type is deeply worrying, the implications / speculations for the individual's internal world and the

care they receive deeply disturbing, however it is my contention that the unexpected presence of the 'victim' analytic theme is heartening and offers hope for change in the way individuals with PD are constructed and treated.

The 'victim' theme, existing in stark contrast to themes such as 'threat and danger', 'criminal', 'object of control', invites us to enter a different discursive economy, one where liberatory discourses of ethics, of human rights, of civil liberties are mobilised as opposed to limiting discourses of violence, law and order, and criminality. One where individuals with PD are constructed as victims of persecution, mistreatment, neglect, as opposed to being vilified, maligned, and denigrated. One where feelings of sympathy, pity, caring, empathy, and concern may be evoked in others as opposed to fear, disdain, and contempt. One where individuals with PD may feel heard, cared for, protected as opposed to misunderstood, alienated, rejected and stigmatised. One where others may endeavour to alleviate their suffering, to help and protect them rather than seeking to reject, distance, contain and punish them. In elaborating the consequences of this alternative discursive framework it becomes possible to envisage a scenario whereby constructions could positively impact the lives of individuals with PD⁽³⁹⁾. With this vision in mind, the 'victim' theme offers us space for resistance and opposition to the dominant disparaging account and it is precisely this space upon which we must capitalise in our fight against the stigmatisation, negative discrimination, rejection and exclusion all too commonly experienced by individuals with PD.

So how can this be done? In looking to the future, to how we can act to promote alternative, more desirable constructions and practices, a brief foray into recent history may be beneficial. For example, by speculating upon the arrival of the 'victim' analytic theme, isolated against all other disparaging constructions, it may be possible to identify not only suitable mediums for intervention, but also those individuals or organisations who exert influence.

In exploring the recent historical context it is my belief that a number of things happened that have led to the arrival of the 'victim' analytic theme: debate around the Mental Health Act reforms; increasing evidence of treatment effectiveness; service user literature. These events have succeeded in opening up the discourse and have, I believe, acted as a counter to the dominant disparaging account. Government proposals for Mental Health Act reform proved highly controversial and were greeted by a barrage of criticism in the form of literature, campaigns, petitions, lobbying from service user and carer groups, voluntary organisations and charities, professional bodies, service providers. Such opposition has brought to the fore discourses of civil liberties and human rights. In fact, one can even hypothesise that initial proposals for reforms were a response by the government to the pressure of dominant discourse/construction of PD being something that needs to be controlled, detained and that the subsequent delay in legislation, and abandonment of 2 draft bills ('Draft Mental Health Bill' June 2002; 'Revised Draft Mental Health Bill' September 2004), may be accounted for by the increasing presence of alternative, less dominant constructions and discourses such as the 'victim' analytic theme. Looking at recent academic literature we see increasing acknowledgement of the considerable distress often associated with PD for the patient (Castillo 2003; Byrt & Woods 2006), encouraging evidence of treatment effectiveness (Bateman & Tyrer 2004a), and optimism expressed about working with this client group (Sampson, McCubbin, & Tyrer 2006). The result has been a move away from the untreatable, 'bad not mad' (Hinselwood 1999; Moller 2002) viewpoint of old to one where individuals with PD are constructed as victims of illness, as suffering, in need of care and treatment. Then let us consider the 'emerging account of the inner world of those who had attracted a diagnosis of PD' (Castillo 2003, p. 155). Recent books by individuals diagnosed with PD (Kreisman 1991; Mason 1998; Moskovitz 2001; Reiland 2004; Kraus 2005), websites⁽⁴⁰⁾ and service user research (Castillo 2003; Fallon 2003; Perseus et al. 2003) have elucidated the pain, distress, and stigmatisation they endure and accounts have served as a useful corrective to the dominant disparaging account.

Such activity, I argue, is acting to subvert dominant discourses through the repositioning of the subject and brings us closer to the scenario we wish to create, the

scenario where individuals with PD are respected and cared for, as opposed to demonised, disparaged, vilified. Willig (2001, p. 107) comments 'it is in the nature of language that alternative constructions are always possible and counter-discourses can, and do, emerge eventually'. Arguably we are at a point of transition in conceptualising PD and alternative constructions and counter-discourses have thankfully begun to appear. It is therefore vital that powerful and influential bodies such as those identified (i.e. mental health alliance, service user and carer groups, voluntary organisations and charities, professional bodies, service providers) continue to discuss, publish, campaign, lobby, demonstrate in order to build upon these alternative and preferable ways of perceiving, talking, and acting in reference to individuals diagnosed with PD. There is no reason why we must passively wait for alternative constructions and counter-discourses to 'emerge eventually' (Willig 2001, p. 107), whilst the possibility of accelerating the process exists. Indeed applying discourse analytic research such as this may further facilitate this process. The dissemination of such research may succeed in raising consciousness and empowering individuals to act. Not only does it expose disparaging constructions and their worrying implications for subjective experience and treatment, it identifies space for resistance and alternate preferable counter-constructions. Armed with the insights of such work individuals may become more empathic to the plight of those diagnosed with personality disorder, more aware of their own language use and its effects, may be empowered to resist and challenge the dominant account by selectively attending to and promoting alternative constructions.

(39) There are of course limitations of this 'victim' theme. Although the theme invites us to enter a different discursive economy whereby different positions are offered, one could argue that individuals with PD remain relatively powerless in their positioning. Within this theme, the authority are no longer a powerful actor (serving to justify extreme action, endorse coercive treatment options and punitive correctional measures), but nor are individuals with PD. Constructed as victims, individuals with PD are in the position of requiring someone to act on their behalf, and the public / reader are empowered to do so. The 'victim' theme then, like all others, prescribes limiting positions for individuals with PD which serve to close down opportunities for action and experience.

(40) www.borderlinepersonality.ca; www.borderlinepersonalitydisorder.com; www.bpd411.org; www.bpdcentral.com; www.bpdrecovery.com; www.bpdresources.com; www.mhsanctuary.com/borderline; www.toddvertime.com; www.myborderlinelife.co.uk.

C.5.3 Reflexivity

'Reflexivity is a term which is widely used in social constructionist writing, and, confusingly, it is not necessarily used in the same way by different writers'

(Burr 1995, p. 161).

In approaching the topic of reflexivity in the present research, the initial intention was to reserve a section of the final chapter for discussion of the meaning and importance of reflexivity in discourse analytic work, and for exploration of how reflexivity issues arose throughout the course of the study. The bewildering array of definitions and uses of the term reflexivity in the literature, as alluded to in the above quote, and the equally bewildering collection of reflections discovered upon revisiting the paper trail in the present research, however, led to the decision to adopt a somewhat different approach, an approach focusing on including, amidst other sections of the thesis, only those aspects of reflexivity that serve to enhance the present thesis and will be of interest to the reader. Within this section, I shall briefly justify this decision, a somewhat ruthless and painful decision for the researcher bearing in mind the reams of reflective comments recorded throughout the course of this research.

Reflexivity in discourse analytic work, whilst universally deemed necessary (Parker 1992, p. 21; Squire in Wilkinson & Kitzinger 1995, p. 157), is a concept that has been used varying in reference to: disclosure of the researcher's personal ideological orientation and motives for undertaking the research (Yardley 1997, p. 28); reflection on how the context (social, political, cultural, linguistic) in which the research and researcher is located may have affected the material obtained (Yardley 1997, p. 28; Alvesson 2002, p. 179); addressing the ways in which a researcher's involvement influences, acts upon and informs the research (Nightingale & Cromby 1999, p. 228); the manner in which the conclusions presented have been constructed and justified (Yardley 1997, p. 28); epistemological questions concerning how the research question may have defined and limited what could be 'found' (Willig 2001, p. 10); personal reflections on

how the research may have affected and possibly changed us as people as researchers (Willig 2001, p. 10). Providing just a flavour of the definitions and functions of reflexivity in social constructionist discourse analytic work, this, rather intimidating, list illustrates the dilemmas faced when attempting to provide a coherent, useful and concise account of reflexivity in a research write up. In attempting to find a way out of this reflexive confusion, it was hoped that a review of reflexive notes from the paper trail would elucidate those pertinent issues that arose throughout the course of the present research and provide direction.

Exploring my reflexive diary was certainly validating from a developmental point of view tracking the academic journey from being a novice qualitative researcher, confused and overwhelmed, to a competent discourse analyst having a firm grasp of the concepts and language of discourse analysis, having developed an analytic mentality, and ability to articulate the research process. It was challenging, enlightening and enriching from a personal point of view documenting how I coped with fluctuating levels of motivation; overcame emotional struggles such as competing demands of work, family life and research; and experienced moments of insight where, for example, through reflection and supervision I was able to acknowledge and temper my perfectionistic personality traits, endeavour to create a research thesis fit-for-purpose rather than a never-ending lifetime's work! Whether detailing such reflections in my final thesis would be warranted, relevant to the finished product, or indeed interesting for the reader however is dubious. Indeed, Burman (1991 in Yardley 1997, p. 39) warns of the 'risk that reflexivity may degenerate into futile narcissism' and Squire (in Wilkinson & Kitzinger 1995, p.157), rather cynically comments, 'discourse analysts also often seem to envisage reflexivity as something you have to address – but just in order to get it over with'. Stainton Rogers (1991, p. 10) stresses the need 'to weave a coherent, plausible, user-friendly story for you that will stimulate and retain your interest'. In the spirit of such authors, although tempting, I shall not be drawn down the lengthy path of potentially narcissistic, self indulgent, perhaps even futile, reflections upon the process of the present research. Discussion of anxieties and frustrations I faced in sampling, in analysing data, in selecting material for inclusion in the write up are no doubt common issues faced by all

researchers attempting discourse analytic work and, in this sense, would be wasted words. Instead, I offer reflections upon the quality and usefulness of this piece of research in the following section C.5.4. Evaluating the Work. In addition, I explore issues of 'personal reflexivity' (Willig 2001, p. 10) in section C.5.5. Relevance to Counselling Psychology, exploring the ways in which my own values, experiences, interests, and beliefs have stimulated and shaped the research, how the research has influenced me, has affected and changed me as a practicing psychologist in my work with clients and colleagues. Such reflections, I feel, are particularly pertinent bearing in mind the context of the research as partial fulfilment of the practitioner doctorate requirements.

C.5.4 Evaluating the Work

In order for discourse analysis to be taken seriously there must exist criteria, which allow the quality of an analysis to be evaluated.
(Henwood & Pidgeon 1992; Potter 1996; Coyle 2006).

Owing to the different theoretical assumptions in discourse analytic work, traditional approaches to evaluating research (i.e. positivist concepts of reliability and validity) are inappropriate. In search of alternative means of justifying or validating analyses, numerous criteria have been posited (e.g. Potter & Wetherell 1987; Henwood & Pidgeon 1992, 1994; Stiles 1993; Potter 1996; Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh 1997), but there appears to be no method of validation for discursive research which is undisputed and universally accepted. Indeed, Harper (1999) suggests an onus placed upon researchers in this kind of work, to clarify what would be appropriate criteria for judging their studies. In response to such a challenge, I suggest two main categories for evaluating the present research, those of 'Craftsmanship' and 'Usefulness'.

C.5.4.1 Craftsmanship

The process of discourse analysis, although difficult to describe (Harper 1999), must be skilfully articulated in order to allow judgments to be made upon the skill of the analyst

and the credibility of interpretations. Many authors have highlighted the importance of clarity, linearity, coherence and structure in accounts (Potter & Wetherell 1987; Turpin et al. 1997; Harper 1999; Coyle 2006). Others have stressed the need for a transparency to the analysis (Harper 1999), and the necessity for inclusion of rich and extended material in order to demonstrate how analytic conclusions were reached and to justify interpretations (Harper 1994; Potter 1996; Coyle 2006).

Heeding the advice of such authors, in the present study, I endeavoured to provide a detailed and explicit description of my analytic procedure ⁽⁴¹⁾. Mindful of potential analytic shortcomings as outlined by Antaki et al. (2003) (e.g. under-analysis through summary, over quotation, isolated quotation, spotting, false survey), I externalised analyses and interpretation by presenting original materials in parallel with analyses and endeavoured to balance the ratio of analytic comment to raw data extracts ⁽⁴²⁾. In so doing, I hope to enable the reader to judge for themselves not only my skill as a discourse analyst, but also whether my interpretations are coherent, warranted and convincing.

(41) See C.3. Methodology.

(42) See C.4. Analysis of Themes.

C.5.4.2 Usefulness

In evaluating the present study on the basis of usefulness, I look to explore its potential applicability / practical utility (Willig 1999), fruitfulness in terms of generating new research questions (Potter & Wetherell 1987; Coyle 2006), and whether it has succeeded in building upon previous insights (Potter 1996), offering new theoretical insights (Harper 1999), and so added to the field of study.

C.5.4.2.1 Applicability

Willig (1999, p. 10) explores the applicability of discourse analytic research and in so doing identifies three ways in which research has attempted to address social and political

practice: 'discourse analysis as social critique'; 'discourse analysis as empowerment'; and 'discourse analysis as guide to reform'. Discourse analysis as social critique aims to expose the ways in which language legitimates and perpetuates unequal power relations (Willig 1999, p. 10). Discourse analysis as empowerment seeks to identify spaces for resistance to dominant discourses, moving beyond deconstruction and critique, to advocate the identification and promotion of counter discourses (Willig 1999, p. 12). Discourse analysis as guide to reform is praxis-oriented in seeking to use the results of discourse analytic studies in order to develop social interventions (Willig 1999, p. 15).

The present study aimed to explore the discourse around personality disorder and reveal its constructed nature, functions and implications⁽⁴³⁾. In evaluating the study's usefulness, however, it can be seen that a great deal more has been achieved. The research has served not only as 'social critique' by exposing dominant disparaging constructions and their worrying implications for subjective experience and treatment of individuals with personality disorder, but also as 'empowerment' through the identification, exploration and promotion of alternative and preferable constructions and positionings (i.e. 'victim' analytic theme). In addition, the suggestion for dissemination of this research to specific target audiences, such as those in positions of power or influence, raises the possibility of this research being used as a 'guide to reform'. Armed with the insights of this work, mental health professionals, politicians, policy makers, trainers and supervisors, academics, professional bodies, service providers, voluntary organisations and charities may intervene to bring about positive change through providing a space for alternative constructions, raising consciousness through education and training, campaigning, lobbying (Willig 1999). We can see then that such research is far from 'a kind of intellectual indulgence which lacks the practical significance of, say, a survey or a clinical trial' (Yardley 1997, p. 44). Instead, through exposing and challenging existing practices, and creating an alternative way of looking at things, it has the potential to produce very real material effects.

(43) See C.2. Introduction.

C.5.4.2.2 Generating New Research Questions

What discourse analysts do is produce readings of texts. They do not claim to 'discover' the 'truth' or even produce a 'definitive' reading, for all analyses are situated in the researcher and the sample (Henwood & Pidgeon 1992; Stiles 1993; Harper 1999). The present research has succeeded in producing a reading of the texts analysed, but this is just one reading among many other possible stories about reality.

Throughout the course of this research, extensive reading of the literature around the topic of personality disorder has revealed the suggestion of other constructions, constructions that are perhaps silenced or hidden in the data set analysed. Other academic literature, like the present research, constructs individuals with personality disorder as a difficult client group, but interestingly not on account of dangerousness, but rather as emotionally challenging or demanding. The undesirability appears to be the same, but the construction is quite different. Texts speak of individuals with personality disorder as being attention-seeking, demanding, manipulative, emotionally challenging (Bowers 2002; Castillo 2003; Watson & McGregor Kettles 2006; Aiyegbusi 2006). Perhaps those academic texts analysed in the present study were authored by researchers / academics as opposed to practitioners actually working with clients with this diagnosis. Perhaps these 'insider' constructions are more evident in texts by authors at the cold face / ground level of treatment. The present research may indeed have failed to reflect this 'insider' discourse through the methodological decision to analyse articles from impact rated peer reviewed journals, as opposed to books or professional texts (e.g. *The Psychologist*, *Nursing Times*, *Psychiatric Times*). It would certainly be interesting in terms of future research to analyse texts authored by practitioners active in the field.

Similarly throughout the course of this research, as already mentioned, there has been a growth in service user accounts. The aim of the present research was to open up contemporary political, academic, cultural texts, but it would be equally fascinating and fruitful to subject other literature such as accounts provided by individuals diagnosed

with personality disorder to such analysis. Would they share the same constructions and discourses, take up positions identified in this research, I wonder?

These are just two examples (literature from practising mental health professionals and individuals with diagnoses of personality disorder) whereby future analysis may broaden the spectrum of constructions identified. With greater resources, the scope of this study could also be expanded to include a variety of other data e.g. cultural (television; film; fictional literature), political (Mental Health Act 2007, Department of Health 2007; recent government documents on personality disorder published by National Institute for Mental Health England / Department of Health 2003a, 2003b). All these suggestions could enrich the analysis produced, and remain possibilities for improvement and future studies in this area.

C.5.4.2.3 Adding to the Field

Attempting to discuss the present study in relation to existing research exploring the same or related phenomenon and utilising comparable methodology is a tall order. Only four studies have been found exploring the topic of personality disorder from a social constructionist perspective (i.e. Parker et al. 1995; Hazelton, Rossiter, & Milner 2006; Manning 2000, 2002, 2006; Wright, Haigh, & McKeown 2007). Although these studies differ in terms of data type analysed and method of analysis, they are certainly of relevance in considering the findings, interpretations and evaluating the usefulness of the present research.

In the study by Parker et al. (1995), accounts of 'psychopathy' in theoretical literature and the talk of staff and patients in a special hospital (from semi structured interviews), were first identified through the application of Q methodology (McKeown & Thomas 1988) and later analysed to reveal a series of locations within which individuals, subject to detention by the legal category of 'psychopathy', could be 'read' and 'positioned'. Six themes emerged in the research: the psychopath is treatable; the psychopath is immutable; the psychopath is a moral agent who has elected to adopt a deviant lifestyle;

the psychopath has a plausible surface appearance but a devious depth reality; the psychopath is a victim of labelling; psychopathy is an objective scientific fact. Parker et al. (1995) comment that, despite these accounts not seeming particularly 'user friendly' to psychopaths, there is evidence of 'subjectification', of patients actively participating in a discourse that constrains and regulates their lived reality. Akin to the present study, the authors advocate resistance of oppression of dominant narratives. They suggest the possibility of successfully resisting marginalisation or devaluation through 'individuals grasping the action function of discourse and reflecting upon themselves as the objects of a scientific discourse' (Parker et al. 1995, p. 89).

Hazelton, Rossiter, and Milner (2006) conducted a discourse analysis (utilising the method of Potter & Wetherell 1987, 1995) of focus group interview data pre- and post-staff training in the use of 'dialectical behaviour therapy'. Analysis of pre-training data revealed discourse 'characterised by a pervasive therapeutic pessimism, built on interrelated sets of connotations that consumers with borderline personality disorder were (impossibly) difficult to work with and that the available treatments were inadequate' (Hazelton, Rossiter, & Milner 2006, p. 127): 'staff splitting'; manipulative; attention-seeking; intimidating and difficult consumers; enmeshed and dysfunctional families; untreatable; inconsistent treatment; ineffective treatment. The authors conclude that 'consumers with borderline personality disorder were characterised as being both 'trouble' (to themselves and others) and 'troubling' (to staff)' (Hazelton, Rossiter, & Milner 2006, p. 126). Post-training transcripts however indicated a discursive shift towards much more optimistic understandings and therapeutic outlooks. This study is of interest in the light of the present research for two reasons. Firstly, the pre-training analysis appears to capture those 'insider' constructions discussed in the present study as an area for future research and, secondly, the pre-post training discursive shift suggests that confronting and challenging negative, pessimistic constructions, 'targeting patterns of thinking, attitudes and behaviours that are presently well established in both individual staff and service wide' (Hazelton, Rossiter, & Milner 2006, p. 122), an area advocated by the present research, can be effective.

Papers by Manning (2000, 2002, 2006) discuss the psychiatric classifications 'personality disorder' (PD) and, more specifically, 'dangerous and severe personality disorder' (DSPD) from the perspective of the sociology of knowledge, exploring how the diagnostic categories have evolved, how they have stabilised and the consequences of basing mental health legislation and services upon them. Manning (2002) suggests the category 'dangerous and severe personality disorder' (DSPD) is a good example of the social construction of a new category of disorder occurring as a result of complex interaction between policy makers, academics and other professionals. He questions whether disorders are really scientific or socio-political, and whether it is possible that 'contrary to our conventional way, treatments may lead to disorders, and not the other way round' (Manning 2006, p. 1964). Manning (2002, p. 659) suggests that, culture-driven classifications such as these provide 'an insecure and disputed base for the treatment and legislative innovation they have set in motion'. These writings are of course relevant to the present study bearing in mind the researcher's concern that mental health care legislation, treatment philosophy, availability and delivery may be adversely influenced by dominant constructions of personality disorder.

Although it cannot be considered a formal research study, Wright, Haigh and McKeown (2007) draw upon social constructionist theory in commenting anecdotally upon the language employed by students in teaching and learning exercises on the University of Central Lancashire's personality disorder courses. Examples of the sort of terminology that students used initially to describe individuals with personality disorder typically defined people in terms of negative or moralistic references to behaviour: manipulating; abusive; bad; dependent/clingy; attention seeking; difficult; uncooperative; saboteurs (of care and the care of others); unappreciative; inconsistent; disinhibited; disrespectful; unreliable/will let you down; and liars. Once again, this resonates with the suggestion in the present research of 'insider' constructions and those identified in the research by Hazelton, Rossiter, and Milner (2006). What is particularly interesting about the study by Wright, Haigh and McKeown (2007) however are proposals that consciousness can be raised and that constructions can be recognised for what they are (essentially fictions) and then deconstructed. The authors further suggest reconstruction along more wholesome,

progressive, or helpful lines. They argue seeing personality disorder as part of human development, perhaps linked to previous psychological harm or trauma, opens up possibilities for compassion and empathy. Such sentiment forms the crux of the present study.

Considering these four studies, not only validates the emphasis placed in this research upon challenging and resisting disparaging constructions and promoting alternatives, but illustrates how the present research has made a significant contribution to the field through the analysis of a novel data set and the production of new theoretical insights, namely the emergence of the subordinate 'victim' theme.

C.5.5 Relevance to Counselling Psychology

`Discourse analysts who want to make a difference do not, of course,
act only as discourse analysts`
(Willig 1999, p. 156)

As stated in the introduction to this thesis, I began this research 'impelled by a sense of fascination for language, a sense of injustice at the seemingly blatant stigmatisation of individuals with personality disorder, and a sense of urgency considering the topical nature of the subject in terms of mental health act legislation' (p. 67). Such personal values, experiences, interests, and beliefs have stimulated, driven and shaped the process of this research, but so too has the process of the research stimulated, driven and shaped me.

My increased recognition of the power of discursive practices has helped me as a counselling psychologist to be more critically aware of the impact discourse can have on my clients and my professional interactions and has contributed to my professional development. My greater awareness of the context in which my clients and myself are immersed, and the implications of this context for the lives of my clients has enabled me to work more empathically with my clients. My recognition of the possibility of dominant

disparaging constructions being taken up by practitioners has enabled me to reflect upon possible biases that I may carry into the therapeutic encounter, biases which may adversely affect my ability to form therapeutic relationships and fully engage with my clients. My strong belief that dominant disparaging constructions need to be challenged and alternative positive ones promoted has motivated me to continue to act. The unique role of counselling psychologists (as agents of psychological treatment, as important sources of education, learning, and supervision, as researchers) offers me an opportunity, through future discourse, to reach a wide range of individuals and so have the potential to bring about positive change in the lives of individuals with personality disorder. This is an opportunity I shall not miss.

‘Behind each personality disorder there is a personality
and behind each personality there is a person’
(Byrt, Graley-Wetherell, Studley, et al. 2006, p.43).

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D: Professional Practice

Anger and Personality Disorder: A Cognitive Behavioural Approach to Formulation and Treatment

D.1 Introduction

The rationale for choosing this case to present as part of my doctoral portfolio is that it has been, I believe, one of the most challenging cases of my career to date and, perhaps more importantly, it has been instrumental in shaping my subsequent career as a psychologist. This client work was completed some five years ago, immediately prior to commencing my doctoral studies. The case work was challenging owing to the nature and complexity of the client's difficulties and my relative inexperience at the time of working with clients with this diagnosis. However, it is with this early work that my fascination with the topic of personality disorder arose. This fascination has since permeated my research interests, training received and delivered, and career choices. I have chosen to revisit this case work as it has been so influential in my career, continues to fascinate me, and as a result of subsequent training and experience, I feel I can now offer a more informed and thoughtful position on how best to engage and work with this client.

The case study that follows is divided into two parts. D.2 is the original case study completed, as mentioned, some 5 years ago now. D.3 consists of a reformulation of the case and reflections upon this early work (i.e. what I did well and what I would now do differently).

D.2 Case Study: Simon ⁽⁴⁴⁾

D.2.1 The Referral and Context for the Work

Simon was a 32-year-old white man of British origin who was referred by his local Community Mental Health Team (CMHT) to an Intensive Case Management team (ICM). Owing to numerous risk management issues encountered in working with Simon and on account of his verbally abusive and threatening behaviour towards staff, the generic CMHT felt ICM would be a more appropriate service to engage with this client.

The ICM team was established to work in a community setting with clients with serious ongoing mental health problems that are difficult to engage and have multiple and complex needs. The team was staffed by five mental health professionals (one team leader/community psychiatric nurse, one social worker, two senior support workers, one psychologist), and one part time administrator. Clients referred to the team typically lived chaotic lives punctuated by episodes of self neglect, self harm and suicide attempts, drug and alcohol abuse, violent aggressive behaviour and often criminal involvement.

The referral letter described Simon as suffering `paranoid personality disorder with explosive tendencies` and suggested that he would benefit from seeing a psychologist for anger management sessions.

(44) All names and identifiers have been changed for reasons of confidentiality.

D.2.3 Brief Profile of Client

| | |
|-----------------------------|--|
| Client: | Simon. |
| Gender: | Male. |
| Age: | 32. |
| Nationality: | English. |
| Ethnic Origin: | White UK. |
| Relationship Status: | Single. No children. |
| Accommodation: | Lives alone in council flat. |
| Parents: | Father, aged 54. Unemployed. History of violence. Poor relationship with client. Mother, aged 51. Unemployed. History of depression & attempted suicide. Good relationship with client. |
| Siblings: | 1 sister, aged 30. Unmarried with 2 children. Good relationship with client. |
| Occupation: | Unemployed, receiving income support. |
| Diagnosis: | Paranoid Personality Disorder ⁽⁴⁵⁾ . |
| Medication: | Carbamazepine (200mg, mood stabiliser) Zopiclone (7.5mg, sedative) Diazepam (5mg, benzodiazepine, anxiolytic) Sertraline (100mg, SSRI antidepressant) |

(45) See Appendix D1 for information on Diagnostic Issues, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2

D.2.3 Background History of Client

Simon had a longstanding history of aggression and violence, being both victim and perpetrator since early childhood.

Simon had an unstable childhood punctuated by episodes of violence. His father physically assaulted him whilst he was growing up. He was bullied at primary school and was disruptive, flying into rages even then. He mentioned arriving home in tears from school after being bullied and being subsequently beaten by his father who then sent him back to school to seek vengeance on the bully. At age 11, he was referred to an educational psychologist, but his mother refused and encouraged him to take up boxing instead to release his aggression. He subsequently became very good at boxing, often winning trophies. At age 15, Simon states he got into the “wrong company” and started glue sniffing. He was caught by police on several occasions, fell out with his father and began truanting from school resulting in him being expelled. Simon was then thrown out of home by his father and spent a few years “living on the streets” until his sister helped him to get a flat. Whilst living on the streets he became involved in “bare knuckle fighting for money”.

Simon had a variety of unskilled jobs in his life. His last period of employment was five years ago when he worked for a chemical firm for three years. He was fired from this job following a violent argument with his boss. In addition, Simon has a significant forensic history including petty crime from the age of 14 onwards, two illicit drugs cautions, two convictions for road rage / criminal damage, and being acquitted of ‘grievous bodily harm with intent’ due to lack of evidence.

D.2.4 Therapeutic History

Prior to my work beginning with Simon, his therapeutic history is as follows:

- August 2001. Simon referred to generic CMHT by GP for anger management.

- October – December 2001. Due to Simon’s financial difficulties, a social worker (from the generic CMHT) became involved to help him renegotiate affordable repayments with his creditors (telephone company, bank). She refused to continue working with Simon on account of the racial verbal abuse and threats he made towards her. Simon made a formal complaint to the NHS Trust stating “she did not help at all”.
- November 2001. Simon was sent a couple of appointments with the forensic psychiatric nurse attached to the generic CMHT. He failed to attend these appointments.
- January 2002. Simon was offered 6 sessions with a nurse behaviour therapist attached to the generic CMHT for anger management using a cognitive behavioural framework. He attended 2 sessions. The therapist then announced she was moving jobs but would still see him for the scheduled number of sessions. Simon complained of being abandoned and failed to attend their last 4 scheduled sessions.
- April 2002. Simon referred to Intensive Case Management team by generic CMHT.

D.2.5 Presenting Problems

Simon stated he had difficulties since May, 2001 when he had a series of traumatic incidents leading to despair and re-emergence of his easy loss of temper. He lost his job and girlfriend in quick succession and subsequently states he “went to pieces”. He felt everything he had tried had failed and he could not see much point in continuing. He had become socially isolated stating that he shut himself away in his flat to avoid trouble. Simon feared the consequences of his behaviour when angry and was extremely worried about his potential to harm people. He did not wish to injure anyone so he confined himself to his flat. Despite receiving support from his family, he felt he could not cope and would like assistance with controlling his violent temper.

D.2.6 Theoretical Approach

D.2.6.1 Therapeutic Decision

In terms of therapeutic approach, following an initial assessment, a therapeutic decision was made to adopt a cognitive behavioural framework for anger management for further sessions. Factors influencing this decision were:

- The client's goals to feel calmer and find more effective ways of dealing with his violent temper (suggesting the need for a skills based approach).
- The nature of Simon's presenting concerns and research evidence advocating cognitive behaviour therapy techniques in the treatment of anger⁽⁴⁶⁾.
- The client's previous experience of a cognitive behavioural approach (2 sessions with a nurse behaviour therapist).
- Discussion of the case in supervision.

(46) See following section D.2.6.2. Cognitive Behaviour Therapy for Anger Management, for details of psychotherapy outcome studies.

D.2.6.2 Cognitive Behaviour Therapy for Anger Management

Cognitive behaviour therapy (CBT) is a collaborative, time limited, problem oriented, structured therapy dealing with the here and now. It aims to provide the client with a rationale for understanding his/her difficulties in addition to equipping them with skills and techniques to manage their symptoms.

A variety of cognitive behavioural strategies exist for anger management. These strategies differ primarily in terms of the target of the intervention.

The more cognitive oriented therapies (e.g. Cognitive Therapy – Beck 1976, Rational Emotive Behaviour Therapy – Ellis 1962, Self Instructional Training – Meichenbaum 1985) target cognitive distortions and are based upon the hypothesis that a client's thoughts, interpretations, and self statements about external events influence their

emotional and behavioural functioning. Cognitive distortions and unrealistic appraisals of events are viewed as causal and maintaining factors in the anger response. The goal behind these therapies is to help clients identify and challenge irrational and distorted thinking patterns and assist them in constructing more adaptive, realistic appraisals and responses to problematic situations, thereby reducing anger and improving the client's control over their symptoms. Empirical support for cognitive interventions comes from research studies examining the effectiveness of self instructional training (Hazaleus & Deffenbacher 1986; Deffenbacher, Story, Brandon, Hogg & Hazaleus 1988) and Beck's cognitive therapy (Whiteman, Fanshel & Grundy 1987).

Therapies with a more behavioural focus include relaxation techniques targeted at assisting clients in reducing the physiological arousal associated with anger (e.g. progressive muscular relaxation, guided imagery) and skills training therapies targeting specific behaviours associated with the anger response and aimed at teaching clients to identify, evaluate and implement alternative, more appropriate, responses to problematic situations (e.g. problem solving, assertiveness training). Such interventions are supported by effectiveness studies into relaxation (Whiteman, Fanshel & Grundy 1987; Davison, Williams, Nezami, Bice & Dequattro 1991) and problem solving techniques (Moon & Eisler 1983; Whiteman, Fanshel & Grundy 1987; Deffenbacher, Thwaites, Wallace & Oetting 1994).

Multi-component treatments (e.g. Stress Inoculation – Novaco 1975) combine several of the above techniques (e.g. relaxation and self instructional training) and are based upon the premise that a combination of techniques 'will yield superior effects over any single approach' (Tafrate 1995, p. 124). Effectiveness has been demonstrated in research by: Novaco 1975; Story, Stark, Hogg & Brandon 1987; Whiteman, Fanshel & Grundy 1987; Deffenbacher, Story, Brandon & Hazaleus 1988; Deffenbacher & Stark 1992; Deffenbacher, Deffenbacher, Thwaites, Wallace & Oetting 1994.

D.2.7 Negotiating a Contract

In the first session, the client was presented with a contract detailing confidentiality, number and length of sessions I could offer, namely 12 weekly sessions at 50 minutes in the first instance. It was agreed that we would then have a review to assess progress and arrange further sessions if necessary. The contract was discussed and the client given an opportunity to raise any concerns⁽⁴⁷⁾. A request was made by myself to tape record sessions for the purposes of reflection on therapeutic practice and evaluation by my supervisor, however the client refused to allow the sessions to be tape recorded.

(47) See Appendix D2, in 'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology', Volume 2.

D.2.8 Pattern of Therapy

My work with Simon involved 24 scheduled sessions. He was actually seen 18 times in total, failing to attend 4 sessions and cancelling 2. Our first 8 sessions were held weekly, but due to his frequent non attendance and late arrival at sessions towards the beginning of therapy, we negotiated to move to fortnightly sessions. Sessions were held in onsite facilities at the outpatient health centre where the ICM team and three CMHTs are based. On account of the client's history of violence and threatening behaviour, sessions were conducted with a male psychiatric nurse present for my own safety.

D.2.9 Client Presentation

Despite his slight build, Simon is an incredibly intimidating man. His mood is extremely labile within sessions - fluctuating from periods of intense seething rage where he is overtly aggressive and hostile to extreme distress and tearfulness. This fluctuation occurs in a matter of minutes. Whilst in a rage, Simon presents as being perilously close to losing control – contorted facial expressions, bulging eyes, foaming at the mouth. He repeatedly thumps his chest with a clenched fist, bangs his head and rams his fist into the chair. He is verbally abusive and very threatening. Following these rages, Simon enters

bouts of sobbing accompanied by child like utterances and apologies quickly superseded by further episodes of hostility. His mental state is extremely volatile and unpredictable.

D.2.10 Analysis of Client's Difficulties from a Cognitive Behavioural Perspective

Viewing this case from a cognitive behavioural perspective, Simon's difficulties may be conceptualised as follows:

Episodes of anger and aggression characterised by:

Physical Symptoms:

- Increased heart rate.
- Increased muscle tension (clenched fists, contorted facial expressions, and postural changes).
- Trembling, shaky feelings / tingling sensations in limbs and extremities.
- Sweaty palms.
- Rapid breathing.
- Reddening of the skin and hot sensations.
- Restlessness, agitation.
- Exaggerated startle reaction.

Cognitive Appraisals:

- A belief that he has been treated unfairly, trespassed on, or violated.
- Blaming of others and outside events for the extent of problems, angry feelings and reactions.
- Inflammatory labelling (cursing people or events involved).
- A belief that anger and aggression are justified because of the nature of outside events.
- Thoughts and images associated with harming, seeking revenge or retaliation against the source of the provocation.
- Brooding and angry ruminations about the provocation.

- Racing thoughts and concentration difficulties.

Behavioural Outcomes:

- Verbal expressions of anger and aggression (threats, curses).
- Overt motor behaviour (aggression and violence) directed towards the perceived agent of provocation.

With respect to aspects of Simon's life that are currently affected by his difficulties, his frequent anger and aggression have resulted in:

- Conflict in interpersonal and familial relationships (e.g. Simon's sister will not allow him into her house for fear he may frighten or harm her children).
- Disrupted vocational performance (e.g. fired from his job as a result of angry outbursts).
- Impairment in social activity (e.g. Simon refuses to leave his flat for fear of harming someone and has consequently become socially isolated).
- Significant personal distress.

When encountering a situation he perceives as provocative, Simon routinely employs a consistent pattern of physically and verbally aggressive behaviours accompanied by intense angry affect and physiological symptoms. Taking into account aspects of Simon's history, this pattern appears to have been learned in childhood, modeled and reinforced by aggressive and violent family members (father) ⁽⁴⁸⁾.

(48) See D.2.3. Background History of Client, for more details.

D.2.11 Therapeutic Techniques Employed and Progress of Therapy

Due to Simon presenting for sessions in a state of high emotional arousal, as described earlier, our initial work together primarily focused on establishing a working alliance (a prerequisite for cognitive behavioural work) and equipping Simon with skills for managing his symptoms (i.e. controlling his anger) within sessions. His rage was so

intense that, not only was it frightening for myself, he himself lost the ability to concentrate. Simon would typically enter a session by discussing a particular complaint or concern and subsequently introduce numerous grievances into the conversation, which then served to fuel his anger. The angrier he became, the more difficult it was to communicate with him. Therefore from the beginning, I was acutely aware that unless we developed a way of dissipating his rage within sessions, the chances of therapeutic gain would be limited.

In order to address this, Simon and I set out to develop ways to control his anger within sessions. We began by gathering information and isolating triggers for Simon's anger response by discussing examples of situations where Simon found himself getting aroused. We then moved on to explore behavioural techniques for Simon to manage his symptoms (e.g. controlled breathing, time out, distraction), practiced these techniques within sessions and succeeded in developing a valuable tool (See Box D1 below) for Simon to refer to when feeling angry (both within and between sessions).

Box D1: Client Tool for Controlling Anger

Triggers for anger response:

- **Figures in authority.**
- **Situations where you believe you are being treated unfairly.**
- **When you pick up on certain words.**
- **Dealing with organisations associated with “the system”.**

Things that seem to help:

- **Controlling your breathing.**
- **Focusing on bringing your tension levels back down when you get aroused.**
- **Leaving the situation until you feel calmer.**
- **Recording your thoughts and feelings on paper.**

The earlier you can recognise the symptoms, the easier it is to stop yourself from getting too angry.

So having developed techniques for controlling Simon's anger within sessions, I attempted to shift the focus of our sessions from behavioural to more cognitive work. In the process of developing the above tool (Box D1), I had been struck by the cognitive content of Simon's trigger situations. I believed that his angry response was primarily mediated by unrealistic appraisals and, if we were able to identify and replace these distorted thinking patterns, I believed this would have a significant impact upon his anger. I began by introducing the rationale behind cognitive behavioural therapy, the central notion being that it is not the events per se, but rather an individual's expectations and interpretations of events that are responsible for negative emotions such as anger. Simon appeared able to relate to this model, stating that he often picked up on certain words, possibly misconstrued their meaning and got angry with the speaker.

Simon and I then moved on to discuss the nature of anger (e.g. positive and negative functions, when anger becomes a problem). At this stage, Simon was given reading material as a homework assignment ⁽⁴⁹⁾.

We discussed the possibility of Simon keeping an anger diary ⁽⁵⁰⁾ to enable us to examine some of the thoughts that contribute to his anger. I hoped that this tool would assist us in identifying cognitive appraisals, provide me with a basis for introducing the idea of information processing biases (such as those suggested by Beck 1976; Novaco & Welsh 1989; Dunne 1990 ⁽⁵¹⁾) and lead on to attempts at cognitive restructuring. I wanted to demonstrate to Simon how cognitive processes (attributions, expectations, appraisals) about an event contributed to his anger and aggressive outbursts. I wanted to work collaboratively to isolate these processes, examine the evidence for and against these cognitions, establish the realistic probability of each interpretation and introduce the possibility of substituting these cognitions with alternative explanations. I wanted to target his self-talk and change his appraisals such that provocative stimuli were no longer perceived or responded to in the same way.

Unfortunately, Simon did not welcome my attempts to shift the focus of our sessions. He refused to complete an anger management diary and his frequent rage, heightened emotional arousal and sensitivity to challenges made it difficult to engage in more cognitive work. Cognitive interventions were opportunistic and often met by an increase in arousal necessitating reiteration and reinforcement of the effectiveness of behavioural techniques from earlier sessions.

In summary, our work together involved the following features of cognitive behaviour therapy:

- Within session training in behavioural techniques to manage symptoms (i.e. controlled breathing, time out, distraction).
- Education (CBT model, nature of anger).

- Homework assignments (i.e. reading material, controlled breathing exercises to practice, anger management diary).
- Monitoring and reinforcing progress.
- Rudimentary attempts at cognitive restructuring.

(49) See Appendix D3 in *'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology'*, Volume 2.

(50) See Appendix D4 in *'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology'*, Volume 2.

(51) See Appendix D5 in *'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology'*, Volume 2.

D.2.12 Complications in the Work, Professional Dilemmas and Making Use of Supervision

I encountered numerous complications in working with this client; complications that I feel diverted us from the focus of our sessions (cognitive behaviour therapy for anger management) and impacted upon our therapeutic relationship. Box D2 below lists some of these complications and describes strategies developed, with the assistance of supervision and liaison, for dealing with such difficulties. Appendix D6 (in *'A Portfolio of Work on Stigma, Personality Disorder and Counselling Psychology'*, Volume 2) describes the content of a particularly memorable session further illustrating some of the difficulties encountered.

Box D2: Complications Encountered and Management Strategies Devised

| Complication | Management Strategy |
|--|---|
| Client's rage within sessions. | <p>Attending to signs and cues that client becoming angry and:</p> <ul style="list-style-type: none"> ▪ Informing client that it was difficult to understand his concerns while he was so angry and encouraging him to concentrate on his breathing and on calming himself before he spoke again. ▪ Constantly reinforcing the usefulness of behavioural techniques, coping strategies previously discussed (e.g. controlled breathing and time out) and emphasise that he has the skills to control his anger. ▪ Containing his anger and preventing escalation by keeping him focused on his initial concern and informing him that it is difficult to deal with all his concerns at once. ▪ Using silences constructively (informing client that I would wait until he was ready to indicate to me that he could continue the conversation). <p>Exercising caution in language I used, taking care not to be perceived as patronising or challenging. Ensuring my voice was calm and remained at a similar tone and pitch.</p> |
| Fears for my own safety. | <p>Strategies to ensure personal safety developed in supervision:</p> <ul style="list-style-type: none"> ▪ Sit near the door or panic button. ▪ Never see client alone. ▪ See client early in the day to allow time to seek vital supervision for my own mental health. ▪ Inform other professionals of our appointments and the location of sessions. |
| Threats made by client within sessions towards other professionals (psychiatrist, GP). | <p>Supervision to discuss professional role in responding to threats verbalised in sessions. Liaison and formal meetings arranged with CMHT manager and other professionals to discuss risk management issues. Decision made to inform target individuals of threats made.</p> |
| Client's disclosure within session that he routinely carries a weapon (knife). | <p>Supervision to discuss how to respond to disclosure. Discussion with client on implications of carrying weapon - reminded him that it was a criminal offence to harm anyone and stated that he did not have a mental illness (as defined by the Mental Health Act 1983) and was therefore responsible for his behaviour.</p> |
| <p>Frequent crises:</p> <ul style="list-style-type: none"> ▪ Court summons for road rage incident. ▪ Difficulties associated with medication. ▪ Financial concerns. | <p>Liaison with other professionals:</p> <ul style="list-style-type: none"> ▪ Police and solicitor re: court summons. ▪ Psychiatrist re: medication. ▪ Social worker re: debt management. |
| <p>Substance misuse:</p> <ul style="list-style-type: none"> ▪ Cannabis. ▪ Diazepam. ▪ Alcohol. | <p>Discuss with client impact of drug use on his presentation at sessions (agitation, paranoia, difficulty concentrating) and how this acted to impede our work together. Agreement from client that he would not consume drugs other than prescribed medication prior to our sessions.</p> |

D.2.13 The Therapeutic Ending

The initial contract made between Simon and myself was for 12 sessions. On account of our slow progress and Simon's complicated presentation, my supervisor and I felt it necessary to extend this contract by 12 sessions. Due to a change of employment, I was unable to offer Simon additional sessions beyond this.

I experienced mixed feelings about ending my work with Simon. On the one hand, I felt we had developed a good therapeutic relationship, made significant progress bearing in mind the complications in the work mentioned earlier and, in this sense, I felt Simon could have benefited from further sessions. However, I was also aware of the significant impact this work had upon my own mental health (e.g. the dread prior to sessions, the fear within sessions, the migraines following sessions) and a large part of me welcomed a period of respite in order to replenish my personal reserves and consolidate the work in terms of professional learning.

Simon and I scheduled a review of our progress for our final session. On account of Simon having difficulties in the past when the therapist he was working with announced she was leaving, I was anxious that he might feel rejected or abandoned by my departure and consequently fail to attend our final session. However, Simon did turn up for our final session and I feel this was testament to the strength of the therapeutic relationship we had developed over the year we had worked together. We managed to review the skills he had learned and *emphasise the progress he had made* and, in this sense, our final session was better than I had anticipated.

D.2.15 Evaluation

In evaluating my work with Simon, it was not by any stretch the traditional time limited, structured CBT. On account of his volatile and crisis-laden presentation at sessions, it was often difficult to focus on the objective of our sessions and adhere to cognitive behavioural agendas. We succeeded in developing strategies for Simon to dissipate /

control his rage within sessions, but attempts at cognitive restructuring were rudimentary, opportunistic and hampered by Simon's refusal to complete his homework diary or make use of the reading material I provided him with. In sum, I feel our work together focused primarily on containment, crisis management and within session training in behavioural techniques to manage his symptoms.

D.3 Reformulation and Reflections

`much of the puzzlement encountered by professionals who cannot understand why their interventions are not met with predictable response comes from the failure to consider the simultaneous presence of personality disorder`
(Bateman & Tyrer, 2002).

In the opening paragraph of the introduction, I stated that this case work was influential in shaping my subsequent career. As can be seen from D.2., numerous difficulties were encountered in the work and these difficulties have continued to haunt me beyond the therapeutic ending. Why had I struggled so much with this client? Why was the therapeutic process so turbulent? Why had the client been so resistant? Why had the work had such a personal effect upon me? In an attempt to answer such questions, my explorations began into the topic of personality disorder.

Since working with Simon, I have engaged in a wealth of reading on the topic of personality disorder; received training in `Dialectical Behaviour Therapy for Borderline Personality Disorder` and `Cognitive Therapy for Personality Disorder`; facilitated training for CMHT staff on `Working with Personality Disorders`; worked, and continue to work, in forensic secure settings with clients diagnosed with personality disorder; contributed to the establishment of an inpatient dialectical behaviour therapy service for females with borderline personality disorder; and, of course, embarked on doctorate level research with a personality disorder focus. As a result of such experiences, I now realise Simon's difficulties, and indeed many of the difficulties encountered within the therapeutic work and relationship, were driven by his underlying personality disorder.

In this, D.3., I shall now consider the significance of Simon's diagnosis, something which I failed to do in the original work. I shall draw upon the knowledge and experience I have gained over the last few years in reformulating the case, in commenting upon my approach, on what I did well and what I would now do differently. In so doing, I shall reveal a more informed and thoughtful position on how best to engage and work with this client.

D.3.1 Cognitive Behavioural Models of Personality Disorder

Under the rubric of cognitive behavioural therapy, three main approaches have been developed in order to work with individuals with personality disorder: Cognitive Therapy (Beck et al. 1990), Schema Focused Therapy (Young 1999), Dialectical Behaviour Therapy (Linehan 1993). All three share the central tenets of cognitive behavioural approaches in being collaborative, goal directed, problem solving therapies that focus on teaching clients specific skills to improve current functioning, however each, of course, have their distinctive features.

Cognitive therapy of personality disorders as described by Beck et al. (1990) focuses on the dual levels of the symptom structure (manifest problem) and underlying schemas (inferred structures). Schemas are understood as directing rule-guided behaviour, including maladaptive behaviour of individuals with personality disorder. Beck et al. (1990) outline maladaptive schema stemming from childhood (abandonment and loss, unlovability, excessive dependence, subjugation, mistrust, inadequate self discipline, fear of losing emotional control, guilt, emotional deprivation). Therapy focuses on reconstructing, modifying or reinterpreting schemas, training clients in self-help and self-monitoring skills, and developing crisis intervention strategies. Similarly, schema focused cognitive therapy as described by Young (1999) concentrates on identifying and modifying 'early maladaptive schemas' thought to underlie personality disorder and have their origins in adverse childhood experiences. Schemas are defined as broad pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout ones lifetime, and dysfunctional to a significant degree (Young

2003). Schemas cover themes around five principal domains: disconnection and rejection; impaired autonomy and performance; impaired limits; other directedness; over vigilance and inhibition. Therapy consists of identifying and activating core schemas and modifying them using cognitive reconstruction, behavioural and experiential techniques.

In contrast to cognitive therapy and schema focused therapy which target structures within the cognitive domain (i.e. schema), dialectical behaviour therapy is more behavioural in focus, emphasising the importance of learning theory in the development and maintenance of problematic behaviours associated with personality disorder (Feigenbaum 2006). Dialectical behaviour therapy (Linehan 1993) is rooted in the assumption that borderline personality disorder is essentially the result of a pervasive skills deficit. The approach posits that those with borderline personality disorder lack the capacity to regulate emotions, the ability to tolerate emotional distress, are ineffective in managing interpersonal conflicts and lack adequate capacity to control attention in order to 'skilfully participate in the moment' (Feigenbaum 2006, p. 81). The dialectical behaviour therapy (DBT) model suggests that individuals have learnt dysfunctional means of managing or coping with their intense emotional experiences e.g. suicidal or self-harm behaviours. The primary focus of DBT is on reducing these dysfunctional behaviours and increasing functional means of modulating emotional responses. During therapy, skills (i.e. mindfulness, emotional regulation, interpersonal effectiveness, problem solving) are taught and learnt through discussion, modelling, role play and rehearsal with the therapist or within a group. The dialectical aspect of the therapy refers to the balancing of acceptance with change, throughout the therapy.

D.3.2 Case Reformulation: Simon

Early Experiences.

Physical abuse by father.

Bullied at school.



Formation of Schema.

People cannot be trusted: they will hurt, humiliate or take advantage of me.

Other people are a threat to me: I must be vigilant and on guard at all times.



Critical Incident

(Schema Activated).

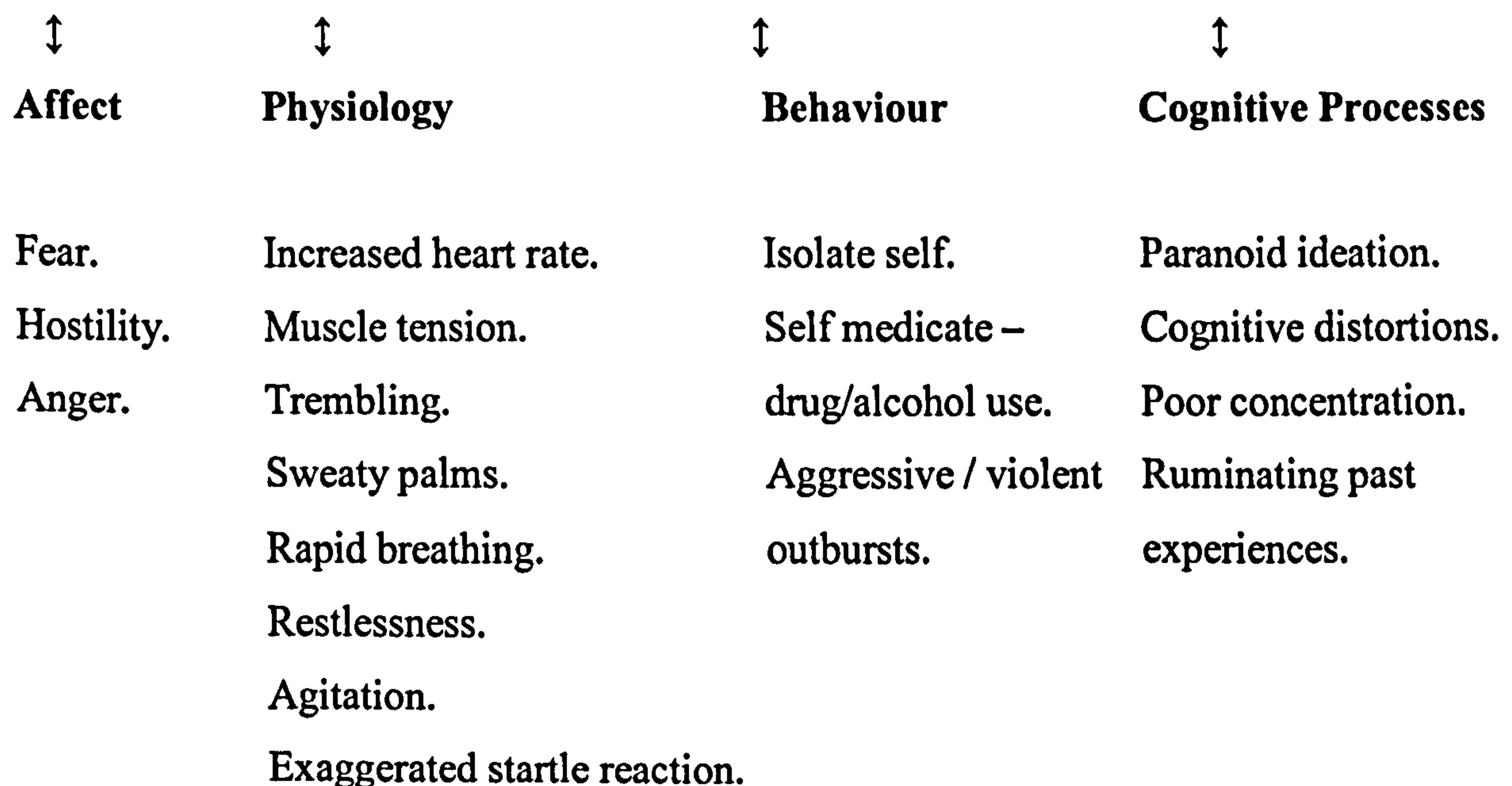


Negative Automatic Thoughts.

Don't trust them: they don't really care and will only let you down.

They're taking advantage of me.

They're threatening me.



D.3.3 Summary of Reformulation

Simon had a number of adverse life experiences in his early life (e.g. physical abuse) which led to the development of schemas (e.g. 'people cannot be trusted: they will hurt, humiliate or take advantage of me'). Although such schemas may no longer be reality based, at one point they would have been a realistic appraisal of Simon's situation. As a result of the violence / physical abuse he suffered as a child, Simon likely developed schemas concerned with being harmed and vulnerable and mistrusting of others. These schemas are realistic given his childhood circumstances, but, given their pervasive nature in adulthood, are neither realistic nor adaptive as Simon continues to mistrust others, expecting that he will be abused, hurt, or humiliated.

Simon's schemas are reinforced through the behavioural coping styles of maintenance, avoidance, compensation. Schema maintenance (Young et al. 2003) is the process by which information or evidence that would disconfirm the schemas is resisted, through cognitive distortions (e.g. Simon's search for hidden meanings, reading hostile intentions into the actions of others, interpreting actions of others as deliberately threatening or demeaning) and through self defeating behavioural patterns (e.g. confrontation). Simon cannot take into account new information that would disconfirm what he believes to be true of himself or other people and information that would appear to be evidence directly disconfirming a schema is dismissed or discounted or ignored. In rejecting others who show him care, concern or affection, for example failing to attend sessions at mental health services, Simon resists information that disconfirms his beliefs that others cannot be trusted, mean him harm. Schema avoidance (Young et al. 2003) occurs when a combination of schema activation (critical incident) and intense emotions are so unpleasant that individuals automatically attempt to suppress or avoid triggering schema or the unpleasant affect associated with the schema at a cognitive, affective, or behavioural level. Simon's schemas are activated by a large variety of situations (critical incidents) and intense negative affect is associated with this schema activation. By avoiding situations or events (e.g. isolating self in flat, avoiding contact with father, rebuffing others attempts to engage) likely to activate schemas, Simon does not allow

himself the opportunity to test out his schemas that others cannot be trusted and mean him harm. Schema compensation (Young et al. 2003) involves overcompensating for a negative schema by acting in the direction opposite to the schema content. Simon's schema content renders him vulnerable to being harmed by others for which he compensates by an interpersonal style of hostility, intimidation and bullying. Antagonistic and combative interactions merely reinforce Simon's beliefs that others cannot be trusted, and mean him harm. Simon's aggressive violent behaviour therefore serves to reinforce his maladaptive schemas thus keeping him in a pattern of self fulfilling prophecy.

D.3.4 Why CBT Failed: Insights from Schema Focused Therapy

Young et al. (2003) argue that three main characteristics of personality disorder, i.e. rigidity, avoidance and long term interpersonal difficulties, lead to considerable difficulty in applying cognitive behavioural therapy because these characteristics are not compatible with the core features of the model. They further state that traditional cognitive behavioural therapy is unlikely to be successful for clients with personality disorder because they lack certain basic characteristics: the ability or willingness to access feelings, thoughts and images; the motivation to complete homework assignments and to learn self-control strategies; and ability to engage in a collaborative relationship with the therapist.

For cognitive behaviour therapy to succeed clients need to have relatively easy access to their cognitions and emotions, and, following brief training, to develop the skills to observe, record, and report their thoughts and feelings. However, in many individuals with personality disorder, such thoughts and feelings are habitually avoided because of the accompanying negative affect and they are therefore unable to do so.

Traditional cognitive behaviour therapy assumes that clients are motivated to reduce symptoms, build skills and solve their current problems and that therefore they will comply with the necessary treatment procedures. However for clients with personality

disorder their motivations and approaches to therapy are complicated and they are often unwilling or unable to comply with therapy procedures. They may fail to complete homework assignments and demonstrate a reluctance to learn strategies for helping themselves. Bateman and Tyrer (2004) comment that many people with personality disorders have conditions with which they themselves are comfortable (i.e. they are egosyntonic) and have no wish to change. Similarly, Young et al. (2003, p.4) state:

‘their self-destructive patterns seem to be so much a part of who they are that they cannot imagine altering them. Their problems are central to their sense of identity and to give them up can seem like a form of death - a death of a part of the self. When challenged, these patients rigidly, reflexively, and sometimes aggressively cling to what they already believe to be true about themselves and the world’ (Young et al. 2003, p. 4).

Cognitive behavioural therapy also assumes that clients can engage in a collaborative relationship with the therapist after a relatively brief period of time. However, one of the key features of personality disorder is difficulty in forming and sustaining interpersonal relationships. It is therefore not surprising that clients with personality disorder often have difficulty forming a therapeutic alliance.

Young et al. (2003) propose that in order for therapy for personality disorder to have any chance of success, therapists need to address the core psychological themes that are typical of clients with personality disorder. These core themes are termed ‘early maladaptive schema’ and are regarded as the deepest level of cognition. If the therapist were to primarily focus on automatic thoughts, cognitive distortions and underlying assumptions as is the case with short term cognitive behaviour therapy they would not be able to overcome the rigidity, avoidance and interpersonal difficulties that have developed as a result of the person’s maladaptive schemas.

Reflecting on Young et al’s ideas (Young et al. 2003) in relation to my work with Simon, the characteristics of rigidity, avoidance and interpersonal difficulties were certainly present and perhaps accounted for my difficulties in applying the cognitive behavioural model. In our work together, Simon was able to isolate and report on triggers to his angry

response, physical symptoms and behavioural outcomes, but was resistant to cognitive interventions and, with the exception of anger, was unwilling or unable to disclose any affective states, emotions or feelings. He was either unable to access or habitually avoided thoughts and feelings and associated negative affect, which according to Young et al. (2003) contraindicates traditional CBT. In addition, Simon's lack of compliance with homework assignments and failure to attend sessions caused me to question his willingness and motivation to engage in therapy. Within session, Simon frequently related his violent exploits with an air of arrogance or pride, leading me to believe that he felt powerful and strong whilst engaging in such activity and that his violent behaviour was in fact egosyntonic. To rid him of such behaviour would render him vulnerable – for him an intolerable emotional state. As regards the formation of a collaborative relationship, Simon's overt hostility and aggression made the formation of a therapeutic alliance problematic and brought to the fore issues of countertransference, an issue that shall be explored further in the penultimate section D.3.6. What I Did Well.

Schema Therapy (Young et al. 2003) helps clients and therapists to make sense of chronic, pervasive problems and to organise them into a comprehensible manner. The model traces early maladaptive schemas, 'a result of toxic childhood experiences' (Young et al. 2003, p. 7), to the present with particular emphasis on the client's interpersonal relationships. Using the model clients gain the ability to view their personality problems as egodystonic and thus become more empowered to give them up. The therapist allies with the client in fighting their schemas, utilising cognitive, affective, behavioural and interpersonal strategies. Cognitive strategies include: critically examining evidence that supports the schemas; reviewing evidence that contradicts the schemas; illustrating to the client how he discounts contradictory evidence; developing flashcards that contradict the schema; and challenging the schema whenever it is activated inside or outside therapy (Young et al. 2003). Affective techniques include creating imagery dialogues with the client's parents and emotional catharsis. Interpersonal techniques include the use of the interpersonal relationship itself, to provide a therapeutic relationship that counteracts early maladaptive schema ('through "limited reparenting" the therapist supplies clients with a partial antidote to needs that were not

adequately met in childhood' Young et al. 2003, p. 6). The aim of behavioural techniques is to change schema-driven behaviours, through assisting the client in changing long term behaviour patterns that have reinforced the schemas for most of their life.

A knowledge and application of Schema Therapy (Young et al. 2003), I feel, would have certainly been advantageous to my work with Simon.

D.3.5 Why Anger Management Failed: Insights from Dialectical Behaviour Therapy

Despite the fact that dialectical behaviour therapy (Linehan 1993a) was developed specifically for use with borderline personality disorder, I have chosen here to draw upon the model in revisiting my work with Simon because it is a model that I have come to value enormously. Unlike Alwin et al. (2006, p. 18) who stated 'it is not however a generalised approach to personality disorder', it is my belief, and experience, that it can help a lot of clients with personality disorder - be it borderline, antisocial, paranoid - and would have been particularly useful in the case of Simon.

As mentioned earlier ⁽⁵²⁾, the aim of dialectical behaviour therapy is first and foremost to target and reduce dysfunctional behaviours characteristic of individuals with borderline personality disorder and, following this, to promote change in the emotional dysregulation that is judged to be the core of the disorder. The dysfunctional behaviours to which the model refers are suicidal or self harm behaviours, therapy-interfering behaviours, quality-of-life interfering behaviours (Linehan 1993a). Could Simon's aggression and violence not be viewed as dysfunctional behaviours? Could his difficulties with anger not be viewed as emotional dysregulation? I wonder now whether dialectical behaviour therapy techniques would have been more useful than anger management bearing in mind Simon's underlying personality disorder.

Sarkar and Adshead (2006) have recently discussed the fact that childhood maltreatment and insecure attachment places individuals at risk of developing dysregulated,

disorganised affective systems, and personality disorder. They further state heightened perception of threat seems to be a major problem for people with personality disorders, one that emphasises a lack of safety with and an essential untrustworthiness of others. This is compounded by an inability to repair the emotional states stimulated by threat or fear. They seem to lack the capacity to soothe themselves after fearful experiences (van Der Kolk & Fisler 1994) becoming and remaining hyper-aroused in an uncontrollable, dysregulated manner. Such a description certainly resonates with my experiences of working with Simon. It is my belief that Simon suffered affective dysregulation associated with paranoid personality disorder. His increased suspiciousness and arousal was based on the excessive fear that arose from his heightened perception of threat, underregulation of fear and a fight/flight response pattern which often resulted in reactive violence elicited in response to frustration or threat.

In conceptualising Simon's behavioural difficulties as deficits in emotion regulation, his aggression and violence as behavioural solutions to intolerably painful emotions, a dialectical behaviour therapy approach could have been usefully employed in teaching him the skills to regulate his emotions. During dialectical behaviour therapy numerous skills are taught and learnt through discussion, modelling, role play and rehearsal with the therapist or within a group. Emotion regulation skills such as: identifying and labelling emotions; identifying obstacles to changing emotions; reducing vulnerability to emotions; increasing positive emotional events; increasing mindfulness to current emotions; taking opposite action; and distress tolerance skills such as crisis survival strategies of distracting, self-soothing, improving the moment, focusing on pros and cons (Linehan 1993b) would have been invaluable in my work with Simon.

(52) See D.3.1. Cognitive Behavioural Models of Personality Disorder.

D.3.6 What I Did Well

As can be seen from the previous two sections, there is much that I feel could have been improved in my work with Simon: a thorough formulation at the outset; a recognition of,

and therapeutic focus, on underlying schema; an application of dialectical behavioural therapy techniques to target emotional dysregulation. However, perhaps in D.3. Reformulation and Reflections, I have taken a rather overly critical view upon my work with this client. Before closing I shall, therefore, in the spirit of balance, comment on those things I feel I did well, the things of which I am proud.

Since Heimann's (1950) classic paper on countertransference, it is now widely accepted that therapists and mental health professionals in general have inevitable emotional reactions to their clients. As touched on in D.2., I found working with Simon enormously difficult in terms of the impact it had upon my own mental health. His labile presentation, his verbal threats, his disclosure that he carried a weapon, his graphic tales of violence, meant that within and even beyond sessions I was plagued with a sense of fear. I was fearful that if I challenged him within session I might become a target for his violence. I was fearful that he would act upon the verbal threats he had made to others. I was fearful that should he encounter a person or situation on his way home that he perceived as threatening or demeaning this may trigger a violent outburst. This fear manifested in a kind of behavioural hypervigilance within myself as I found myself constantly looking over my shoulder upon leaving work increasingly convinced that the world was an unsafe place.

So how did I cope with such feelings?

Of course there were the practical strategies I took to ensure my safety and the safety of others such those highlighted earlier in Box D2. In addition, I delved into literature on working with personality disorder, on vicarious trauma and burnout. I sought supervision, recognised and monitored my countertransferential feelings. But most importantly, I endeavoured to see the person behind the behavioural façade. I tuned in to Simon's emotional suffering, his loneliness, his isolation, his fear, his vulnerability and lack of self esteem. I separated his behaviour from him as a person and viewed its intensity as indicative of the intensity of pain and torment he was experiencing. I reminded myself of the abuse he had suffered and of the fact that every human being is deserving of

compassion and empathy. I strove to understand his torment, to validate his experiences and persevered despite his attempts to distance me and reject the help on offer.

This is something of which I am proud. It was not easy to witness or tolerate the sheer rage and rawness of his emotion, but I stayed with him. I did not react like others may have in rejecting or evading him, so compounding his insecurity and confirming a negative self-image (Pilgrim 2001).

D.4 Conclusion

In this case study: I have detailed a cognitive behavioural formulation, treatment plan and approach to the client's presenting concerns; I have highlighted complications in the work and management strategies devised; I have hypothesised about the origins of the difficulties; I have critiqued the work by acknowledging my initial therapeutic naivety and suggested alternative ways of conceptualising the case and working therapeutically with this client.

In closing I would like to comment that I feel the therapeutic journey was painful for both Simon and myself and would appear to have been at best a partial success in that neither significant and lasting changes in the structure of his inner world nor the distress and dysfunction experienced in his day to day living occurred. However, I remain hopeful that the regular contact and support I offered, the quality of the therapeutic relationship established, and the respect I showed for his suffering and dignity as a human being was a positive experience for Simon and encouraged him in future help seeking.

`It is well recognised in psychotherapy that, although not always immediately obvious or easy to assess, the seeds of the possibility of future change may still be sown`

(Kerr 1999, p. 433).

D.5 References

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