Volume 1

Borderline Personality Disorder: A Personal Construct Approach

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There can be only one permanent revolution – a moral one; the regeneration of the inner man. How is this revolution to take place? Nobody knows how it will take place in humanity, but every man feels it clearly in himself. And yet in our world everybody thinks of changing humanity, and nobody thinks of changing himself.

Three Methods Of Reform" in *Pamphlets: Translated from the Russian* (Tolstoy 1900) as translated by Aylmer Maude, p. 29.

"Man looks at his world through transparent patterns or templets which he creates and then attempts to fit over the realities of which the world is composed. The fit is not always very good".

George Kelly (1955).

"All of our present interpretations of the Universe are subject to revision or replacement".

George Kelly (1955)

1.   ABSTRACT

In 2003, Winter, Watson, Gillman-Smith, Gilbert and Acton criticised the DSM-IV's psychiatric conceptualisation of BPD, proposing a set of alternative descriptions based on Kelly's (1955) Personal Construct Psychology (PCP) and diagnostic constructs. According to Winter et al. (2003), PCP offers not only a less "pre-emptive" stance towards BPD but is more clinically useful given its intrinsic implications for treatment. This correlational research study aimed to determine whether BPD symptomatology is associated with these proposed characteristics of construing. In addition, it was hypothesised that those with a belief that BPD was a part of their identity and untreatable would display higher levels of hopelessness. Ten participants with an existing diagnosis of BPD completed the following measures: a) Personal Construct Inventory (PCI; Chambers & O'Day, 1984); b) Millon Clinical Multiaxial Inventory, Third Edition, (MCMI-III, Millon, 1994); and c) Beck Hopelessness Scale (BHS; Beck & Steer, 1988). Participants were also asked to complete a repertory grid and a Likert Scale indicating the extent of their belief that: a) BPD is an intrinsic part of them; and b) BPD is a treatable condition. Two of the participants are presented as case examples.

The most significant finding related to the hypothesis that greater BPD symptomatology would be associated with a higher degree of change in self-construction over time ('*slot-rattling*'). Contrary to our prediction, *similarity* of construing of the elements 'Me Now' and 'Me in the Past' was correlated with greater BPD symptomatology. This may indicate a belief among participants that they are unable to change or may represent Kellian hostility. Construing one's mother and father similarly to one's therapist was associated with greater BPD symptomatology, as was construing one's father and partner similarly, suggesting, as hypothesised, that those diagnosed with BPD tend to construe current relationships in the same terms as early relationships. Pre-emptive construing and poorly elaborated self-construction were also found to be associated with increased BPD symptoms as predicted. Content analyses performed on elicited constructs revealed that emotion regulation is the most salient area for participants. While the majority of participants considered that BPD was a part of their identity, most were uncertain as to whether BPD is treatable although these findings were not significantly correlated with levels of hopelessness. Participants' feedback about their experiences of being diagnosed with BPD raises important ethical questions. Further hypotheses are generated based on the study findings and suggestions are made for a revision of the way in which psychological distress is conceptualized, with a particular emphasis on the utility of the PCP approach towards BPD. Clinical implications, limitations of the study and possibilities for further research are discussed.

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2   INTRODUCTION

2.1   Introduction to the Literature Review

Before considering the main research questions of the paper, it is important to situate the concepts to be discussed within a contextual background; to review how our understanding of BPD has evolved over time. I will begin by introducing BPD as we have come to know it presently, after which I will consider its historical development. It is hoped that this will provide a foundation from which we can examine the limitations of the contemporary diagnostic categorisation of BPD and the potential benefits of an alternative approach; namely, Personal Construct Psychology (PCP).

2.2   The Borderline Personality Disorder Diagnosis

'Borderline Personality Disorder' (BPD) has only recently gained status as a diagnostic category, first appearing in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III, American Psychiatric Association, 1980), and currently in the DSM-5 (2013). Given that this study attempts to validate the PCP model of BPD as an alternative to the symptom criteria as laid out in the DSM-IV (2000), I shall focus on the DSM-IV categorisation of BPD throughout. However, consideration will be given to the subsequent changes that have been introduced into the DSM-5 in the 'Discussion' section. The DSM is based on the 'multiaxial system', the philosophy of which is that psychopathology can be understood in terms of the medical paradigm. The fundamental tenet is that while mental 'illness' is linked to visible signs and symptoms and environmental determinants, the individual's propensity for defending against 'illness' is also of importance and is determined by the structure and functioning of the personality (which can be viewed as a metaphorical 'immune system'). As such, mental 'illness' is categorised within one of three axes; Axis I, which relates to clinical syndromes (such as anxiety or depression); Axis II to personality disorders (e.g. Borderline, Histrionic) and Axis IV to psychological stressors (such as marital, socioeconomic, etc).

According to the DSM-IV, BPD is classified as an 'Axis II' disorder within the multi-axial system, a category reserved for disorders characterised by an early onset, a chronic and pervasive course and significant levels of impairment. It is considered to be one of the 'Cluster B' Personality Disorders (along with Narcissistic, Histrionic and Antisocial Personality Disorders) within which the underlying process is believed to be erratic behaviour. Indeed, DSM-IV states that BPD is characterised by "a pervasive pattern of instability in interpersonal relationships, self-image, affects and marked impulsivity,

beginning in early adulthood in a variety of contexts" in addition to five or more additional criteria relating to hypersensitivity to abandonment, unstable interpersonal relationships, identity disturbance, impulsivity, suicidal behaviour/self-harm, affective instability, transient paranoia and difficulty controlling anger. Five or more of these nine criteria must be met in order to warrant a diagnosis.

2.2.1   Epidemiology

Knowledge and awareness of the disorder has increased dramatically since its first inclusion into the DSM-III. Indeed, it is now the most widely diagnosed of the personality disorders (Loranger, 1990; Loranger, Janca and Sartorius, 1997; Widiger & Trull, 1993), with an estimated prevalence rate of approximately 1 to 3% of the general population (Lenzenweger, Loranger, Korfine and Neff, 1997; Swartz, Blazer, George and Winfield, 1990; Torgersen, Kringlen and Kramer, 2001; Zimmerman & Coryell, 1989). Those with the diagnosis represent roughly 25% of inpatients and 10-15% of outpatients (Widiger & Weissman, 1991; Koenigsberg, Kaplan, Gilmore and Cooper, 1985). Women are predominantly diagnosed, comprising approximately 75% of cases (Nehls, 1998).

2.2.2 Etiology

Whilst it is widely accepted that BPD develops during adolescence and early adulthood, numerous routes have been put forward to account for its pathogenesis.

Internal Factors – Biological Correlates

Research suggests that there is a biological component to BPD. Indeed, twin studies have revealed a 35% concordance in monozygotic twins who meet BPD criteria (Torgersen et al., 2000). Concordance rates are similarly high among samples of twins who display phenotypic traits of BPD (such as emotion dysregulation and impulsivity) but do not meet the diagnostic threshold (Livesley, Jang and Vernon, 1998).

Subdued levels of serotinergic activity have been observed in those with BPD (Hansenne et al., 2002; Skodol, Gunderson, Pfohl, Widiger, Livesley and Siever, 2002), leading to the proposition that abnormalities in serotinergic pathways underlie BPD-type behaviours, such as impulsive aggression (Paris, Zweig-Frank, Kin, Schwartz, Steiger and Nair, 2004). However, specific neural pathways have not been identified. Furthermore, the serotinergic hypothesis of BPD neither accounts for the lack of BPD-type behaviours in those suffering from depression (Golden & Gilmore, 1990), nor explains the fact that SSSRI medication yields a minimal treatment effect in those with BPD (Soloff, 2005).   Further biological

hypotheses have linked the impulsivity in BPD to dysfunction within the prefrontal cortex (Lyoo, Han and Cho, 1998; Vollm et al., 2004) and emotional dysregulation to atypical vagal nerve regulation (Austin, Riniolo and Porges, 2007), hypersensitivity in the hypothalamic-pituitary-adrenal system (Rinne, de Kloet, Wouters, Goekoop, DeRijk, Vanders and van den Brink, 2002) and reduced volume within the hippocampus and amygdala (Tebartz van Elst et al., 2003).

Environmental Factors – Trauma

Research findings have shown a considerable correlation between childhood trauma and the development of BPD. There is now a large body of literature indicating that abuse during childhood, particularly childhood sexual abuse (CSA), is linked with BPD (Herman, Perry, Van der Kolk, 1989; Links, Steiner, Offord, Eppel, 1988; Ogata, Silk, Goodrich, Lohr, Westen and Hill, 1990; Paris, Zweig-Frank & Guzder, 1994; Westen, Ludolph, Misle, Ruffins and Block, 1990; Zanarini, Gunderson, Marino, Schwartz and Frankenburg, 1989) as is childhood neglect (Zanarini et al., 1997) and the experience of traumatic separation or loss of one or both caregivers during childhood (Bradley, 1979; Frank & Paris, 1981, Soloff & Millwood, 1983). Despite these findings, some researchers have argued that while childhood abuse is a significant etiological factor in subsequent development of BPD, it is not a prerequisite (Paris, 1997); pointing out that some with the disorder have no (reported) history of abuse while others with a history of abuse do not go on to develop BPD (Binder, McNiel & Goldstone, 1996). Such findings indicate that while trauma may be a significant risk factor, the relationship between trauma and the development of BPD is not direct and the mediating factor at play is emotional dysregulation or 'affective instability'.

Interaction of Internal (Biological) and External (Environmental) Factors

The present consensus is that BPD develops through a complex interaction of biological, social and environmental factors (Paris, 1994). Indeed, both the 'Biosocial theory' (Linehan, 1993) and the 'Transactional model' (Fruzetti & Iverson, 2006; Fruzetti, Shenk and Hoffman, 2005) consider the fundamental feature of BPD to be 'emotion dysregulation', which develops as a consequence of interactions or rather transactions between an individual's emotional vulnerability (i.e. sensitivity or reactivity) and invalidating reactions of significant others. According to Linehan (1993), when an individual has a biological vulnerability (predisposition) to react strongly to stress and is brought up in an environment within which their feelings are unacknowledged, considered inappropriate and thus invalidated, the child learns not to trust or accurately label their feelings. It is thought that such families place a great emphasis on self-control and thus there may be an underlying sense that the individual

is to blame for their emotional reactions. Within this context, problem behaviours (such as rapid swings between emotional inhibition and emotional disinhibition) and self-harm in individuals with BPD are viewed as attempts to reduce or avoid emotion dysregulation, which may become intermittently reinforced. Linehan further states that the result is an individual who cannot accurately identify or control their emotions. Following on from her 'Biosocial Theory', Linehan devised 'Dialectical Behavioural Therapy' (DBT); a form of therapy within which emotion regulation skills are learned amidst a therapeutic relationship characterised by both validation of current feelings and gentle encouragement towards change. Empirical research suggesting that DBT is clinically effective is promising (Feigenbaum, Fonagy, Pilling, Jones, Wildgoose, Bebbington, 2012).

2.2.3 Comorbidity

Research shows BPD to be highly comorbid with depression, substance abuse and other personality disorders (Oldham, Skodol, Kellman, Hyler, Doidge, Rosnick and Gallagher, 1995; Skodol et al, 1999; Trull, Sher, Minks-Brown, Durbin and Burr, 2000; Zanarini et al., 1998; Zimmerman & Mattia, 1999). Such findings have led some researchers to posit that personality disorganisation is the common, underlying pathological feature of BPD and similar disorders (Kernberg, 1984, Millon, 1981). However, this also begs the question, where does the line (if indeed there is one), between BPD and other types of disorder lie? It appears that the lines drawn by psychiatry are somewhat arbitrary, with researchers estimating that approximately two thirds of those diagnosed with BPD also meet the criteria for other Axis I diagnoses (Fabrega, Ulrich, Pilkonis and Mezzich, 1992).

2.2.4 Prognosis

BPD is associated with chronic and high levels of distress affecting social and occupational functioning. BPD presents a serious challenge to mental health services. Indeed, those with the diagnosis show higher levels of impairment and present more frequently to crisis services than those with other personality disorders (Hueston, Mainous and Schilling, 1996). BPD also represents a significant risk factor for self-harm and suicide. Indeed, suicidal acts and gestures have come to be regarded as the behavioural hallmarks of BPD (Gunderson & Singer, 1975; Mack, 1975), with rates of completed suicide highest among those with BPD as compared with any other disorder (Duberstein & Conwell, 1997). Approximately 10% of people with the diagnosis eventually successfully commit suicide (Paris, 2003). The prognosis for BPD has traditionally been poor and it continues to be seen as a disorder that is unresponsive to treatment or therapeutic intervention despite findings indicating that most people with the diagnosis show some signs of improvement over time (Paris, 2007).

2.3 Origins of the BPD Diagnosis

2.3.1 The 'Difficult' Patient

Attempts to explain 'abnormal' behavior by demarcating and categorising specific personality types is not a new endeavour. Indeed, as early as around 400 BC, Hippocrates noted and described various rapidly shifting moods, which he attributed to an interaction between the four innate bodily 'humours' and the environmental seasons. In 1921, Kraepelin described the 'excitable personality', whose features bear a striking resemblance to what we now refer to as 'borderline' personality symptoms (Millon, 1996). More recently, the notion of personality disorder was further developed by Schneider (1950), who classified several personality disorder types ('psychopathologic personalities') that have undoubtedly influenced our current diagnostic system, one of which was 'labile personality' disorder, which corresponds to our current conceptualisation of BPD. However, the BPD concept as we understand it originally emerged from and is usually attributed to the field of psychoanalysis; the constellation of features to which the term BPD now refers was first described by early analysts. The introduction of the term 'Borderline' is usually credited to Stern (1938), who used it to describe patients who displayed tendencies that rendered them distinct from both their psychotic and neurotic counterparts. These patients were deemed difficult or even impossible to treat using traditional analytical methods. Within psychoanalytic thinking at that time, psychopathology was considered to exist on a continuum from 'normal' to 'neurotic' to 'psychotic' (Linehan, 1993). The pathology of 'Borderline' patients did not fit neatly into either category and they were thus considered to lie on the border between neurosis and psychosis. The term borderline became more popular over the years, bestowed upon a fairly heterogeneous population, typically the 'difficult patient' (Kernberg, Selzer, Koenigsberg, Carr and Appelbaum, 1989). In 1953, Knight further popularised the term 'borderline', detailing features he considered to be unique to the borderline patient. His assertion was that while these individuals were often able to function reasonably well, there were also areas of pathology related to weaknesses in "secondary process thinking, integration, realistic planning, adaptation to the environment, maintenance of object relationships and defenses against primitive unconscious impulses" (as cited in Stone, 1986, p. 165).

In a further attempt to account for the specific and enduring nature of difficulties seen in these patients, perhaps the most influential theoretical advance was made by Kernberg (1967; 1975), who incorporated the term 'personality', offering a hypothesis about the borderline personality structure. He argued that patients with '*borderline personality*'

experience rapid and severe mood swings, lack insight and tend to categorise others as all good or all bad (Kernberg, 1980), a primitive defence referred to by psychoanalysts as 'splitting'. In his view, the underlying characteristics of this maladaptive personality structure were identity diffusion and pathological defence mechanisms (splitting, primitive idealisation, denial, projective identification, omnipotence and devaluation) albeit with the retention of the capacity for reality testing. Whilst ordinarily not psychotic, these patients were considered to enter into transient psychotic states and to regress to primitive states during times of stress. Fundamentally, he regarded these patients as having never achieved libidinal object constancy, the ability to integrate positive and negative introjects or to master what Mahler (1971) later referred to as '*separation-individuation'*.

2.3.2   Searching for the 'Truth' Behind BPD

In 1968, Grinker and colleagues sought to introduce a more robust, medical conceptualisation by conducting the first empirical study into what he later termed the '*borderline syndrome'*. It was hoped that the empirically-based organisation of symptoms would eventually lead to a causal explanation. Later, in 1975, Gunderson & Singer conducted a review of all relevant literature surrounding borderline patients, from which they were able to develop a structured diagnostic interview, the 'Diagnostic Interview for Borderline Patients' (Gunderson, Kolb and Austin, 1981). It was felt that, by using this tool, clinicians would be able to diagnose borderline patients with a degree of reliability according to a set of unique characteristics. Following this, Spitzer, Endicott and Gibbon (1979) were largely instrumental in further developing these characteristics into a cluster of symptoms and a diagnosis that finally entered into the DSM-III.

2.4   The Stigma of BPD: A Hopeless Diagnostic Label?

Foucault's (1967) reference to the mediaeval practice of placing 'mad' or 'insane' individuals in exile on ships in rivers (commonly depicted in artistic and literary works as the 'Ship of Fools') is often cited. While it has been proposed that this is something of a modern myth (Maher & Maher, 1982), few would deny that the mentally distressed have been subject to stigmatisation and marginalisation throughout history. From our current position, we may look back on these times with disbelief. However, the application of the medical model to mental distress and the perpetuation of the construct of 'mental illness' arguably represents a similar social response. As Watzlawick (1984, p. 66) reminds us, the fundamental assumption of the medical model is that there is an objective and knowable reality, while "'a person's sanity is the degree of his 'reality adaptation'". Thus, those who are considered to have deviated from the social norms ('*mentally ill'*) are judged, labelled and separated

('*diagnosed*') from the rest of society ('*mentally well*').

Of all the diagnostic categories, BPD in particular continues to be surrounded by controversy and stigma (Hersch, 2008). Indeed, it has been condemned as the most 'misused and abused' of psychiatric diagnoses (Becker, 1997, p. 152). Furthermore, Herman (1997, p.123) refers to the diagnosis of BPD as 'little more than a sophisticated insult', arguing that the so-called 'symptoms' of the disorder are better understood as coping strategies (albeit maladaptive) adopted as a response to trauma. This has led some to propose that BPD is, in fact, a chronic form of post-traumatic stress disorder (Herman & van der Kolk, 1987; Zanarini et al, 1989). Furthermore, Gunderson & Links (2008) suggest that one of the reasons for the typically chronic course of BPD is that, in fact, many treatments have been detrimental to sufferers, leading him to posit that BPD, as we currently understand it, is an '*iatrogenic disorder*'. Indeed, Fonagy & Bateman (2006, p.2) state that treatment for BPD has often "impeded the borderline's capacity to recover…and prevented them from harnessing advantageous changes in their social circumstances" (as cited in Gunderson & Links, 2008).

It has been suggested that at least some of the negative characteristics attributed to those diagnosed with BPD, rather than being firmly located in the borderline patient, may be a reflection of therapists' disowned countertransferential reactions (Gunderson, Bateman & Kernberg, 2007). As Vaillant (1992) states, the diagnosis of BPD is often meted out to patients whom clinicians dislike. Studies have revealed that clinicians tend to view patients diagnosed with BPD more negatively and with less empathy than patients with other mental health diagnoses (Bourke & Grenyer, 2010; Cleary, Siegfried and Walter, 2002; James & Cowman, 2007; Markham & Trower, 2003). Moreover, the BPD patient has a reputation for being rather manipulative (Deans & Meocevic, 2006), challenging (Woollaston & Hixenbaugh, 2008) and attention-seeking (Castillo, 2000). The intense reactions and frequent crises of the BPD patient leave many mental health workers feeling frustrated (Commons Treloar, 2009) and unfortunately can elicit rejecting responses from the very people enlisted by society to provide care (Aviram, Brodsky and Stanley, 2006). Indeed, in one study, while most clinicians reported recognising BPD as a valid diagnostic category, a large number also acknowledged that they would prefer to avoid such patients (Black et al., 2011).

If our present diagnostic understanding of BPD is not helpful to (and may even hinder) those whom it purports to treat, why does it persist? As Dovidio, Major and Crocker (2000)

propose, the stigma surrounding 'mental illness' triggers an existential anxiety within us as we are reminded of our own vulnerabilities. It would seem that creating endless divisions for the various nuances of experience and perpetuating an illusion of separation alleviates this threat somewhat. Indeed, this tendency has also been found among recipients of diagnoses, who consider themselves separate and distinct from those with the label they have received. As Fransella (1977, p.65) adeptly states, "We know we are not mad by having a very clear idea about what madness is". Interestingly, Warner & Wilkins (2003) argue from a feminist perspective that the label of BPD "serves as the container in which to segregate those parts that are socially feared" (p.178). Thus, they suggest that the diagnosis of BPD is symptomatic of a society that attempts to contain and ultimately control those individuals who dare to controvert its conventions (in this case, women who go against normative definitions of femininity by expressing anger).

Diagnostic labels (such as BPD) encourage us to overlook individual differences between those who are distressed, to cluster them together as a group, separate and distinct from the 'normal population'. While this may reduce anxiety on the part of the clinician, by locating pathology within the individual and ignoring contextual factors, the implication is that the BPD patient is somehow to blame for their predicament. As Walker (2004. pp. 21) argues, "to say that someone's personality is disordered or faulty is to place a judgement on someone's whole sense of 'being'".

The consequences of diagnostic labels are well-documented (Couture & Penn, 2003; Penn & Wykes, 2003) and it is well established that they can promote social exclusion, rejection and discrimination. In addition, they may also bring about an internalisation of stigma and negative views of the self. Demonstrating the well-known self-fulfilling prophecy (Merton, 1957; Watzlawick, 1984), they are more likely to display behaviours in keeping with the label (Knight, Wykes and Hayward, 2003), which can negatively influence their chances of recovery (Anthony, 1993). Recent research (Horn, Johnstone and Brook, 2007) has revealed that while those who go on to receive sufficient access to services and therapy tend to view their diagnosis in a positive light, many of those who receive the diagnosis of BPD have reported viewing the label as a negative judgment for not fitting in. Furthermore, many also reported feeling hopeless as though the label signified the closing off of any possibility of change.

2.5   The DSM and the Medical Model: A Construct in Need of Revision?

Clinicians have for some time questioned the suitability of our current diagnostic system,

accusing it of being fundamentally flawed in its attempt to apply the medical model to human experience, for its positivist assumption that it is possible to clearly distinguish between the 'mentally well' and 'mentally ill' and thus its perpetuation of stigma (Sartorius, 2002). As such, there is an ongoing controversy amongst mental health professionals as to what constitutes a 'personality disorder' (PD) and the utility of this construct. Livesley (2011) argues that the assertion that PDs are separate and distinct from general personality is wrong. Critics have also highlighted issues with validity and reliability of the DSM-IV, citing the arbitrary nature of diagnostic thresholds (Morey, 1988), heterogeneity within recipients of diagnoses (Widiger & Sanderson, 1995), the high level of comorbidity between personality disorders (Oldham, Skodol, Kellman, Hyler, Rosnick and Davies, 1992), the failure to consider contextual factors (Fruzetti, 1996) and overall lack of a scientific basis for many of the disorders (Clark, 2007; Widiger & Mullins-Sweatt, 2010). Indeed, with regard to BPD specifically, Fruzetti et al. (2005) point out that given only five of the criteria need to be met for a diagnosis, this would mean that individuals with a diagnosis of BPD at any one time may share only one of the symptom criteria. Moreover, while the DSM considers BPD to follow a chronic course, there is evidence to suggest that, in fact, it is not necessarily a stable diagnostic entity and that, as such, a less symptom-focused approach to diagnosis may be more appropriate (Garnet, Levy, Mattanhah, Edell and McGlashan, 1994). In terms of clinical utility, the DSM-IV was found to be unable to classify around 40% of disorders (Westen & Arkowitz-Westen, 1998) and, perhaps unsurprisingly, approximately 80% of clinicians expressed dissatisfaction with the DSM-IV (Bernstein et al., 2007).

Given the apparent shortcomings of a categorical taxonomy of PD, a number of authors have proposed a dimensional model and in recent years, the Five-Factor Model (FFM) has been the focus of many such propositions (Widiger & Frances, 1994). In 2008, the DSM-5 Personality and Personality Disorder Work Group (PPDWG) set about revising the conceptualisation of personality disorders. They eventually proposed a hybrid dimensional-categorical system of classification, the idea being that within such a system, the lines of demarcation between 'normal' personality and PDs would become less distinct. In addition to the presence of impairments in self and interpersonal functioning, the proposed dimensional trait model consisted of five higher-order domains (Antagonism, Psychoticism, Disinhibition, Negative Affectivity and Detachment) each with three to seven trait facets, which would then used to determine one of six proposed PDs (Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive and Schizoptypal, (Skodol, 2012).

Within the field of Clinical Psychology specifically, there appears to be some ambivalence

with regard to the use of diagnoses (Boyle, 2002); on the one hand they may be viewed as incompatible with psychological thinking (Carr & McNulty, 2006) and on the other, there is the realisation that the diagnostic system adds a certain legitimacy to proceedings. However, in 2011, The Division of Clinical Psychology (DCP), a subgroup of the British Psychological Society (BPS), rallied against the continued application of diagnoses to mental distress stating that diagnostic categories are subjective, based on social norms and represent a medicalisation of normal responses to experiences. They emphasised the importance of taking psychosocial (social, cultural, familial and personal) factors into account. In essence, the DCP propose *formulation* as a more helpful and ethical alternative to diagnosis. According to the DCP (2010, p5), formulation "will draw on psychological theory and research to provide a framework for describing a client's problems or needs, how it developed and is being maintained". It has been suggested that formulations, unlike diagnoses, cannot be classified as correct (Butler, 1998), given that they are based upon hypotheses, rather than categorical facts. Rather, the focus of formulation is upon utility rather than truth; on ongoing and collaborative meaning-making with the distressed individual (Harper & Moss, 2003). As such, they can be considered person- rather than problem- specific. More recently, the DCP, in response to the DSM-5, released a 'Position Statement' (DCP, 2013) within which they propose a paradigm shift away from the symptom-based DSM towards a psychosocial model. However, such proposals are by no means new.

2.6 The Advent of Postmodernism – Revisiting the Nature of 'Truth' and 'Reality'

It is clear that the construct of BPD has experienced something of its own identity crisis over the years, metamorphosing conceptually from a personality *organisation* to a *syndrome* and finally to a *disorder,* as Gunderson (1994) points out. Perhaps unsurprisingly, these developments have mirrored the epistemological changes within the field of Psychology over the last 100 years. Over the last fifty years or so, there has been a shift within the field of Psychology away from the positivist approach within which mental illness is seen as determined by essential 'qualities' within individuals towards a postmodernist outlook in which distress is viewed as dependent upon context, both individual and social, a movement philosophically rooted in *social constructionism* and *constructivism*. It is worth mentioning here some of the points of similarity and difference between the latter two approaches before elucidating as to their relevance to BPD. Both approaches reject the notion of 'truth' in the positivist sense, objectivism and the idea that we are governed by universal, nomothetic laws. However, social constructionists posit that rather than reflecting an ultimate reality, experiences (and thus distress) are created by and mediated through *social* processes. Thus, reality is co-constructed. So, how might a social constructionist view

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BPD? They might ask whether BPD represents an actual phenomenon or whether, in fact, it is a social construction, a concept mediated by discourses and other societal mechanisms or ways of 'knowing'. Indeed, as Burr (2003, p.3) points out, "…the categories with which we as human beings apprehend the world do not necessarily refer to real divisions". Furthermore, Pilgrim (2002, p.77) suggests "the category of personality disorder is not inherent to those who gain the label but is a by-product of our professional discourse". Social constructionists highlight the societal processes that impact upon us all. In particular, they would consider the role of power and gender in relation to BPD and might be particularly curious about the fact that women are the predominant recipients of the diagnosis. They might therefore ask whether this reflects a true difference between men and women or rather represents a manifestation of the disempowerment of women within the field of mental health.

Within the constructivist model, again there is a rejection of the notion of a knowable, objective reality. I use the term constructivism loosely here; however, there are many types of constructivism (Neimeyer & Raskin, 2001) and as, Raskin (2002) suggests, the term 'constructivisms' may be more fitting. These various 'constructivisms' separate and divide at various points in the extent of their rejection of the concept of a directly knowable objective reality. So, while epistemological constructivism (i.e. Kelly, 1955; von Glaserfeld, 1974; 1984; 1995) reflects the belief that there is such a thing as an independent, external reality but that it can only be known through the constructions of the individual, hermeneutic constructivism (Maturana & Varela, 1992) insists that there is no reality independent of the observer but rather 'knowledge' is mediated through the processes of language and discourse. As Chiari & Nuzzo (1996, p. 174) point out, "all these approaches share a view of knowledge (and truth) as interpretation".

People continue to search for knowledge, truth and meaning. Arguably, this enables us to make sense of, predict and ultimately reduce the uncertainty of events around us; to provide us with stabilising co-ordinates of our position in space and time. In 1955, George Kelly saw this same principle as applying to *all* people, including the mentally distressed.

2.7   Personal Construct Psychology and Constructive Alternativism

2.7.1   The Personal Construct Approach: Man as 'Scientist'

Personal Construct Psychology (PCP) theory, developed by Kelly (1955), asserts in its *'fundamental postulate'* that all psychological experiences are organised according to the

way in which we anticipate events. PCP posits that, as such, people[1] can be seen as *scientists*, attempting to create order by seeking to predict and ultimately control events and thus their own experience. This anticipation occurs by means of our '*construing*', the term used to describe the way in which we interpret and make sense of the world based upon previous experiences or 'replications'. Construing is assumed to occur by means of '*bipolar constructs*', dimensions of meaning achieved through an abstractive process of relative comparisons of similarity and difference ('*Dichotomy Corollary*'). So, while an individual might view the world through the construct pole, 'successful', he/she may view its opposite pole to be 'unselfish' whilst another individual may consider its opposite to be 'lazy', neither being assumed to be more correct than the other. Thus it follows that, according to PCP, our '*personal construct system*' influences the way we experience the world.

PCP is rooted within constructive alternativism, a philosophical stance elaborated by Kelly within which the main argument is that there are innumerable ways of viewing the world ('*Individuality Corollary*'). Whilst most therefore consider it a constructivist model (Neimeyer, 2009), social and relational factors are not ignored. As such, Kelly's (1955) Theory of Personal Constructs has also been regarded as a social constructionist theory (Shotter, 1993). Indeed, Kelly posits that there are points of agreement and thus widely accepted 'truths' within society, which Kelly refers to as the '*Commonality Corollary*', presumably without which there would be no points of reference and utter chaos.

According to Kelly, individuals make an '*elaborative choice*', they choose the pole of a bipolar construct they consider most appropriate for a given situation ('*Choice Corollary*') in accordance with whichever is deemed to be the most successful in either adding to ('*extending*') or confirming ('*defining*') their existing personal construct system. Constructs may or may not be considered relevant or applicable across a range of situations and contexts ('*Range Corollary*'). Constructs, as hypotheses, are replaceable based on new evidence or experiences that may invalidate our previous construing ('*Experience Corollary*') although this is viewed as dependent upon the degree to which existing constructs can be applied to and make sense of new experiences (the notion of 'permeability' in the '*Modulation Corollary*').

Not all constructs are created equal, however. The '*Organisation Corollary*' posits that individuals organise their construct systems in a hierarchical manner, with some constructs ('subordinate') forming elements of larger overarching constructs ('superordinate'). For

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[1] In Kelly's Psychology of Personal Constructs, he refers to "man as scientist".

example, 'good' might be superordinate to a number of other subordinate constructs such as 'generous' or 'honest'. Furthermore, not all constructs employed are compatible with each other ('*Fragmentation Corollary*') as can be seen when we, like chameleons, alter our behaviour depending upon the situation we are presented with.

Lastly, Kelly spoke of the '*Sociality Corollary*', by which he referred to the need for an understanding of the personal construing of the other in order for successful social interaction. It is important to mention here that Kellian sociality does not signify similar or identical construing between two individuals but rather the ability to appreciate the outlook of the other, even if it is alien to our own. So, how does Kelly account for the minds of those society deems as disordered?

2.7.2 The 'Reality' of 'Mental Illness' from a PCP Perspective

Kelly was not in favour of diagnostic labels, arguing that diagnosis is often "an attempt to cram a whole live struggling client into a nosological category" (Kelly, 1991, Vol 2, p.154) and as such, was opposed to a nomothetic stance. Kelly did not entirely reject the idea of 'reality'. Rather, he emphasised the fact that there are innumerable ways of perceiving 'reality' and 'truth'. Furthermore, as Fransella (1995) points out, Kelly posits in his paper, 'The Language of Hypothesis' (1969) that our use of '*indicative*' as opposed to '*invitational*' language causes us to "attribute the condition to the object rather than our interpretation of that object". So, in applying this philosophy to the field of mental health, the diagnostic label becomes merely an interpretation and does not refer to a concrete, 'real' entity. All that we can be certain of is that it refers to our current understanding of a set of experiences and, according to Kelly, no one should insist that one interpretation is true while another is false. Rather than representing an intrinsic and disordered aspect of the individual, mental distress is seen as the result of unhelpful meaning-making; or in his own words, it is the result of "any personal construction which is used repeatedly in spite of consistent invalidation". (Kelly, 1991, Vol. 2, p.193). Thus, psychological disorder is linked to the individual's unique personal construct system.

2.7.3 Formulation and the Transitive Diagnosis

While Kelly was against diagnosis in the traditional sense, he recognised the need for a shared understanding of an individual's difficulties before embarking on the joint work of therapy. Kelly (1955/1991, p.454/Vol. 2, p.147) mentions two distinct types of formulation-based approach ('*structuralisation*' and "*construction*"). While the former of these refers to the collection of more generic clinical information, the latter describes the process through

which the therapist examines the client's behaviours within the context of their personal construct system and then attempts to bring this within his own construct system ('*subsuming*'). Subsuming requires the therapist to suspend his own values and beliefs, to adopt a '*credulous*' stance. In essence, Kelly was proposing that rather than imposing our 'expert' view of 'reality' upon the individual, we must first attempt to understand their unique representation of reality and way of viewing the world without preconceptions or moral judgment.

Kelly proposed a system of '*diagnostic constructs*' through which clinicians could attempt to construe the construing of the client. He was keen to highlight the fact that his theory could be applied to all and not only those considered to be 'mentally ill'. Indeed, he states that it is "designed around the problem of reconstruing life, but it is not a system built upon psychopathology" and further that, "Our approach to psychological disturbance is altogether in terms of dimensions rather than in terms of disease entities" (Kelly, 1955/1991, p. 830/Vol. 2, p.192). As such, Kelly appears to be arguing against a separation between the 'well' and the 'ill' (in fact, he viewed his theory as one in which the therapist should just as easily see himself as his client) and asserting that an individual's construct system and thus experience of the world is subject to change.

By adopting the term '*transitive diagnosis',* Kelly emphasised the need to consider the individual's life in transition. He believed that the focus of psychoanalysis upon the past was disempowering for the individual, arguing that "a man may not now choose his past, but he may select his future' (Kelly, 1955/1991, p.835/Vol 2., p.194). Rather than a prison within which the client is forever marginalised, the aim of the transitive diagnosis is to serve as a point from which movement is possible. The individual is seen (as a scientist), as being able to experiment with alternative ways of being in and experiencing the world, as is illustrated by Kelly's famous statement: "…no one needs to be the victim of his biography" (Kelly, 1991, Vol 1, p.11). Essentially Kelly's formulation-based approach adopts a propositional ('as-if') as opposed to pre-emptive ('nothing but') stance.

2.8   Kelly's Diagnostic Constructs

2.8.1   Problems with Constructs

Mental distress, according to Kelly (1955) may occur as a result of constructs that are largely outside of the awareness of the construer, akin to the unconscious in psychodynamic thinking. Constructs may be '*preverbal*', having been established prior to the development of

language and thus without being assigned verbal labels. Furthermore, one end of a construct ('*pole*') may be '*submerged*' or hidden and thus not visible to the individual, in order that the bipolar construct be protected from being put to the test. Lastly, '*suspension*' is the term used to refer to those constructs or elements that are forgotten in the process of reconstruing. Therapeutic exploration and subsequent awareness of these unconscious constructs (like the psychodynamic concept of 'insight') is viewed as enabling the individual to consider alternative possibilities and to make informed choices about construct experimentation.

Kelly also believed that diagnostic assessment of an individual's construct system and planning of therapeutic interventions should take into account the hierarchical status of particular constructs. As previously mentioned, some constructs ('*superordinate*') subsume others ('*subordinate*'). Superordinate constructs carry greater importance for the individual's meaning-making system. Among the individual's superordinate constructs are '*core constructs*', which, unlike '*peripheral constructs*', are intrinsically linked to the individual's sense of "identity and existence" (Kelly, 1955, p.482). When core constructs are challenged, it is experienced as "an awareness of an imminent comprehensive change in one's core structures" (Kelly, 1955/1991, Vol 2, p.6), or '*threat*'. It presents the individual with a sense that everything they have come to believe about themselves and the external world has been plunged into chaos. It is for this reason that Winter and Procter (2013) advise clinicians not to directly challenge core constructs during therapy, at least not until a trusting therapeutic relationship has been established. Perhaps unsurprisingly, superordinate constructs play an important role in whether change occurs within the individual and have been found to be resistant to change (Hinkle, 1965). This leads to an intuitive question; that of why individuals do not change, and one that numerous psychological theories have attempted to answer. In PCP, Hinkle (1965) referred to '*implicative dilemmas*', a form of conflict that arises as a result of a discrepancy between the present pole of a construct and desired pole (or the actual and ideal self) when movement towards the desired pole would simultaneously constitute a move towards an undesirable pole of another construct. For example, a female might view herself as docile in the bipolar construct 'docile-assertive' and while she may construe her ideal self as 'assertive', she may also view assertive people as aggressive, thus presenting her with a dilemma. Another form of conflict referred to in PCP, is that of "cognitive conflict". Bell (2004a) states that cognitive conflict (aka '*triadic conflict*') arises when "an element is at the same time similar or close to two 'construct poles' which are themselves different or distant" or when "an element is similar or close to one construct pole and at the same time is different to or distant from another construct pole, where the

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two construct poles are similar or close". As such, in this sense, cognitive conflict can be considered a form of what psychoanalysts refer to as *ambivalence*. Cognitive conflict has been associated with cognitive complexity (Winter, 1983).

It would seem that resistance to change may also occur as a result of attempts to preserve certainty, meaning and coherence within the construct system. Indeed, as Fransella (1970) argues, symptoms may become a part of the identity and thus the loss of symptoms would be synonymous with a loss of the sense of self. Furthermore, Button (1983) suggests (in the case of anorexic patients) that symptomatology may be maintained by virtue of a lack of alternative constructs through which to make predictions about themselves, others and the world around them. In each case, the self-concept is protected despite the negative repercussions and "mental illness" can be seen as an individual's attempt at coherent meaning-making. As Dorough, Grice and Parker (2007) point out, cognitive conflicts (Freud, 1923; Festinger, 1957) have long been recognised as a major contributor to the maintenance of psychological distress. Interestingly, Bell, Winter and Watson (2004) suggest that conflicts in relation to the self are linked to previous psychological trauma. Moreover, research has shown that conflicts within the construct system, or implicative dilemmas, are closely linked to symptom severity (Feixas, Saul and Avila-Espada, 2009).

2.8.2   Problems with Construing

The Experience Cycle, Dilation and Constriction

Kelly (1955) felt that it was not only structural issues that could lead to mental distress but *ways* of construing. Given Kelly's fundamental assertion that individuals attempt to make predictions about the world, in PCP, psychological distress relates directly to the way in which individuals respond when their predictions fail ('*invalidation*'). Rather than using invalidation as a catalyst for growth within the construct system (Mancini & Semarari, 1988) by integrating new knowledge, mental distress is associated with the maintenance of a disproven system. Indeed, Winter (1992, p.15) defines psychological difficulties in terms of attempts to "cope with invalidation and to avoid uncertainty".

Like scientists, we are continually faced with evidence that challenges our assumptions about the order of things and, as such, are required to review and change our constructs to accommodate new information. Kelly (1970) referred to this process as the '*Experience Cycle*', which consists of five stages: *anticipation, investment, encounter, confirmation or disconfirmation and constructive revision*. As always, there are options and choices. When faced with information from the environment that challenges our existing construct system,

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we may choose to broaden our construct systems to accommodate the new evidence (*'dilation'*). Alternatively, we may seek instead to maintain the status quo by narrowing the perceptual field (*'constriction'*). According to PCP, our ability to revise our constructs following invalidational evidence is closely linked to our psychological wellbeing. Indeed, Neimeyer (1985) suggests that various psychological difficulties correlate with areas of stuckness within the cycle and the earlier in the cycle that difficulties arise, the more severe the disorder.

Loose vs Tight Construing

According to Kelly (1955), psychological movement or change takes places through a fluid process of loosening and tightening of constructs. Loose constructs are vague and often lead to changeable predictions and individuals who construe loosely display weaker relationships between constructs. As such, they are observed to frequently change their opinions and views about themselves, others and the world. Bannister (1960, 1962) showed that those diagnosed with schizophrenic thought disorder exhibit loose construing and posited that this was the result of '*serial invalidation*' (Bannister, 1963, 1965). According to Bannister, loose construing is a defensive strategy employed as a result of, and to prevent further, invalidation and involves the loosening of connections between previously linked constructs. The less specific and concrete one's predictions are, the more protected they are from invalidation. On the other hand, tight constructs are stable, defined and characterised by very specific predictions, rendering them vulnerable to invalidation. Conversely, as Bannister (1963, 1965) states, repeated validation of constructs leads to a strengthening of the links between constructs, which, in turn, leads to cognitive simplicity (Bieri, 1955). While we may all at times indulge in loose and tight construing, the tendency to consistently use either extreme loose or tight construing has been shown to be associated with psychological distress (Dalton & Dunnet, 1992). An additional response to invalidation is "slot-rattling", a term coined by Kelly (1955), which describes a rapid shifting from one pole of a construct to another and perhaps back again. While the PCP model promotes experimentation with construing through therapeutic methods such as 'fixed role therapy', Kelly (1955) considered slot-rattling to be primitive and simplistic.

2.8.3   Problems of Control

Circumspection-Preemption- Control (CPC) Cycle.

Kelly (1955) introduced the notion of the '*Circumspection-Pre-Emption-Control* (CPC) *Cycle*', also known as the 'Decision-Making Cycle', in order to describe the process through which individuals make decisions. The first stage, known as '*circumspection*', involves a

consideration of all of the possibilities. This is followed by '*preemption*', the stage during which we narrow down our search and select the most viable (or superordinate) of the possibilities. Lastly, during the '*control phase'*, we choose one pole of a construct and act upon our decision. Difficulties can arise when individuals spend too long or not long enough in any of the three stages. For example, individuals may be observed to make impulsive decisions as a means of reducing the anxiety and threat evoked by the uncertainty of multiple possibilities. Conversely, we may spend too long in the circumspection stage for fear of making the wrong decision. Control is achieved when we achieve a balance between these two stages.

2.8.4   Problems with Dependency

Kelly viewed dependency as a characteristic present throughout all life and not just childhood (Kelly, 1962, 1969). He considered that, as we mature, we elaborate our dependencies, allowing them to incorporate others and not solely our parents or primary caregivers. Rather than relying on various people for a number of different needs, some individuals exhibit '*undispersed dependency',* manifest either as an over-reliance on only one or a small number of people or on a large array of people to meet all one's needs. Kelly believed that such dependencies enhance the individual's vulnerability to psychological distress.

2.8.5   Problems with Sociality

Linked to the dispersion of dependencies, is the concept of sociality. The Sociality Corollary states that, "To the extent that one person construes the construction processes of another, he may play a role in a social process involving the other person" (Kelly, 1991, Vol 2, p. 5). Sociality can be understood as the PCP equivalent to 'Theory of Mind' or the psychodynamic concept of 'Mentalisation" (Procter, in press). It refers to our ability to understand the construing or world-view of others and governs our social interactions. Later, Leitner, Faidley and Celentana (2000) proposed a PCP model of disorder emphasising a link between developmental history and sociality. They posit that childhood trauma brings about arrested development of self- and other-construing, which ultimately influences the way an individual interacts interpersonally. Thus, trauma may lead to a retreat from '*role relationships*' and from exploration of the minds of others as these are considered dangerous, unpredictable and pose the threat of invalidation.

2.8.6   Emotion: Stability vs Change

PCP has been criticised for focusing heavily on cognitive processing to the detriment of

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emotion. However, Kelly did not neglect feelings and as Procter (2009) points out, constructs represent emotions as much as cognitions. Difficult emotions, in the Kellian sense, all relate in some form or another to the maintenance of stability, or rather to difficulties of transition. *Anxiety*, for example, is defined as "the awareness that the events with which one is confronted lie mostly outside the range of convenience of one's construct system" (Kelly, 1991, Vol 2, p7). In other words, it is the subjective feeling we are left with when faced with the unknown together with the sense that we have no known tools within our repertoire with which to deal with the given situation. According to Kelly (1991, Vol 2, p7), *fear* is the "awareness of an imminent *incidental change* in one's core structures". *Threat*, on the other hand, is considered to be the result of an imminent *comprehensive* change in one's core structures. *Guilt* occurs as a result of a sense that we have compromised our core identity. *Aggression* constitutes the "active elaboration of one's perceptual field". While others may be put out by such endeavours, it can be differentiated from *hostility,* which is "the continued effort to extort validational evidence in favour of a type of social prediction which has already been recognised as a failure" (Kelly, 1991, Vol 2, p7).

2.9   A PCP Approach to BPD

In 2003, Winter, Watson, Gillman-Smith, Gilbert & Acton criticised the DSM-IV conceptualisation of BPD as "pre-emptive", arguing that the diagnosis of BPD is, in all likelihood, a reflection of attempts to relieve the uneasiness felt by clinicians when faced with those with the 'disorder'. In their view, those with BPD represent a challenge to us perhaps because they "force us to dilate our systems and develop new constructs" (p. 342). Furthermore, they remind us of the fact that DSM-IV itself is a construct system, a means by which we attempt to predict (and arguably control) the symptoms and behaviours we have come to associate with BPD. The authors propose a set of alternative characteristics of construing of people with BPD corresponding to the DSM-IV's eight symptom criteria (see Table 1 below).

Table 1. Proposed characteristics of construing in BPD (Winter et al., 2003).

DSM-IV Diagnostic Criteria	Possible Characteristics of Construing
i) A pattern of unstable and intense relationships characterised by alternating between extremes of overidealisation and	Tendency to pre-emptive construing; slot-rattling; superordinacy of constructs concerning valuation of self and others; fragmentation; low sociality.

devaluation.	
ii) Impulsiveness in at least two areas that are potentially self-damaging.	Foreshortening of the CPC cycle.
iii) Affective instability	Slot-rattling; loose construing.
iv) Inappropriate intense anger or lack of control of anger.	Dearth of validation and failure to reconstrue following invalidation.
v) Recurrent suicidal threats, gestures or behaviours, or self-multilating behaviours.	Lack of verbalisation of constructions or demands expressed in suicidal behaviour; hostility.
vi) Marked and persistent identity disturbance	Poorly elaborated or fragmented self-construction.
vii) Chronic feelings of emptiness and boredom.	Failure to be aggressive (Kellian) and complete new experience cycles.
viii) Frantic efforts to avoid real or imagined abandonment.	Dependency path characterised by threat; construction of current relationships in the same terms as early relationships.

These propositional characteristics of construing are based on Kelly's eleven corollaries and attempt to provide not only observations of symptoms but underlying reasons for symptomatology. As such, the authors consider that their model has important implications for treatment.

2.9.1   Proposed Characteristics of Construing in BPD

I will now review each proposed characteristic of construing of BPD according to Winter et al. (2003), providing some theoretical background for the terminology used.

Tendency to Pre-Emptive Construing

According to Winter et al. (2003), the symptom of "unstable and intense relationships" as described within the DSM-IV, can be understood within the PCP model as the "*tendency to pre-emptive construing*". As mentioned earlier, circumspection is the first stage of the CPC Cycle and is characterised by an opening up to all of the possibilities. Pre-emption is the stage during which we narrow down our search, selecting those constructs that we consider to be the most suitable while eliminating others. Bypassing the circumspection stage and surging forward into pre-emption means that we may miss viable possibilities often resulting in the viewing of elements of our experience as all or nothing. A pre-emptive construct

assumes that its elements pertain exclusively to itself; "If this is a ball, it is nothing but a ball" (Bannister & Fransella, 1971). It is the 'black-and-white thinking' (Beck, 1979), or 'splitting' according to the psychodynamic model, that we hear about in descriptions of those with a diagnosis of BPD. Good and bad qualities within an individual are seen as mutually exclusive and thus cannot be incorporated within the same construct.

Slot-rattling

Winter et al. (2003) propose that "*slot-rattling*" may also account for the relationship difficulties experienced by those diagnosed with BPD. Slot-rattling describes the shifting of construing (of people, events, or the self) from one pole of a construct to its opposite. To those observing, this may appear as a rapid and dramatic change in attitude or identity. However, despite appearances, the resulting behaviour change is superficial, and not rooted within an elaborated system. As such, the individual tends to revert back to the original form of construing following invalidation within the environment. It is not difficult to see how such a strategy might contribute to confusion in those closest to the person diagnosed with BPD. Furthermore, this to-ing and fro-ing from one construct pole to another could just as easily lead the individual with BPD to be confused about their *own* feelings and thoughts about themselves and others. As such, slot-rattling was also put forward by Winter et al. (2003) as an explanation for DSM-IV's "*affective instability*".

Superordinacy of constructs concerning valuation of self and others

As mentioned earlier, some constructs are superordinate to others. In proposing that the superordinate constructs of those with BPD will be concerned with the valuation of self and others, Winter et al. (2003) are suggesting that value of self and other and self in relation to others forms an important focus of how those with BPD organise their world psychologically. According to this hypothesis, a large number of events or experiences will be linked or attributed to the relative value of the self or other people. Furthermore, strongly held feelings are likely in relation to the value of self and other. Taking this argument into account, this can easily explain the "extremes of overidealisation and devaluation" to which the DSM-IV refers.

Low Sociality

As Leitner (1988) points out, humanity has simultaneously a need for and a terror of intimate '*role relationships*'. Throughout the psychodynamic literature, this characteristic is highlighted as particularly prevalent among those with BPD, by virtue of their '*disorganised*

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attachment style', '*approach-avoidance dilemma*' and '*annihilation fears*'. Given the high incidence of childhood trauma and invalidation in those diagnosed with BPD, it is not difficult to see how and why interpersonal difficulties might develop. When the minds of others have historically been unpredictable, unfathomable and ultimately threatening, a reluctance to explore this dangerously uncertain territory can arise. Indeed, it would seem that the aforementioned retreat from 'role relationships' (Leitner et al, 2000) is a self-protective move, in which the aim is to maintain integrity of the core self. Unfortunately, this retreat leads to a further reduction in the capacity to understand and to make predictions about the thoughts and behaviour of others. The ability to construe the construing of others has been found to be correlated with meaningful engagement in intimate relationships (Leitner & Dill-Standiford, 1993). Building on this, Winter et al. suggest that the "unstable and intense relationships" described in the DSM-IV are down to problems with sociality.

Foreshortening of the CPC Cycle

Winter et al. (2003) put forward that 'foreshortening of the CPC cycle' is the underlying cause for the impulsivity referred to in the DSM-IV. In prematurely reaching the '*control*' phase without adequate time spent reviewing the possible outcomes in the '*circumspection*' and '*pre-emption*' phases, decisions appear to be made hastily and without consideration of long-term goals or safety.

Loose construing

Winter et al. (2003) suggest that loose construing may also contribute to the 'affective instability' of those with BPD. Given the known link between BPD and childhood invalidation (Bryant, Yarnold & Grimm, 1996; Rosenthal, Cheavens, Lejuez & Lynch, 2005), this argument certainly seems plausible. By producing construing that has little predictive power (loose construing), the individual avoids further invalidation, a strategy referred to by Walker (2002) as '*non-validation*'. Unfortunately, the downside to this coping mechanism is that the loose construer is unable to produce structured, testable predictions about the world, which undoubtedly leads to further anxiety. Furthermore, the loose construer may act differently at various times within the same situation, leaving those close to them unable to predict their behaviour.

Dearth of validation and failure to reconstrue following invalidation

Invalidation is put forward by Winter et al. (2003) as the reason for the 'inappropriate and intense anger' displayed by those with BPD. The authors assert that following invalidation, those with BPD fail to reconstrue, that is, they fail to reorganise their construct systems to fit

with their new experiences, and instead hold on to construct systems that are likely to lead to further inaccurate and unwanted results. It would seem that those with BPD do so in order to maintain some degree of certainty in their inner world as a response to the uncertainty of the external environment even if it makes little sense or results in an undesirable outcome. Indeed, Kelly (1977, p.6) points out, we often display a preference for "certainty over meaning". Arguably, this trait can be viewed as patently amongst those with chronic mental distress in holding onto unhelpful ways of being as it can be seen among the scientific community in refusing to dispense with outdated ideas. Again, unfortunately this strategy ultimately leads to yet further invalidation.

Lack of verbalisation of constructions or demands expressed in suicidal behaviour
Winter et al. (2003) suggest that the suicidal gestures performed by those with BPD can be attributed to a behavioural expression of their demands or constructions. According to PCP, deliberate self-harming behaviours can be thought of as '*validating act*s' (Kelly, 1961; Stefan & Von, 1985). However, Kelly (1961) distinguishes between suicide performed as a '*dedicated act*' and '*mere suicide*'. The former was considered an individual's attempt to extend and validate their construct system; paradoxically to give meaning to their life. The latter incorporates 'two limiting conditions of realism and indeterminacy'. By 'realism', Kelly means certainty and the sense that "the course of events seems so obvious that there is no point in waiting around for the outcome" (Kelly, 1961, p.260). Conversely, by indeterminacy, he refers to the chaotic predicament that "everything seems so unpredictable that the only thing is to abandon the scene altogether" (Kelly, 1961, p.260). Chaotic suicide is a process of constriction, a pulling in and strengthening of one's own barriers against an unpredictable world. Indeed, Landfield (1971; 1976) found that suicide attempts were linked to a disorganised construct system, leading him to conclude that in a world characterised by inevitable and unrelenting uncertainty, suicide represents a finite means of proving that there is some certainty in life, even in death. This is further supported by the finding that among self-harmers, uncertainty about the future self is associated with hopelessness (Winter et al, 2000).

With regard to Winter et al.'s reference to "lack of verbalisation", Kelly (1991, Vol 2, p.6) argued that not all constructs are elaborated or organised verbally within the construct system, referring to them as '*preverbal*'. These constructs still govern our reactions and behaviour and may have developed at a time prior to the acquisition of language. Winter et al.'s (2003) assertion that suicidal behaviour occurs as a result of lack of verbalisation of constructions is supported by research findings that show that *alexithymia*, or inability to

identify one's own feelings, is a mediating factor between childhood abuse and self-injurious behaviour (Paivio & McCulloch, 2004). Interestingly, alexithymia has also been linked to a reduced capacity to understand the perspective of others ('sociality'). Moreover, the capacity for comprehending the self and others is connected with and directly influences emotional regulation (Moriguchi et al., 2006).

Hostility

Hostility was first put forward as a PCP explanation for suicidal behaviour by Lester (1968). Winter et al. (2003) also argue that this underlies the repeated suicidal gestures carried out by those diagnosed with BPD. Hostility, in PCP terms, is the maintenance of a construct system, that, despite its failings, is used consistently; an attempt to change the world in order to maintain one's constructions of it. To further elaborate this concept, I am reminded of Tolstoy's adage: "Everyone thinks of changing humanity but no one thinks of changing himself" (Tolstoy, 1900, p.29). Suicide can be viewed as the ultimate form of hostility, an assertion of the reality of one's own perspective.

Poorly elaborated or fragmented self-construction

According to the 'Fragmentation Corollary', "A person may successively employ a variety of construction subsystems which are inferentially incompatible with each other" (Kelly, 1991, Vol 2, p. 5). Thus, our construct subsystems may be incompatible, which, in turn, can lead to changeable behaviour. Fragmentation is put forward by Winter et al. as an explanation for the DSM-IV's "persistent and marked identity disturbance" observed in those with BPD as well as their troubled relationships.

It would seem that this fragmentation of the self-construct is a survival response to childhood invalidation and trauma. Indeed, research has shown that fragmentation is exhibited by those who have PTSD (Sewell, 1997). Just as the individual avoids invalidation by developing non-committal and non-specific hypotheses, fragmentation (or a poorly elaborated self-construct) can be viewed as a self-protective mechanism whereby the creation of an undifferentiated sense of self maintains the integrity of the whole, 'true' or core self. The downside to this is that the individual is left unsure of their 'true' identity when they are capable of such divergent thoughts, feelings and behaviours. It is little wonder then that among those diagnosed with BPD, the ability to predict or regulate one's own emotional states may be compromised. Arguably, a consistent sense of self-awareness is the sine qua non of the ability to regulate and/or control emotions. It seems obvious then that this predicament would lead to problematic interactions in relationships with significant others

who may be confused by unpredictable, 'difficult' behaviour. Such fragmentation may, thus, unfortunately, lead to the abandonment that is so feared.

Failure to be aggressive (Kellian) and to complete new experience cycles
Winter et al. (2003) suggest that a failure to be aggressive underlies the BPD symptom of "chronic feelings of emptiness and boredom" described in the DSM-IV. Kellian aggression refers to experimentation that involves trying out new constructs for size. In suggesting that those with BPD fail to be aggressive, it is assumed that potential solutions remain hidden and unexplored, resulting in the repetition of unhelpful patterns of behaviour. Paradoxically, it may be this failure to be aggressive that leads to the hostility observed in those with the diagnosis of BPD.

Winter et al. (2003) also propose that those with BPD fail to complete new experience cycles. Building on Kelly's (1955) 'man as scientist' metaphor, if previous attempts to explore and experiment with the world have resulted in inconsistent results, our belief in our ability to make sensible predictions will be shaken. We might decide that being a scientist is not for us after all and give up experimenting altogether. So it may be the case with the individual with BPD. Instead of testing and subsequently modifying their construing, they may choose instead to work with what they already have, utilising outdated construct systems that do not serve them well despite the fact that this leads to inconsistent and invalidating results.

Dependency paths characterised by threat
According to Winter et al. (2003), the "frantic efforts to avoid real or imagined abandonment" can also be explained in terms of dependency paths that are characterised by threat, a hypothesis that derives from an earlier study by Chiari et al. (1994). In all likelihood, the inconsistent caregiving experienced by many of those who later receive a diagnosis of BPD is likely to lead to an association of all types of relationship with a threat to their self-construction. Abandonment and rejection can be seen as the ultimate form of invalidation to the core self and would therefore be avoided at all costs. Furthermore, as Kelly (1969) argued, dependencies are linked to sociality in that as we mature, we become aware of what others can and cannot do for us. If we have undispersed dependencies, we are likely to put all of our eggs in one basket, expecting another individual to cater to a vast array of our needs, leading perhaps to the perception among others that we are very demanding in our interpersonal interactions. It follows then that we may be considered overly-dependent and that from our own perspective, such relationships are viewed as tantamount to our survival. Viewed within this context, "frantic efforts to avoid real or imagined abandonment" become

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much more understandable. Again, paradoxically, the individual diagnosed with BPD appears to both desire and yet fear intimate relationships with others, seemingly slot-rattling between closeness and distance or proximity-seeking versus proximity-avoiding (the psychodynamic 'approach-avoidance dilemma') in close interpersonal relationships.

Construction of current relationships in the same terms as early relationships
Kelly (1955) proposed that the transferences referred to in psychodynamic theory can be understood within the context of constellatory constructs. Specifically, he argued that the therapist who finds himself being treated as the 'father figure' has been stereotyped by virtue of the patient's "highly elaborated and vastly prejudicial stereotype" (Kelly, 1991, Vol 2, p.77). The constellatory construct takes on the elements of other constructs within its realm. In the therapeutic relationship, this is often evident when the therapist who displays some attributes akin to a father figure, by virtue of this association, now takes on other negative characteristics of the patient's father. Similarly, Winter et al. (2003) suggest that the DSM-IV symptom of "frantic efforts to avoid real or imagined abandonment" could be explained in terms of the construing of current relationships in terms of early relationships.

2.9.2   Rationale for a PCP Approach to BPD
Importantly, as Bannister & Fransella (1971) point out, Kelly did not assume that his theory was any greater than its predecessors, merely that it could be seen "as an alternative which does not deny the 'truths' of other theories, but which may provide more interesting, more inspiring, more useful and more elaboratable 'truths'" (p.19). Like the pragmatists, Kelly argued that the validity of a theory was related to its utility. Thus, rather than condemning the DSM-IV conceptualisation of BPD as 'wrong' whilst the PCP approach to BPD may be thought of as 'right', it is perhaps more beneficial to consider how useful each model is. How successful are these respective constructions of BPD in understanding and representing the experience of those with the diagnosis (from their own perspective)? How helpful are they in assisting sufferers to explore and create alternative realities and experiences?

I would argue that a PCP approach to BPD could be a useful alternative to the medical model of the DSM on a number of levels. The DSM-IV with its focus on symptomatology provides little in the way of causal explanations or context concerning the individual experience of BPD from the perspective of the sufferer. It would seem that in an effort to relieve indeterminacy (chaos), we have clung to a structure that provides some certainty despite its apparent failings. Conversely, PCP, with its focus on individual meaning-making, constitutes a move away from nomothetic generalisations of mental distress towards an

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idiographic stance. As such, the PCP perspective offers a less stigmatising conceptualisation of mental distress; the dividing line between sane and insane being disregarded. In contrast to other psychological theories, PCP views the individual neither as an innately disordered person nor a helpless victim of circumstance destined to a life of continued 'mental illness' by virtue of a damaged 'personality'.

Procter (2009) posits that PCP can be used reflexively, as a meta-therapeutic framework within which we can examine professional as well as diagnostic constructs. As scientists, we must consider our own construing and whether or not this is useful for the people we treat. In attempting to impose pre-existing templates onto a heterogeneous group of individuals, are we not thinking pre-emptively, or displaying a lack of sociality, an inability (or rather unwillingness) to see the world through the eyes of the mentally distressed? Are we not exhibiting hostility by continuing to utilise the medical model despite its apparent flaws?

As Bannister (1983) argues, the sense of self is interlinked with our view of how others view us. It is incumbent upon us then, as Psychologists, to consider whether such labels disempower individuals or are guilty of convincing them that change and recovery are not possible. As Proctor (2007) highlights, the experience of powerlessness is a significant contributor to mental distress and the field of Psychiatry has the power to define the distress of the person diagnosed with BPD, to prescribe treatment and to determine the prognosis (Johnstone, 2000; Proctor, 2002; Shaw, 2004). PCP promotes an alternative, more hopeful outlook in which the individual's capacity for change is emphasised (Epting, 1984; Fransella & Dalton, 1990). Indeed, the aim of PCP therapy, with its focus on the client as expert (Viney, 1996), is to elaborate the meaning of distress and to explore and co-create alternative and more helpful possibilities. PCP theory has a growing evidence base, yielding generally positive results (Epting, 1981; Viney, Metcalfe and Winter, 2005; Winter, 1992; Winter & Viney, 2005).

In the spirit of Kelly's (1955, Vol 1, p.13) statement that "a good scientist tries to bring his constructs up for test as soon as possible", this study attempted to validate the proposed characteristics of construing for those diagnosed with BPD as suggested by Winter et al. (2003). In addition, given the undeniable stigma surrounding the label of BPD, the study also investigated whether there is a link between beliefs about the nature of BPD and levels of hopelessness.

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2.9.3 Hypotheses

<ins>Hypothesis 1.</ins>

Participants who show greater BPD symptom severity will exhibit higher degrees of the characteristics of construing as proposed by Winter et al. (2003), as evidenced by correlations. Table 2 shows the predicted correlational results for Hypothesis 1. Detailed explanations as to the measures used will be included later in the Method section.

<ins>Table 2. Predicted correlational results for Hypothesis 1.</ins>

Hypothesis 1	Measures	Prediction
a) Pre-emptive construing.	Personal Construct Inventory and MCMI-III Borderline Scale scores.	Positive correlation.
b) Slot-rattling.	Repertory grids. (Standardised Euclidean Distances between the elements 'Me in the Past', 'Me Now' and 'Me in the Future' and MCMI-III Borderline Scale scores).	Positive correlation.
c) Low sociality.	Repertory grids. (Percentage sums of squares for the element 'How Others See Me' and MCMI-III Borderline Scale scores).	Negative correlation.
d) Fragmentation.	Repertory grids (Conflict scores and MCMI-III Borderline Scale scores).	Positive correlation.
e) Looseness.	Repertory grids. (Principal Components Analysis of grids and MCMI-III Borderline Scale scores).	Negative correlation.

f)	Hostility.	Personal Construct Inventory and MCMI-III Borderline Scale scores.	Positive correlation.
g)	Poorly elaborated self-construction.	Repertory grids. (Percentage sums of squares for the element 'Me Now' and MCMI-III Borderline Scale scores).	Negative correlation.
h)	Construction of current relationships in the same terms as early relationships.	Repertory grids. (Standardised Euclidean Distances between elements 'Mother/'Father' and 'Partner'/ 'Therapist' and MCMI-III Borderline Scale scores).	Negative correlation.
i)	Threat.	Personal Construct Inventory and MCMI-III Borderline Scale scores.	Positive correlation.

Hypothesis 2.

Constructs pertaining to the 'valuation of self and others' will be the most superordinate (salient) among participants, as evidenced by a qualitative content analysis.

Hypothesis 3.

Beliefs about BPD will be correlated with levels of hopelessness. Specifically:

a) Participants who believe that their condition is a part of them will display greater levels of hopelessness.

b) Participants who believe that BPD is a treatable condition will display lower levels of hopelessness.

3   METHOD

3.1   Design

This was a non-experimental repertory grid and questionnaire-based study. A correlational design was used to explore the relationship between proposed characteristics of construing and BPD symptom severity for Hypothesis 1 and between beliefs about BPD and levels of hopelessness for Hypothesis 3. With regard to Hypothesis 2, a qualitative content analysis was performed.

3.2   Participants

A purposive sample of participants were recruited from an NHS Personality Disorder Service. This service works within a psychological rather than psychiatric (medical) framework of BPD running regular group sessions based on the DBT model. The inclusion criteria for the study were that participants should: a) be aged between 18-65 years; b) have had a primary diagnosis of BPD for at least one year; and c) be currently registered with and being treated by the Personality Disorder Service. For ethical reasons, the exclusion criteria were that those who were currently experiencing a crisis or hospital admission should not be invited to participate in the study.

3.3   Power calculation and statistical testing

Given the study's predominantly quantitative approach, consideration was given to the effect size required for the study to demonstrate adequate power. However, bearing in mind logistical resources and time constraints, a sample size of 20 participants was initially decided upon under the proviso that the alpha error be raised to 10% to increase the study's power. Recruitment from the Personality Disorder Service yielded only 9 participants and, consequently, four independent Community Mental Health Teams (CMHTs) within the same Trust were approached about participating in the study. Unfortunately, only one more participant was recruited from one of these teams, which meant that the final sample number was 10. One CMHT was unresponsive, one explained that they were unable to provide any participants because they did not, in fact, inform all of their patients of their BPD diagnoses and another informed me that none of their patients had a primary diagnosis of BPD. Statistical testing was conducted one-tailed given that the hypotheses are specific and directional. Taking into account the low sample size, p values in the region of 10% and 15% were regarded as indicating borderline significant results and effect sizes of above 0.40 were taken as potentially indicating *practical* significance.

3.4   Measures

3.4.1   Hypothesis 1

Personal Construct Inventory (Hypothesis 1a, 1f and 1i)

The Personal Construct Inventory (PCI; Chambers & O'Day, 1984) is a nomothetic questionnaire tool designed to measure Kellian diagnostic constructs such as Threat, Hostility, Pre-Emption, Guilt and Anxiety (see Appendix B). It is comprised of 80 statements and participants are requested to indicate the extent to which they agree with each statement on a scale from 1 to 5 (where 1 means "strongly agree", 2 means "moderately agree", 3 means "uncertain", 4 means "moderately disagree" and 5 means "strongly disagree"). Watson, Winter and Rossotti (1996) raised some issues with the construct validity of the PCI. Despite suggesting the need for further development of the PCI, Watson et al. (1996) consider it to be a fairly useful measure for aspects of construing. The PCI was used to measure pre-emptive construing, hostility and threat as referred to in Hypotheses 1a, 1f and 1i. However, the changes to scoring proposed by Watson et al., (1996) were utilised to increase construct validity.

The Repertory Grid Technique and Grid Measures

Perhaps the best known of Kelly's methods with which to obtain a glimpse into the personal constructs of the individual is the '*repertory grid*'. The repertory grid is a semi-structured interview technique that utilises both a quantitative and qualitative approach to gaining access to and mapping the individual's personal construct system. Grids are matrices comprised of elements and constructs. Elements, which may relate to the self, aspects of the self, other persons, qualities, events or even objects are used to elicit bipolar constructs (such as good vs evil). Subsequently, elements can then be rated or ranked according to elicited bipolar constructs. The resulting repertory grid data can then be analysed mathematically.

The grid employed within this study was designed to measure the proposed types of construing of those with BPD as suggested by Winter et al. (2003). As such, the following elements were chosen:

- o Me Now
- o Me in the Past
- o How I Would Like to Be (Ideal Self)

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- o Me in the Future
- o How Others See Me
- o A Person Diagnosed with BPD
- o Mother
- o Father
- o Partner (can include previous if no current partner)
- o Therapist
- o Person I Admire
- o Person I Dislike

Constructs were elicited using the '*triadic method*' (Kelly, 1955/1991) whereby participants were presented with three random elements at a time and asked in what way two of them were similar and yet different from the third. When a construct pole ('*emergent pole*') was stated (e.g. optimistic), the participant was then asked for its opposite ('*implicit pole*') (e.g. pessimistic). This process was repeated until twelve constructs had been listed. Finally, participants were asked to rate each of the elements on each bipolar construct (e.g. optimism versus pessimism) by allocating a number from 1 to 7 to each element (where 1 is very unlike and 7 very like the emergent pole). The decision to use the 'rating' as opposed to the 'ranking' method was made because the former is considered to afford the participant greater flexibility in defining the elements. In cases where the construct seemed irrelevant or the participant was unsure of the rating of a particular element, the mid-point rating of 4 could be chosen.

Completed repertory grids were analysed using the IDIOGRID computer package (Grice, 2002) and GRIDSTAT (Bell, 2004b) to determine the following characteristics of construing (Hypotheses 1b, 1c, 1d, 1e, 1g and 1h). Table 3 below shows the grid measures extracted.

Table 3. Grid measures extracted to determine characteristics of construing in relation to Hypothesis 1.

Characteristics of Construing	*Grid Measure*
Slot-Rattling (1b)	Standardised Euclidean distances between self in past, present and future elements.
Low sociality (1c)	Percentage sum of squares for 'How Others See Me' element.

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Fragmentation (1d)	Conflict scores.
Looseness (1e)	Variance accounted for by Component 1 in Principal Components Analysis.
Poorly elaborated self-construction (1g).	Percentage sum of squares for 'Me Now' element.
Construction of current relationships in the same terms as early relationships (1h).	Standardised Euclidean distances between parents and partner/therapist.

The quantitative grid measures used in this study are detailed below.

Percentage Sum of Squares (Hypothesis 1 c and 1g)

The percentage sum of squares for an element (or construct) indicates its importance, salience and extent of elaboration within the construct system (Bannister & Salmon, 1967; as cited in Winter, 1992) with higher percentages (i.e. maximum of 100) indicating a greater degree of saliency, superordinacy or elaboration. Lower scores indicate a high degree of midpoint ratings for most constructs. This measure was used to determine the degree to which the elements 'How Others See Me' and 'Me Now' were salient for participants. In relation to Hypothesis 1c ('*low sociality*'), we expected that there would be a negative correlation between the percentage sum of squares for the element 'How Others See Me' and BPD symptom severity. Similarly, in relation to Hypothesis 1g ('*poorly elaborated self-construction*'), we expected a negative correlation between the percentage sum of squares scores for the element 'Me Now' and BPD symptom severity.

Percentage of Variance Accounted for by the components (Hypotheses 1e)

Using 'Principal Components Analysis' within Idiogrid, the percentage of variance accounted for by the first principal component was determined. The higher the percentage of variance accounted for by the first principal component, the tighter the organisation of the construct system. Lower scores, on the other hand, are associated with looser construing. As such, this technique has been put forward by Winter (1992) as a measure of cognitive complexity. Earlier, in 1972, Ryle and Breen compared neurotic participants with 'normals' and concluded that a percentage of variance score of '70' or above constitutes tight construing. This measure was used in relation to Hypothesis 1e ('*looseness*'), the expectation being that

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looseness would be associated with greater BPD symptomatology.

Distances between elements (Hypothesis 1b and 1h)

Using Idiogrid, the distances between elements can be determined using the 'Standardised Euclidean Distances' measure (Grice, 2002). Winter (1992) suggests that a distance of 0 indicates that two elements are construed identically while a distance of 1 would be expected by chance. According to Makhlouf-Norris and Norris (1973), distances below 0.8 are considered to indicate similarity in the construing of two elements while a distance of 1.2 or above suggests dissimilarity. Distances between 0.8 and 1.2 signify neither similarity nor dissimilarity between constructs. With regard to Hypothesis 1b ('*slot-rattling*'), an analysis of distances between the elements 'Me Now', 'Me in the Past' and 'Me in the Future' was as a measure of slot-rattling. Larger distances (which indicate dissimilarity) were considered to be representative of a greater degree of slot-rattling and were expected to be associated with greater BPD symptomatology. With regard to Hypothesis 1h ('*construction of current relationships in same terms as early relationships*'), distances between the elements 'Mother', 'Father', 'Therapist' and 'Partner' were examined. In this case, smaller distances (which indicate similarity) were expected to be associated with greater BPD symptomatology.

Conflict scores

In relation to Hypothesis 1d ('*fragmentation*'), a conflict analysis was carried out using Bell's 2004 GRIDSTAT package in order to determine the degree of conflict within the repertory grids. Higher percentages of overall conflict within grids were considered indicative of greater fragmentation and thus it was predicted that there would be a positive correlation between levels of conflict and BPD symptomatology.

Millon Clinical Multiaxial Inventory, Third Edition

The Millon Multiaxial Clinical Inventory, Third Edition (MCMI-III; Millon, 1994) is a psychological assessment questionnaire developed from and used to measure the extent of psychopathology in clinical populations. It is based upon Millon's (1969; 1981) evolutionary theory of personality and is closely linked to and updated in accordance with diagnostic thresholds of the DSM, both of which are based upon the multiaxial model of psychopathology. Indeed, the latest version, the MCMI-III, was specifically designed to correspond with the DSM-IV. The MCMI-III comprises 175 true-false questions and 24 clinical scales (including a 'Borderline Scale') and 5 scales pertaining to the participants' approach to the test. Norms for the MCMI-III are based on groups of normal subjects and

clinical samples. The test takes approximately 30 minutes to complete. With regard to internal consistency of the MCMI-III's 'Borderline' scale', Millon, Davis and Millon (1996) report an alpha of 0.85. Furthermore, they report the test-retest reliability result as 0.93, suggesting that results are stable over time. The MCMI-III 'Borderline Scale' was used as a measure of current BPD symptomatology (See Appendix A). There are 16 items relating to the 'Borderline' scale (Questions 7, 22, 30, 41, 72, 83, 98, 120, 122, 134, 135, 142, 154, 161, 166 and 171).

3.4.2 Hypothesis 2

In order to test Hypothesis 2 ('*superordinacy of constructs relating to valuation of self and others)*', the following measures were used.

Content Analysis

A qualitative content analysis was conducted on each of the participants' ten elicited constructs using the Classification System for Personal Constructs (CSPC) devised by Feixas, Goldschlager and Neimeyer (2002). This system complements the more structural methods of quantitative analysis (such as correlations) utilising a coded system in which constructs can be categorised according to the following hierarchical classification system: 1) 'Moral'; 2) 'Emotional'; 3) 'Relational'; 4) 'Personal'; 5) 'Intellectual/Operational'; and 6) 'Values and Interests'. A further two supplemental categories as proposed by Neimeyer, Anderson & Stockton (2001) were also included and were coded as: 7) 'Concrete Descriptors' and 8) Existential. Categories are further broken down into various subcategories (i.e. in the 'Moral' category, there are subcategories such as 'Good vs Bad', 'Altruist vs Egoist', 'Humble vs Proud', 'Respectful vs Judgmental', etc). In order to avoid overlap, in cases where a construct is deemed to fit into more than one category, it is coded for the higher level (i.e. category 1 (moral) over category 2 (emotional). The CPSC is used solely to categorise 'value constructs'; constructs relating to the psychological characteristics of self and others. According to Feixas et al. (2002), the CSPC has a high degree of reliability (with indices between 0.90 and 0.95). To establish inter-rater reliability, a colleague of the Main Researcher (a Clinical Psychologist with experience of using the CSPC) was asked to conduct a concurrent content analysis of the data.

Percentage Sum of Squares

Once all constructs had been categorised, the degree of saliency/superordinacy for each construct was established using the 'percentage sum of squares' measure in Idiogrid. For each participant, the two constructs with the highest percentage sum of squares scores were

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considered to be the most superordinate. These constructs and the categories within which they had been coded were noted.

3.4.3 Hypothesis 3

Beck Hopelessness Scale

The Beck Hopelessness Scale (BHS; Beck & Steer, 1988) is a 20 item true-false self-report tool designed to measure three elements of hopelessness (in adults aged 17-80 years) incorporating feelings about the future, loss of motivation and expectations within the past week (see Appendix C). It is also considered to be a reliable indicator of suicide risk (Glanz, Haas and Sweeney, 1995). The BHS was used to measure existing levels of hopelessness.

Beliefs about BPD Likert Scales

A Likert scale was devised to test Hypothesis 3 (see Appendix D). The scale was worded as follows:

"To what extent do you agree with the following statements?"

"BPD is a treatable condition"

"BPD is a part of my personality"

Participants were asked to indicate the number that best represented their answer to these questions using the scale below:

1 = "strongly agree"

2= "moderately agree"

3= "uncertain/not sure"

4= "moderately disagree"

5= "strongly disagree"

3.5   Procedure

At the Personality Disorder Service, clinicians involved in the care of BPD patients were provided with an information sheet about the research (See Appendix H) detailing the study aims as well as inclusion and exclusion criteria. They were also given information packs to hand to potential participants, which contained a participant information sheet (See Appendix I), an opt-in form (See Appendix J) and a stamped addressed envelope. Respondents who completed and posted back their opt-in form were contacted by the Main Researcher and a suitable time was arranged for interview. At this stage, respondents were also asked if they were agreeable to completing the MCMI-III (given its length) in advance

and bringing this with them on the day of the interview. Following their consent to this, the researcher posted the MCMI-III to the patients. Interviews took place in sound-proofed Personality Disorder Service clinic rooms and in other Trust clinic rooms if these were more convenient for participants to get to. Interviews lasted approximately 60 to 90 minutes and during this time, participants were asked to complete the PCI, repertory grid, BHS and Likert scales. In addition, participants were asked when and how they felt about first being diagnosed with BPD.

3.6   Ethical Considerations

Approval to undertake the project was initially obtained through the University of Hertfordshire and approval to approach patients for participation in this study from the Personality Disorder Service was applied for and subsequently obtained through the NHS Research Ethics Committee (REC) in January, 2013 (See Appendix E) and the Trust Research and Development Department in March, 2013 (see Appendix G) and, as such, the recruitment process commenced in April, 2013. Having recruited only nine participants from the Personality Disorder Service, a decision was made to approach four Community Mental Health Teams and to offer a £10 gift voucher to participants. This substantial amendment to the protocol required further ethical approval from the NHS REC, which was obtained in October, 2013 (see Appendix F).

The participant information sheet that formed part of the information pack (see Appendix I) provided to potential participants stated clearly that the decision whether or not to take part in the study would not adversely affect their ongoing treatment. In addition, the information sheet gave details of who to contact (the Trust's Patient Advice and Liaison Service) in case they had any concerns. In order to maintain confidentiality, the Opt-In Form (See Appendix J) that was also included in the information pack asked patients to specify whether they were happy or not for a message to be left on the contact telephone number they had provided.

The consent form (see Appendix K) was presented to participants on the day of testing and in accordance with the protocol, participants were given the opportunity to ask any questions and informed that they could withdraw consent at any point without any impact upon their care. Participants were informed that confidentiality would be maintained and that questionnaires were coded numerically in order to ensure their anonymity.

Given that participation in the study required participants to think about their condition and their relationships with self and others, it was possible that they may have become

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distressed. Consideration of this risk was given prior to the completion of study measures and again, participants were encouraged to stop if they became distressed. Debriefing was available after the interview procedure.

4   RESULTS

In this section, the study findings for the ten participants will be presented. For confidentiality purposes, participants were allocated a numerical code and these shall be used throughout. Two case examples will be presented under pseudonyms.

4.1 Demographic Information

The study sample comprised 10 females with ages ranging from 20 years to 53 years. The mean age of participants was 23.2 (SD=13.72) (See Table 4).

Table 4. Demographic information for participants.

Participant	Sex	Age	Ethnicity
001	F	23	White British
002	F	22	White British
003	F	23	White British
004	F	27	White British
005	F	36	White British
006	F	53	White British
007	F	27	White British/Black Caribbean
008	F	24	White British
009	F	20	White British
010	F	48	White British
Mean (SD)		**30.3 (11.57)**	

The participants had received the diagnosis at various ages and had had the diagnosis of BPD for different amounts of time. Three participants had been diagnosed at the age of 18 years, one at 19 years, one at 25 years, one at 30 years, one at 38 years and one at some point in her early 40s. For one of the participants, it was unclear as to when she had first received the diagnosis.

It is important to mention that one participant (008) informed me that she had initially been diagnosed at the age of 14 years but had been subsequently told by her team of clinicians that this was incorrect as she was too young to receive the diagnosis. Upon reaching the

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age of 18, the participant was again informed that she did, in fact, have BPD. Participant 008 also stated at interview that she had recently been told by her team that she no longer met the criteria for BPD. It was not clear whether this would result in an official removal of the diagnosis from her records and I was informed by a clinician that there was disagreement within the team about the ethical implications of removing the diagnosis. Participant 008 revealed that she had been told by one clinician (outside of the Personality Disorder Service) that she would be back, suggesting a lack of faith in her recovery.

4.2   Descriptive Statistics

4.2.1   Hypothesis 1

PCI

As previously mentioned in the Method section, the PCI is a questionnaire tool designed to measure a number of Kellian diagnostic constructs (for the purposes of this study, we are interested only in pre-emption, hostility and threat). Possible 'Pre-Emption' scores range from a minimum of 6 to a maximum of 30. Possible 'Hostility' scores range from a minimum of 7 to a maximum of 35. Possible 'Threat' scores range from a minimum of 6 to a maximum of 30. Table 5 shows the Pre-emption, Hostility and Threat scores for the ten participants.

Table 5. Personal Construct Inventory scores

PCI Measure
Pre-emptive construing   Min- 8   Max- 20   Mean- 14.8   SD- 0.98   *Hostility*   Min-7   Max- 29   Mean- 14.2   SD- 7.42   *Threat*   Min- 14

Max- 26

Mean- 19.2

SD- 4.57

Repertory Grids

Table 6 shows the descriptive statistics yielded from the repertory grids of the ten participants.

Table 6. Descriptive Statistics for Repertory Grids

Standardised Euclidean Distances between elements 'Mother', 'Father', 'Partner' and 'Therapist' ("Construction of current relationships in the same terms as early relationships")

Mother-Partner (n=9)*

Min- 0.45

Max- 1.36

Mean- 0.92

SD- 0.35

Mother-Therapist (n=10)

Min- 0.31

Max - 1.63

Mean-1.02

SD-0.46

Father-Partner (n=9)*

Min- 0.55

Max- 1.28

Mean- 0.88

SD- 0.28

Father-Therapist (n=10)

Min- 0.42

Max- 1.58

Mean- 0.97

SD- 0.40

Standardised Euclidean Distances between 'Me Now', 'Me in the Past' and 'Me in the Future' elements. ("Slot-rattling")

Me in the Past-Me Now (n=10)

Min- 0.37

Max- 6.86

Mean- 0.73

SD- 0.30

Me Now-Me in Future (n=5)**

Min- 0.47

Max- 0.83

Mean- 0.64

SD- 0.22

Percentage sum of squares of 'How Others See Me' ("Low sociality") (n=5)***

Min- 3.26%

Max- 9.78%

Mean- 5.67%

SD- 3.26

Percentage sum of squares for the element 'Me Now' ("Poorly elaborated self-construction") (n=10)

Min- 2.56%

Max- 23.40%

Mean- 7.92%

SD- 6.27%

Two constructs with highest percentage sum of squares ("Superordinacy of constructs concerning valuation of self and others") (n=10)

001 – 'Lacks confidence-Confident' (10.28%) and 'Relaxed-Uptight' (10.21%)

002 – 'Self-hating-Vain' (11.80%) and 'Crazy-Settled' (10.86%)

003 – 'Confident-Self-conscious' (12.19%) and 'Not right/Has diagnosis-Normal' (10.51%)

004 – 'Hopeful-Failure' (11.04%) and 'With suicidal images-Without suicidal images (10.38%)

005 – 'Accepting-Rejecting' (12.94%) and 'Happy-Unhappy' (11.14%)

006 – 'Kind-Cruel' (9.44%) and 'Caring-Belligerent' (9.44%)

007 – 'Dark-Light' 10.95%) and 'Unsafe-Safe' (10.78%)

008 – 'Sensitive-Insensitive' (10.06%) and 'Trustworthy-Untrustworthy' (9.24%)

009 – In control-Not in control' (11.87%) and 'Depressed-Happy' (11.49%)

010 – 'Ill-Well' (11.76%) and 'Anxious-Calm' (11.54%)

Variance of Component 1, Principal Components Analysis ("Looseness") (n=10)

Min – 48.93

Max – 85.67

Mean: 66.10

SD – 9.99

Conflict percentage ("Fragmentation") (n=10)

Min- 33.2%

Max- 51.1%

Mean- 41.49%

SD- 4.75

* One of the participants was unable to compare "Mother' or 'Father' with 'Partner' as she had, in fact, never had a partner.

** Only five of the participants completed grids including the element 'Me in the Future'.

***Only five of the participants completed grids including the element 'How Others See Me'.

As such, five of the repertory grids had twelve elements while the remaining grids had ten elements. With regard to Hypothesis 1b ('*slot-rattling*'), mean standardised Euclidean distances between 'Me in the Past' and 'Me Now' for the full ten participants (n=10) and mean standardised Euclidean distances between 'Me Now' and 'Me in the Future' for the five twelve-element grids (n=5) were examined. With regard to Hypothesis 1c ('*low sociality*'), only the five twelve-element grids were used as these were the only grids that had incorporated the element 'How Others See Me'.

For Hypothesis 1g ('*poorly elaborated self-construction*') and Hypothesis 1e ('*looseness*'), the elements 'How Others See Me' and 'Me in Future' were removed from the five twelve-element grids in order not to skew the results. Thus, on this measure, all ten grids were compared across the set of *ten* elements.

Table 6 highlights that, on average, the standardised Euclidean distances between 'Mother' and 'Partner', 'Mother' and 'Therapist', 'Father' and 'Partner' and 'Father' and 'Therapist' are

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0.92, 1.02, 0.88, 0.97, respectively, indicating overall neither similarity nor dissimilarity in the construction of these relationships. For four of the participants, the distances meant that 'Mother' and 'Partner were classed as similar (44.44%), for two of the participants, the distances meant that 'Mother' and 'Partner' were dissimilar (22.22%), and for two of the participants, distances were neither similar nor dissimilar (22.22%). For 'Mother' and 'Therapist', four of the participants construed 'Mother' and 'Therapist' similarly (40%), five dissimilarly (50%) and one as neither similar nor dissimilar (10%). For 'Father' and 'Partner', four of the participants construed their father and partner similarly (44.44%, two as dissimilar (22.22%) and three as neither similar nor dissimilar (33.33%). For 'Father' and 'Therapist', 3 participants construed their father and therapist similarly (30%), three dissimilarly (30%) and four as neither similar nor dissimilar (40%).

Table 6 shows that the mean standardised Euclidean distances between 'Me in the Past' and 'Me Now' and between 'Me Now' and 'Me in the Future' are 0.73 and 0.64, respectively, indicating that, on average, participants tend to see themselves now as similar to how they were in the past and even more similar now to how they see themselves in future. For the elements 'Me in the Past' and 'Me Now', 6 participants saw themselves as similar, 2 as dissimilar and 2 as neither similar nor dissimilar.

Table 6 shows that the mean percentage sum of squares for 'Me Now' is 7.92%, suggesting that this is not a particularly salient element and thus may suggest low elaboration of self-construction. Of particular interest is the very high percentage sum of squares for one participant (23.40%).

Table 6 shows that the percentage sum of squares for 'How Others See Me' is 5.67%, indicating that this is not a particularly salient element for participants and may indicate low sociality.

Table 6 shows that the mean variance accounted for by Component 1 is 66.10.

Table 6 shows the two most superordinate constructs for each participant as indicated by the percentage sums of squares for constructs.

Table 6 shows that the mean conflict percentage was 41.49% with a low SD of 4.75.

Appendix M shows Figures 8 to 17 (boxplots), which display the distribution of scores for

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each repertory grid measure. Inspection of the boxplots reveals that many indicate skewness in their distributions. In Figures 9 and 10, for example, there appears to be a skew with a right tail (positive skew) and this is supported by the fact that the medians are far from the centre of the box. In Figure 11, we see that there is one mild outlier and a skew with a left tail (negative skew). In Figure 12, there is one mild outlier and what appears to be a skew with a right tail (positive skew). In Figure 13, the large whisker at the top of the boxplot and the presence of an extreme outlier (participant 010 who obtained a relatively high percentage sum of squares for the element 'Me Now') indicates a severe skew with a right tail (positive skew). In Figure 14, we see what appears to be a slight skew with a left tail (negative skew). In Figure 16 and 17, the slightly longer top whiskers indicate skews with a right tail (positive skew).

Skewness statistics were calculated in SPSS (Statistical Package for the Social Sciences) for all of the data distributions, revealing that the only skew significantly different from symmetry (and thus not normally distributed) was in the distribution of the percentage sum of squares for the element 'Me Now' (skewness statistic of 1.976 and standard error of 0.687).

MCMI-III

Table 7 shows the MCMI-III Borderline Scale scores for the ten participants. According to the MCMI-III scoring criteria, if an individual scores 75 on the Borderline scale, he or she is likely to have clinically significant borderline traits. In contrast, scores of 85 or above are likely to indicate the presence of BPD**.** Of the 10 participants, only 5 met the criteria for the presence of BPD (50%). Two participants met the criteria for the presence of clinically significant borderline traits (20%). Three participants did not meet the criteria for either BPD or borderline traits (30%). The mean MCMI-III Borderline Scale score was 78.9 (SD-19.97).

Table 7. Millon Clinical Multiaxial Inventory, Third Edition, Borderline Scale scores.

Participant	MCMI-III Borderline Scale Score	BPD Criteria Met?
001	72	No
002	90	Yes
003	82	Clinically significant traits of BPD indicated
004	95	Yes
005	82	Clinically significant traits of BPD indicated
006	87	Yes

007	92	Yes
008	71	No
009	91	Yes
010	27	No
Mean (SD)	**78.9 (19.97)**	

4.2.2 Hypothesis 2

Table 8. Content analysis of superordinate constructs.

Participant	Superordinate Construct	Category
001	i) Lacks confidence-Confident	Personal (*Self-Acceptance vs Self-Criticism* subcategory)
	ii) Relaxed-Uptight	Emotional (*Balanced vs Unbalanced* subcategory)
002	i) Self-Hating-Vain	Personal (*Self-Acceptance vs Self-Criticism* subcategory)
	ii) Crazy-Settled	Emotional (*Balanced vs Unbalanced* subcategory)
003	i) Confident-Self-conscious	Personal (*Self-Acceptance vs Self-Criticism* subcategory)
	ii) Not right/has diagnosis-Normal	Emotional (*Balanced vs Unbalanced* subcategory)
004	i) Hopeful-Hopeless	Emotional (*Optimist vs Pessimist* subcategory)
	ii) With suicidal images-Without suicidal images	Concrete Descriptor (*Others* subcategory)
005	i) Accepting-Rejecting	Relational (*Tolerant vs Authoritarian* subcategory)
	ii) Happy-Unhappy	Emotional (*Specific Emotions* subcategory)

006	i) Kind-Cruel	Emotional (*Warm vs Cold* subcategory)
	ii) Caring-Belligerent	Emotional (*Warm vs Cold* subcategory)
007	i) Dark-Light	Emotional (*Optimist vs Pessimist* subcategory)
	ii) Unsafe-Safe	Relational (*Peaceable vs Aggressive* subcategory)
008	i) Sensitive-Insensitive	Emotional (*Warm vs Cold* subcategory)
	ii) Trustworthy-Untrustworthy	Moral (*Sincere vs Insincere* subcategory)
009	i) In control-Out of control	Emotional (*Balanced vs Unbalanced* subcategory)
	ii) Depressed-Happy	Emotional (*Specific Emotions* subcategory)
010	i) Ill-Well	Emotional (*Balanced vs Unbalanced* subcategory)
	ii) Anxious- Calm	Emotional (*Balanced vs Unbalanced* subcategory)

4.2.3 Hypothesis 3

BHS

Table 9 shows the BHS scores for the ten participants. When used clinically, scores ranging from 0-3 are considered 'normal', 4-8 represent 'mild hopelessness', 9-14 indicate 'moderate hopelessness' and scores of 15-20 indicate severe hopelessness. The mean BHS Score for participants was 15, which falls within the low end of the "severe hopelessness" range. Of the ten participants, 7 achieved a score indicative of 'severe hopelessness' (70%), 2 achieved a score suggesting 'moderate hopelessness (20%) and 1 participant obtained a score that fell within the 'normal' range (10%).

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Table 9. Beck Hopelessness Scale scores.

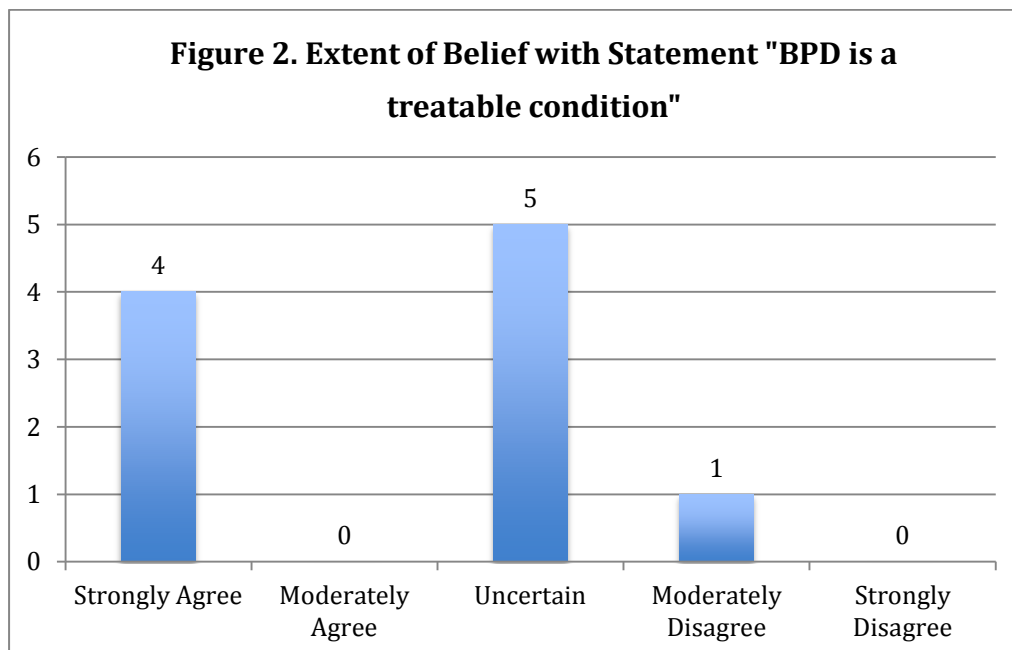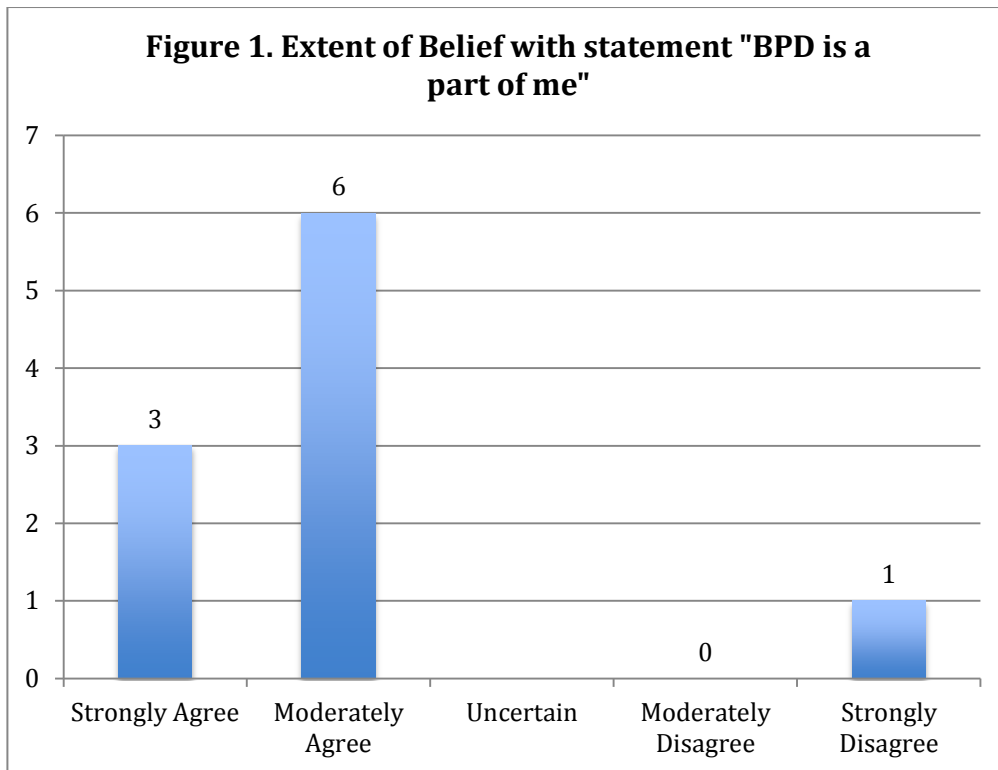| Participant	BHS Score
001	16
002	15
003	18
004	20
005	13
006	19
007	17
008	1
009	9
010	18
Mean (SD)	**15 (5.77)**

Beliefs about BPD Likert Scales

Table 10 is a Frequency Table showing the number of times each category of response was chosen. In addition, Figures 1 and 2 shows the Beliefs about BPD Likert Scale responses graphically.

Table 10. Frequency table showing beliefs about BPD Likert scale scores.

Likert Scale Category	"BPD is a Part of Me'	BPD is a Treatable Condition"
1. Strongly Agree	n = 3 (30%)	n= 4 (40%)
2. Moderately Agree	n = 6 (60%)	n = 0 (0%)
3. Uncertain	n = 0 (0%)	n = 5 (50%)
4. Moderately Disagree	n = 0 (0%)	n = 1 (10%)
5. Strongly Disagree	n = 1 (0%)	n = 0 (0%)

Table 10 and Figure 1 show that in relation to the statement, "BPD is a part of me", the mode response was "moderately agree" (n=6, 60%). Table 10 and Figure 2 show that in relation to the statement, "BPD is a treatable condition", the mode response was "uncertain" (n=5, 50%).

Figure 1. Extent of Belief with statement "BPD is a part of me"

Strongly Agree	Moderately Agree	Uncertain	Moderately Disagree	Strongly Disagree
3	6		0	1

Figure 2. Extent of Belief with Statement "BPD is a treatable condition"

Strongly Agree	Moderately Agree	Uncertain	Moderately Disagree	Strongly Disagree
4	0	5	1	0

Appendix L shows figures 3 to 7 (boxplots), which display the distribution of scores for each symptom severity measure (MCMI-III, BHS and PCI). The thick horizontal line represents the median for the set of scores. The top of the box is level with the upper quartile (75th percentile) while the bottom of the box is level with the lower quartile (25th percentile). The whiskers extend from the ends of the box and reach out to the lowest and highest scores

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(excluding outliers) obtained in the sample on a particular variable. Outliers (any scores that are much lower or higher than all of the other scores) are indicated by a circle in mild cases and an asterisk in extreme cases. Inspection of the boxplots reveals that many indicate skewness in their distributions. Skewness statistics were calculated in SPSS (Statistical Package for the Social Sciences) for all of the data distributions and it was found that of these, the MCMI-III Borderline Scale scores (skewness statistic of -2.276, standard error of 0.687) and BHS scores (skewness statistic of -1.715 and standard error of 0.687) differed significantly from symmetry and as such, we can say that these distributions are not normally distributed.

4.3   Analysis

Hypothesis 1

Results relating to Hypotheses 1a to 1i will now be presented. Throughout this section, non-parametric statistical tests (Spearman's correlations) are used given the small sample size, the presence of outliers and skewed distributions.

PCI

Scatterplots were produced for PCI Scores on Pre-Emptive Construing, Hostility and Threat in comparison with MCMI-III Borderline Scale score.

Hypothesis 1a ('*Pre-emption*')

Figure 18

Scatterplot showing the relationship between MCMI−III Borderline Scale score and PCI Pre−Emption score

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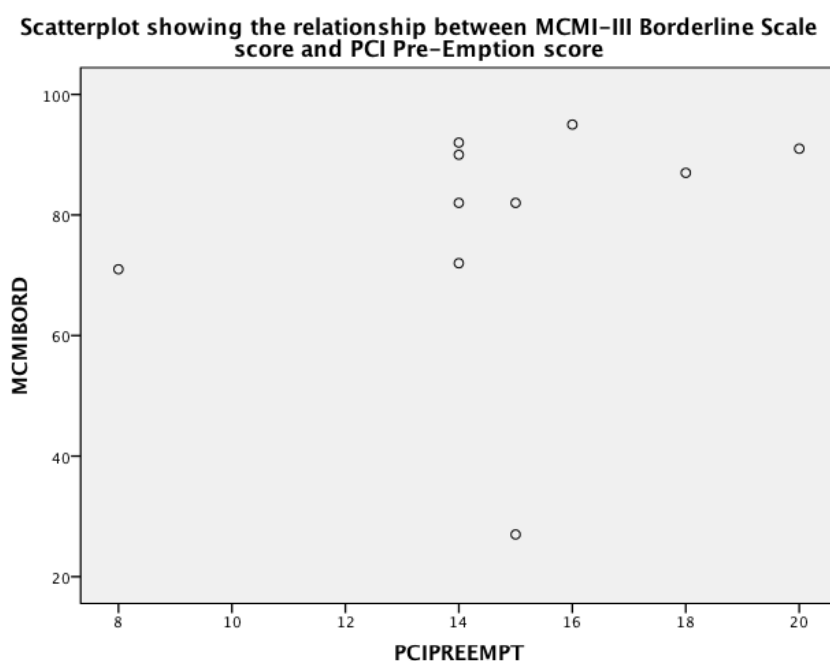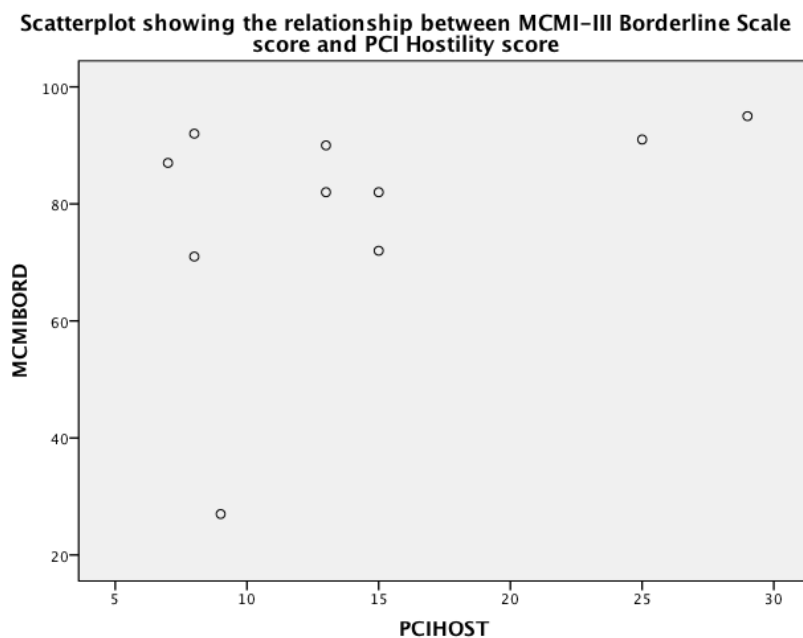Student Number: 10280099

Figure 18 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and PCI Pre-Emption score. It shows a cluster of people who score highly on the MCMI-III Borderline Scale score and who score at approximately the midpoint range on PCI Pre-Emption. The remaining participants score higher PCI Pre-Emption scores. Two outliers were present; one participant who obtains a very low score on the MCMI-III Borderline Scale but who scores around the midpoint range for PCI Pre-Emption and the other who has a moderate score on the MCMI-III Borderline Scale score but has a very low score on the PCI.

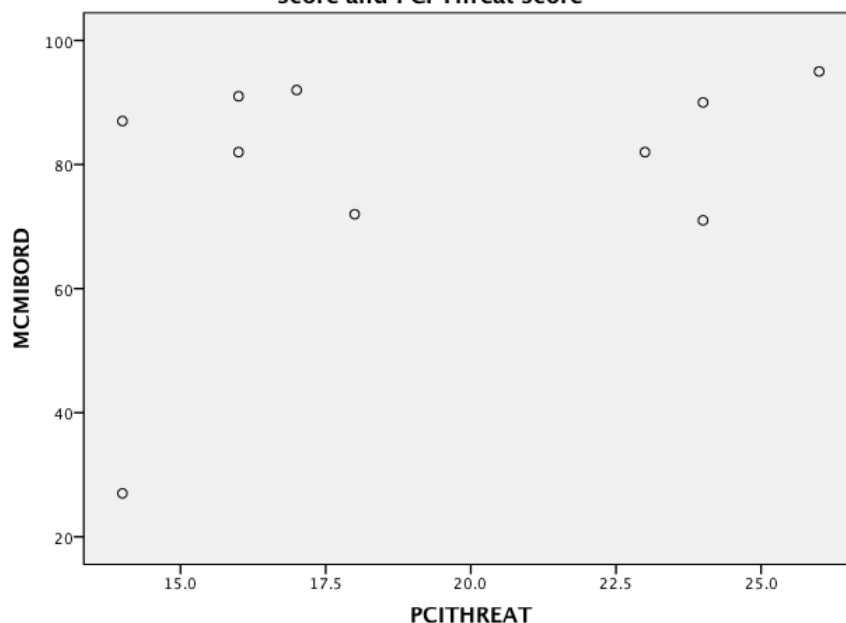*Hypothesis 1f* ('*Hostility*')

Figure 19 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and PCI Hostility score. We can see a cluster of participants with moderate to high MCMI-III Borderline Scale scores and who display low-moderate scores on PCI Hostility and two participants with high MCMI-III Borderline Scale score who have high scores on PCI Hostility. One outlier is present; a participant who has a very low score on the MCMI-III Borderline Scale Score and also obtains a very low score on PCI Hostility.

Figure 19

Scatterplot showing the relationship between MCMI-III Borderline Scale score and PCI Hostility score

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Figure 20

Scatterplot showing the relationship between MCMI-III Borderline Scale score and PCI Threat score

Hypothesis 1i (*'Threat'*)

Figure 20 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and PCI Threat score. Here, there seem to be two populations; one with moderate to high scores on the MCMI-III Borderline Scale and moderate scores on PCI Threat and another with high MCMI-III Borderline Scale scores and high scores on PCI Threat. There is one outlier; again the participant with the very low MCMI-III Borderline Scale score who obtained a moderate score on PCI Threat.

Correlations

For MCMI-III Borderline Scale score and PCI Pre-Emption score, there was a moderate to large, positive relationship (r_s (8) = 0.396, n=10, p=0.128, one-tailed). In this case, the p value can be taken as indicating *borderline* significance and the magnitude of the effect size can be considered as indicating *practical* significance.

For MCMI-III Borderline score and PCI Hostility score, there was a moderate, positive but statistically insignificant relationship (r_s (8) = 0.325, n=10, p = 0.180, one-tailed).

Finally, for MCMI-III Borderline score and PCI Threat score, there was a mild to moderate positive but statistically insignificant relationship (r_s (8) = 0.279, n= 10, p = 0.217, one-tailed). Overall, in relation to Hypotheses 1a, we have some evidence suggesting that higher levels

of pre-emption are associated with greater BPD symptom severity. In relation to Hypotheses 1f and 1i, we have no evidence to suggest that a higher degree of hostility and threat are associated with greater BPD symptomatology, respectively.

Repertory Grids and Grid Measures

Hypothesis 1b ('Slot-Rattling')

As mentioned in the Method section, Standardised Euclidean distances were examined for the elements 'Me Now', 'Me in the Past' and 'Me in the Future' and considered a measure of slot-rattling.

Figure 21 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and standardised Euclidean distance between the elements 'Me in the Past' and 'Me Now'. It shows a large cluster of participants with moderate to high MCMI-III Borderline Scale scores who have low distances between 'Me in the Past' and 'Me Now' suggesting that greater BPD symptomatology is associated with a sense of feeling *similar* now to in the past. There are two outliers: participant 003, who scores 82 on the MCMI-III Borderline Scale score but sees herself as very different now to how she was in the past (a high standardised Euclidean distance of 6.86); and participant 010, with the low MCMI-III Borderline Scale Score of 27, who sees herself as somewhat different now to how she was in the past (standardised Euclidean distance of 1.24).

Figure 21

Scatterplot showing the relationship between MCMI−III Borderline Scale score and Standardised Euclidean distance between 'Me in the Past and 'Me Now'
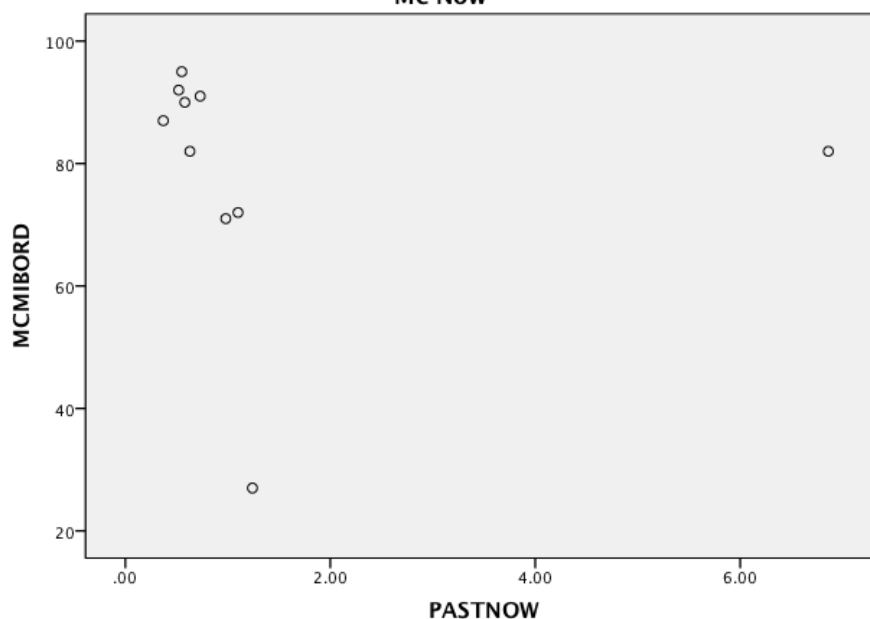
Figure 22

Scatterplot showing the relationship between MCMI-III Borderline Scale score and Standardised Euclidean distance between the elements 'Me Now' and 'Me in the Future'.
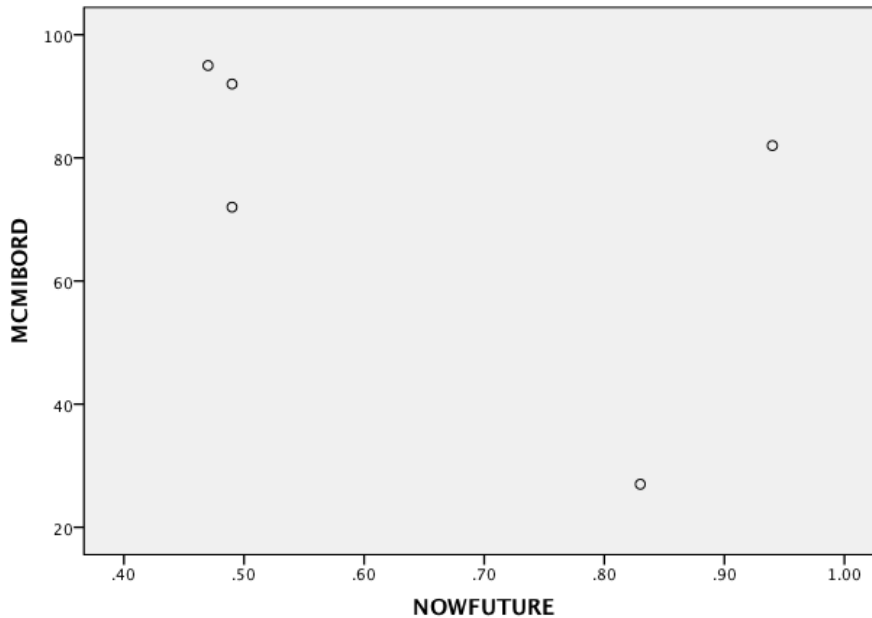

Figure 22 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and standardised Euclidean distance between the elements 'Me Now' and 'Me in the Future'. It shows that most participants score highly on the MCMI-III and have low standardised Euclidean distances between 'Me Now' and 'Me in the Future' (n=3), indicating that they do not expect to change identity significantly over time, while 2 participants considered themselves neither similar nor dissimilar now to how they will be in the future, suggesting an element of uncertainty.

Correlations

A Spearman's correlation was carried out on MCMI-III Borderline Scale scores and standardised Euclidean distances between the elements 'Me in the Past' and 'Me Now', revealing a very strong, negative and statistically significant relationship r_s (8) = -0.705, n= 10, p = 0.011, one-tailed). Not only is this result significant at the 0.05 level but the magnitude of the effect size is notable. We can therefore say that there is a strong relationship between MCMI-III Borderline Scale scores and 'standardised Euclidean distances between 'Me in the Past' and 'Me Now', with an increase in MCMI-III Borderline Scale scores associated with a decrease in standardised Euclidean distance. In relation to Hypothesis 1b, this is the opposite result from that we expected.

Given the missing data (and thus low n) for the element 'Me in the Future, Spearman's correlations were not performed on standardised Euclidean distances between 'Me Now' and 'Me in the Future' and MCMI-III Borderline Scale scores. We cannot, therefore, comment on the significance of any relationship between construction of the self in the present and future and BPD symptom severity.

Hypothesis 1c ('Low sociality')

In relation to Hypothesis 1c, the percentage sum of squares for the element 'How Others See Me' was examined. Figure 23 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and percentage sum of squares for the element 'How Others See Me'. It is important to mention that, again, there was some missing data for the element 'How Others See Me' so in this case, n=5. As a result of the missing data and the low sample size, Spearman's correlations were not performed.

Figure 23 shows two groups of participants; one with moderate to high MCMI-III Borderline Scale scores and relatively low percentage sum of squares scores for the element 'How Others See Me' and the other with moderate to high MCMI-III Borderline Scale scores with higher percentage sum of squares scores for the element 'How Others See Me'.

Figure 23

Scatterplot showing the relationship between MCMI–III Borderline Scale score and percentage sum of squares for the element 'How Others See Me'.
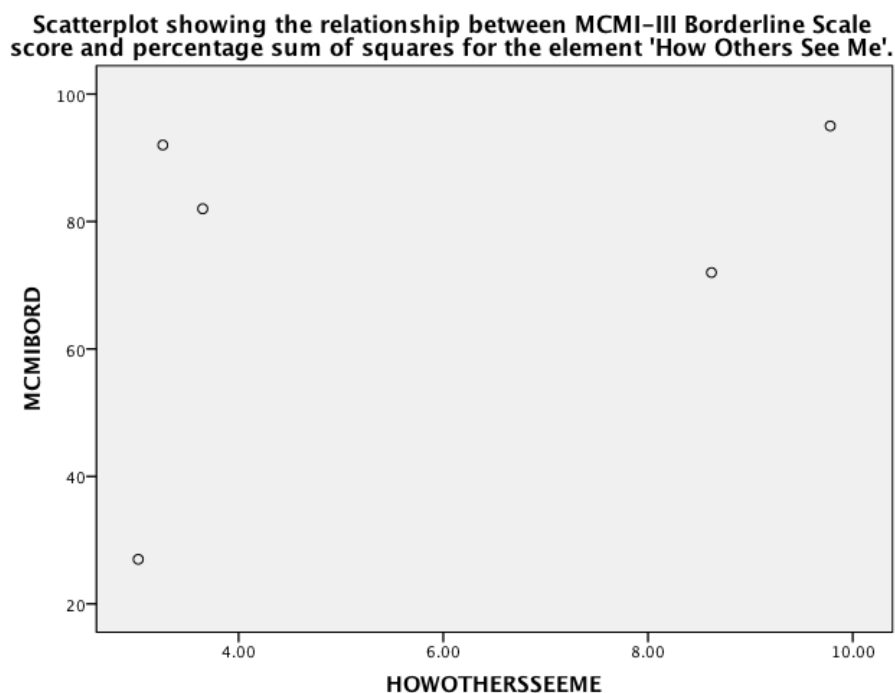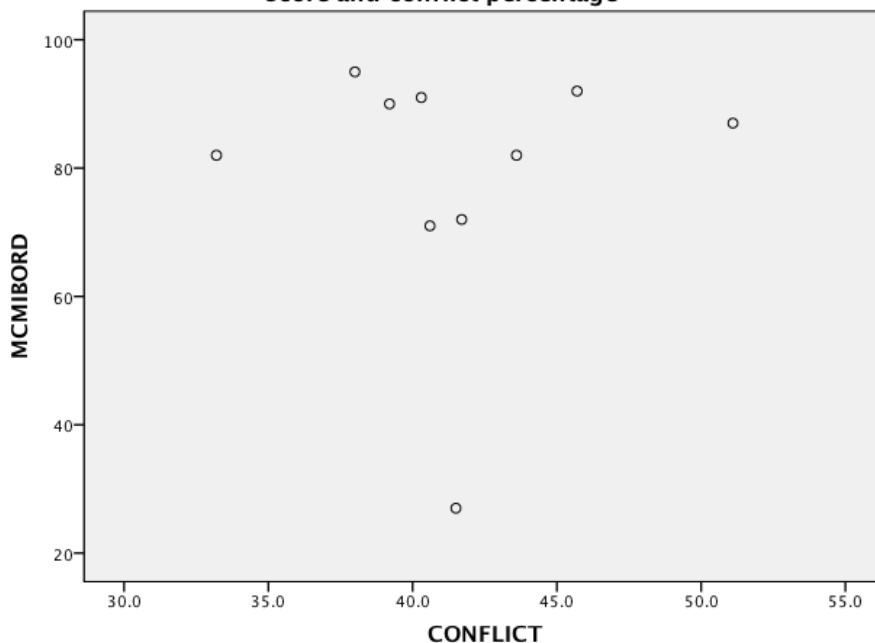
Contrary to the hypothesis, we can see that participant 010, who scored the lowest on the MCMI-III Borderline Scale (only 27) also scored the lowest of the percentage sum of squares on 'How Others See Me' (3.02%), suggesting lower sociality. Furthermore, participant 002, who has the highest MCMI-III Borderline Scale score also has the highest percentage sum of squares for 'How Others See Me' (9.78%), suggesting higher sociality. Although the mean percentage sum of squares for the element 'How Others See Me' is a low 5.6% (3.6 SD), we cannot say that as MCMI-III Borderline Scale score increases the percentage sum of squares for the element 'How Others See Me' decreases (as hypothesised).

Hypothesis 1d ('Fragmentation')

Using Bell's (2004b) GRIDSTAT package, conflict scores were obtained. Figure 24 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and percentage of conflict. We can see that most of the participants obtain moderate to high scores on the MCMI-III and a mixed range of conflict scores. Again, we see the outlier (participant 010) who obtained a low score on the MCMI-III and achieves a moderate percentage of conflict.

Figure 24

Scatterplot showing the relationship between MCMI–III Borderline Scale score and conflict percentage

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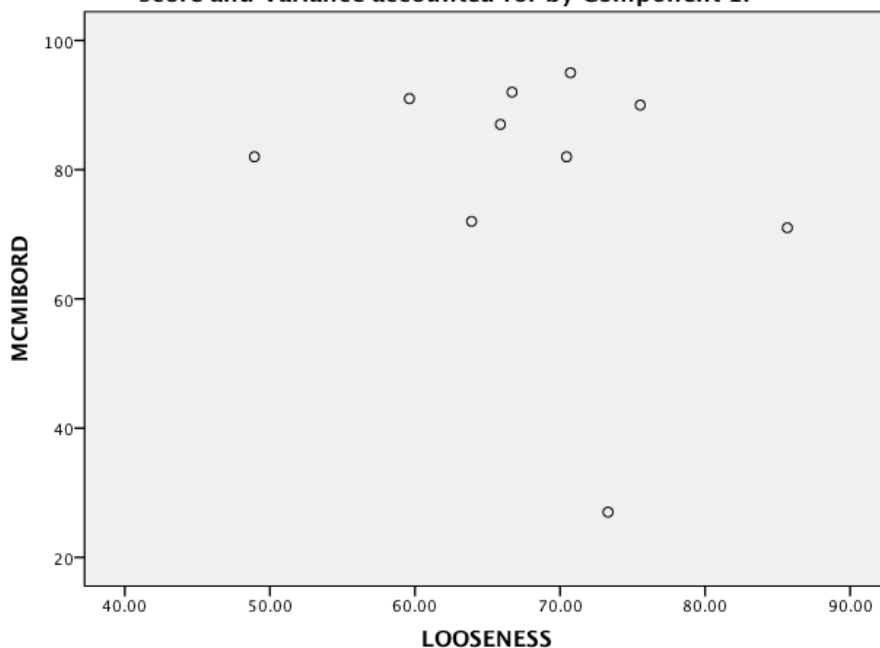Student Number: 10280099

Correlation

A Spearman's correlation was performed revealing a small, negative but statistically insignificant relationship between MCMI-III Borderline Scale score and overall percentage of conflict r_s (8) = -0.134, n= 10, p = 0.356, one-tailed). Therefore, in relation to Hypothesis 1d, we have found no evidence that higher degrees of fragmentation are associated with greater BPD symptomatology.

Hypothesis 1e ('Looseness')

In relation to Hypothesis 1e, the variance of Component 1 was obtained through the Principal Components Analysis function in Idiogrid to determine the degree of looseness in participants' construing. As mentioned previously, the higher the percentage, the tighter the construing so we expected lower percentages to be associated with higher levels of BPD symptomatology. The mean variance of Component 1 was 66.10 (SD 9.99). Figure 25 is a scatterplot showing the relationship between MCMI-III Borderline Scale scores and variance accounted for by Component 1. We can see a cluster of participants who score moderate to high on MCMI-III Borderline Scale score and between 60 and 75% variance. There are two outliers: participant 010, who scored 27 on the MCMI-III, had 73.31% variance and participant 003, who scored 82 on the MCMI-III Borderline Scale, had 48.93% variance, suggesting much looser construing than the other participants.

Figure 25

Scatterplot showing the relationship between MCMI−III Borderline Scale score and Variance accounted for by Component 1.

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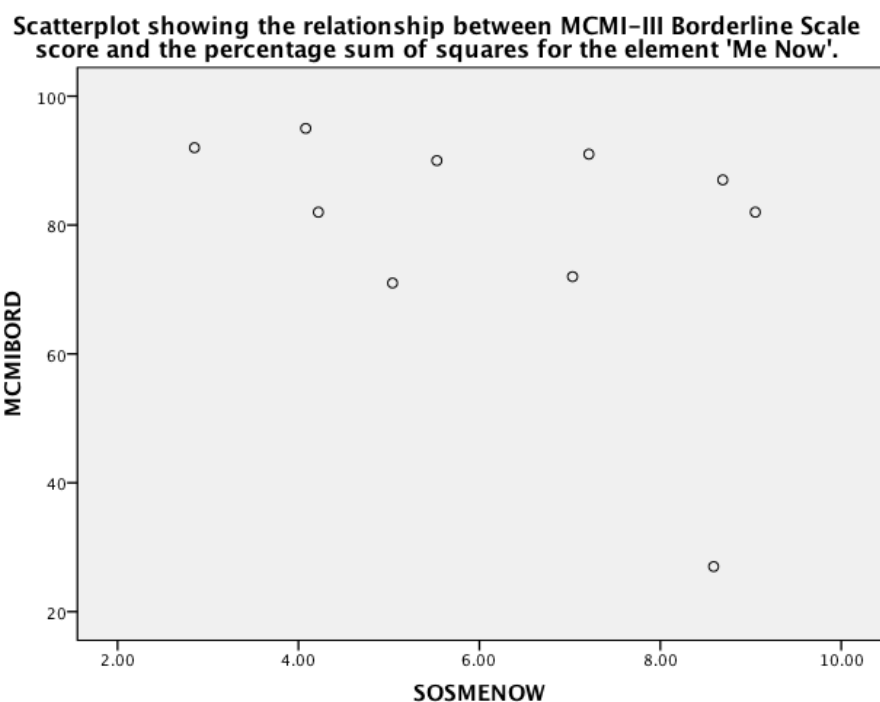Student Number: 10280099

Correlation

A Spearman's correlation was performed revealing a mild to moderate, negative but statistically insignificant relationship between MCMI-III Borderline Scale score and variance of Component 1 (r_s (8) = -0.195, n=10, p = 0.295, one-tailed). So, in relation to Hypothesis 1e, we have found no evidence that loose construing is correlated with higher BPD symptomatology.

Hypothesis 1g ('Poorly elaborated self-construction')

The 'Percentage sum of squares' for the element 'Me Now' was examined within Idiogrid. A higher percentage indicates a greater degree of elaboration of an element. Figure 26 is a scatterplot showing the relationship between MCMI-III Borderline Scale score and percentage sum of squares of the element 'Me Now'. Interestingly, among the set of ten repertory grids, 'Me Now' was the least elaborated element for two of the ten participants.

Figure 26 shows most of the participants who scored moderate to high MCMI-III Borderline Scale scores obtained scores ranging from around to 3 to 9 percent sum of squares. Participant 010 scored a relatively high percentage sum of squares for 'Me Now' (suggesting higher levels of self-elaboration), which seems to tally with her very low MCMI-III Borderline Scale score of 27.

Figure 26

Scatterplot showing the relationship between MCMI–III Borderline Scale score and the percentage sum of squares for the element 'Me Now'.

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Correlation

A Spearman's correlation was performed revealing a moderate to large, negative relationship between MCMI-III Borderline Scale score and percentage sum of squares r_s (8) = -0.438, n=10, p = 0.103, one-tailed). In this case, the p value can be taken as indicating *borderline* significance and the magnitude of the effect size as potentially indicating *practical* significance. We have, therefore, found some evidence suggesting that lower levels of self-elaboration are associated with greater BPD symptomatology.

Hypothesis 1h ('construction of current relationships in the same terms as early relationships')

In relation to Hypothesis 1h, standardised Euclidean distances between the elements 'Partner' and 'Therapist' and 'Mother' and 'Father' 'were examined.

Figure 27 shows the relationship between MCMI-III Borderline Scale scores and standardised Euclidean distances between the elements 'Mother' and 'Partner'. Some participants score fairly highly on MCMI-III and yield relatively small distances between 'Mother' and 'Partner' while others score highly on MCMI-III but obtain relatively large distances. Furthermore, some participants appear to score lower on the MCMI-III but obtain distances suggesting neither similarity nor dissimilarity.

Figure 27

Scatterplot showing the relationship between MCMI–III Borderline Scale score and Standardised Euclidean distance between the elements 'Mother' and 'Partner'.

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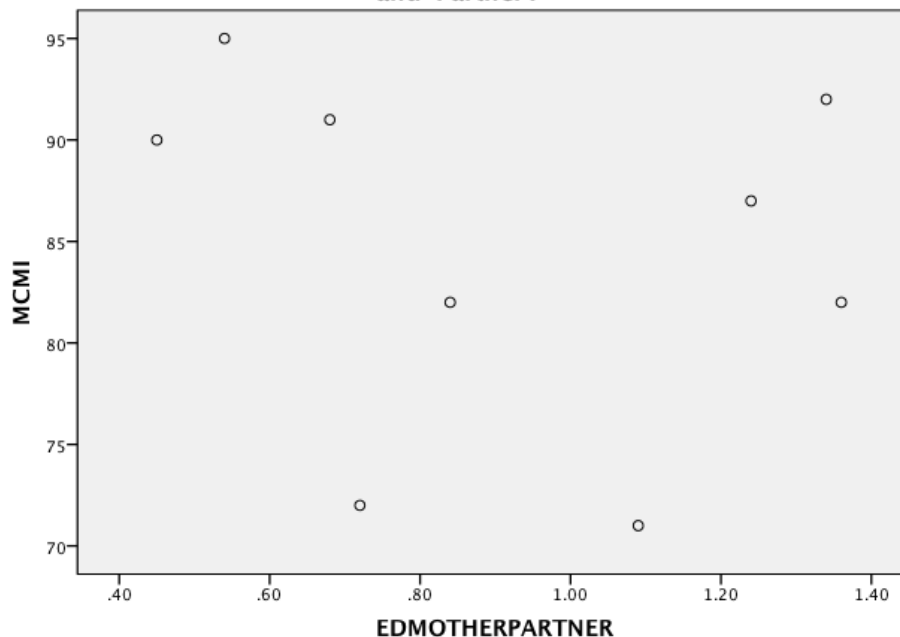
Figure 28

Scatterplot showing the relationship between MCMI−III Borderline Scale score and Standardised Euclidean distance between the elements 'Mother' and 'Therapist'.
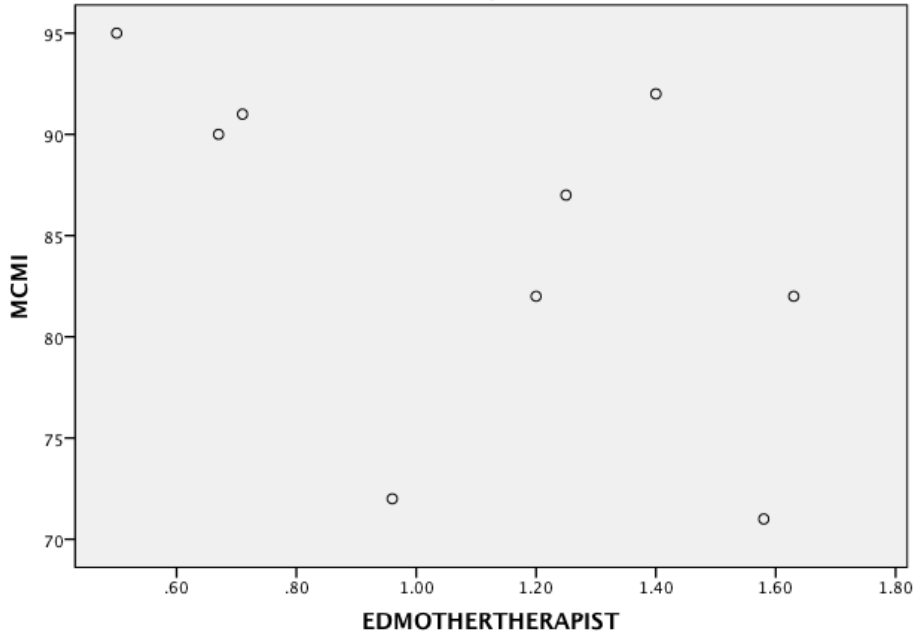

Figure 28 shows the relationship between MCMI-III Borderline Scale score and standardised Euclidean distances between the elements 'Mother' and 'Therapist', with an increase in standardised Euclidean distance associated with a decrease in MCMI-III Borderline Scale scores.

Figure 29

Scatterplot showing the relationship between MCMI−III Borderline Scale score and Standardised Euclidean distance between the elements 'Father' and 'Partner'.
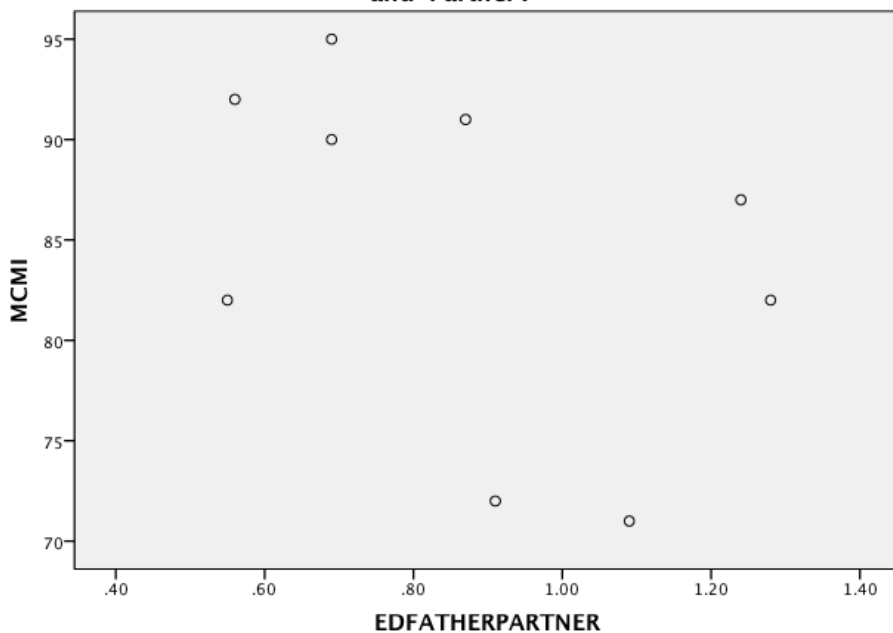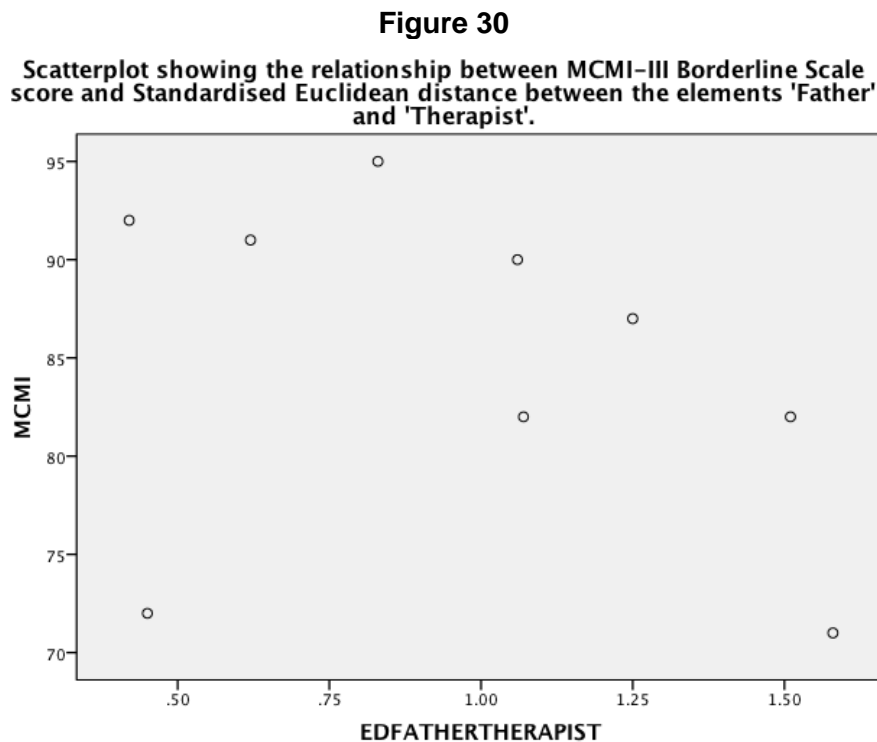
Figure 29 shows the relationship between standardised Euclidean distances between the elements 'Father' and 'Partner' and MCMI-III Borderline Scale scores. Lastly, Figure 30 shows the relationship between standardised Euclidean distances between the elements 'Father' and 'Therapist' and MCMI-III Borderline Scale scores.

Figure 30

Scatterplot showing the relationship between MCMI–III Borderline Scale score and Standardised Euclidean distance between the elements 'Father' and 'Therapist'.

Correlations

A Spearman's correlation was performed to investigate the relationship between MCMI-III Borderline Scale score and distance between the elements 'Mother' and 'Partner', which revealed a moderate, negative but statistically insignificant relationship (r_s (7) = -0.301, n = 9, p = 0.215, one-tailed) suggesting that in relation to Hypothesis 1h, we have found no evidence suggesting that construing one's mother similarly to one's partner is associated with greater BPD symptomatology.

A Spearman's correlation was performed to investigate the relationship between MCMI-III Borderline Scale score and distance between the elements 'Mother' and 'Therapist', which revealed a large negative relationship (r_s (8) = -0.536, n=10, p = 0.069, one-tailed). In this case, the p value can be taken as indicating significance at the 10% level and the magnitude of the effect size can be taken as potentially indicating *practical* significance. We have, therefore, found some evidence suggesting that in relation to Hypothesis 1h, construction of

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one's mother in the same terms as one's therapist is associated with greater BPD symptomatology.

A Spearman's correlation was performed to investigate the relationship between MCMI-III Borderline scale score and distance between the elements 'Father' and 'Partner', which revealed a moderate to strong, negative relationship (r_s (7) = -0.462, n = 9, p = 0.105, one-tailed). Again, in this case, the p value can be taken as indicating *borderline* significance and the magnitude of the effect size can be considered potentially indicative of *practical* significance.

A Spearman's correlation was performed to investigate the relationship between MCMI-III Borderline Scale score and distance between the elements 'Father' and 'Therapist', which revealed a strong, negative relationship (r_s (8) = -0.552, n = 10, p = 0.062, one-tailed). In this case, the p value can be taken as indicating significance at the 10% level and the magnitude of the effect size can be taken as potentially indicative of *practical* significance. We have, therefore, found some evidence suggesting that in relation to Hypothesis 1h, construction of one's father in the same terms as one's therapist is associated with greater BPD symptomatology.

Hypothesis 2

A content analysis was performed in accordance with the CSPC (Feixas et al., 2002) on all elicited constructs. Constructs were coded by both the Main Researcher and a colleague with experience of using the CSPC (to establish inter-rater reliability) and the two raters agreed 90 percent of the time. The two most superordinate constructs for each participant were identified using the 'Percentage sum of squares' function within Idiogrid. Table 8 shows the two most superordinate constructs for each participant together with the category to which they were allocated. We can see that the majority of superordinate constructs were categorised as 'Emotional' (65%) followed by 'Personal' (15%) and 'Relational' (10%). The 'Moral' category was one of the least frequently used categories (1%) together with 'Concrete Descriptor' (1%). None of the superordinate constructs were categorised under the 'Existential' Category. Within the 'Emotional' category, the 'Balanced vs Unbalanced' subcategory was the most frequently used suggesting a particular focus on emotion regulation. Similarly, within the 'Personal' category, the subcategory 'Self-Acceptance vs Self-Criticism' was prominent, indicating the importance of self-evaluation. Of particular interest is the superordinate construct 'Self-hating-Vain', which, in itself, implies that, for participant 002, in order not to be vain, there must be some element of self-hatred. Within

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the 'Relational' category, the subcategories 'Peaceable vs Aggressive' and 'Tolerant vs Authoritarian' were used, suggesting that both interpersonal conflict and acceptance and rejection from others hold important meaning for participants. In relation to Hypothesis 2, while the predominant category and subcategory were 'Emotional' and 'Balanced vs Unbalanced' indicating the importance of emotion regulation, the second most predominant category and subcategory were 'Personal' and 'Self-Acceptance vs Self-Criticism' suggesting that, in fact, valuation of an individual, or more specifically, the value one places upon oneself, is also a particularly salient area for participants.

Hypothesis 3

In relation to Hypothesis 3, BHS scores and Beliefs about BPD Likert scale responses were examined. Tables 11 and 12 are crosstabulation tables showing the beliefs about BPD and BHS scores.

Table 11. Crosstabulation showing extent of belief in the statement "BPD is a part of me" and BHS scores.

"BPD is a part of me"	BHS Score				
	0-3 ('Normal')	4-8 ('Mild')	9-14 ('Moderate')	15-20 ('Severe')	Total
Likert Response					
Strongly Agree	0 (0%)	0 (0%)	1 (10%)	2 (20%)	**3 (30%)**
Moderately Agree	0 (0%)	0 (0%)	1 (10%)	5 (50%)	**6 (60%)**
Uncertain	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**
Moderately Disagree	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**
Strongly Disagree	1 (10%)	0 (0%)	0 (0%)	0 (0%)	**1 (10%)**
Total	**1 (10%)**	**0 (0%)**	**2 (20%)**	**7 (70%)**	**10 (100%)**

Table 12. Crosstabulation showing extent of belief in the statement "BPD is a treatable condition" and BHS scores.

"BPD is a treatable condition"	BHS Score				
	0-3 ('Normal')	4-8 ('Mild')	9-14 ('Moderate')	15-20 ('Severe')	Total
Likert Response					
Strongly Agree	1 (10%)	0 (0%)	1 (10%)	2 (20%)	**4 (40%)**
Moderately Agree	0 (0%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**
Uncertain	0 (0%)	0 (0%)	0 (0%)	5 (50%)	**5 (50%)**

Moderately Disagree	0 (0%)	0 (0%)	1 (10%)	0 (0%)	**1 (10%)**
Strongly Disagree	0 (0%)	0 (0%)	0 (%)	0 (0%)	**0 (0%)**
Total	**1 (10%)**	**0 (0%)**	**2 (20%)**	**7 (70%)**	**100%**

Given the fact that Hypothesis 3 deals with Likert scales (and therefore tied ranks), a Kendall's correlation was performed, revealing a small, negative but statistically insignificant relationship between extent of belief in the statement "BPD is a part of me" and BHS scores $\tau(8) = -0.174$, $p = 0.266$. While the correlation was in the predicted direction (negative), we have no evidence suggesting that belief that BPD is a part of the self is correlated with levels of hopelessness.

A Kendall's correlation was performed revealing a small, positive but statistically insignificant relationship between belief in the extent that BPD is treatable and BHS scores $\tau(8) = 0.112$, $p= 0.344$. While the correlation was in the predicted direction (positive), we have no evidence suggesting that belief that BPD is treatable is correlated with levels of hopelessness.

Table 13 provides an overview of the quantitative results (Hypothesis 1 and 3).

Table 13. Table summarising quantitative results for Hypothesis 1 and 3.

Hypothesis	Prediction	Result
1a) Pre-emptive construing	Positive correlation between PCI 'Pre-Emption' and MCMI-III Borderline Scale scores.	Moderate to large positive relationship ($r_s (8) = 0.396$, n=10, p=0.128, one-tailed). P value indicates *borderline* significance and effect size potentially indicates *practica*l significance.
1b) Slot-rattling	Positive correlations between standardised Euclidean distances between the elements 'Me in the Past' and 'Me Now' and 'Me Now' and 'Me in the Future' and MCMI-III Borderline Scale scores.	For 'Me in the Past' and 'Me Now', there was a very strong, negative relationship, which was significant at the 0.05 level ($r_s (8) = -0.705$, n=10, p = 0.011, one-tailed).

		Spearman's correlation not performed between 'Me Now' and 'Me Future' elements and MCMI-III Borderline Scale scores due to low n.
1c) Low sociality	Negative correlation between 'percentage sum of squares' for the element 'How Others See Me' and MCMI-III Borderline Scale scores.	Spearman's correlations not performed between 'percentage sum of squares' for the element 'How Others See Me' and MCMI-III Borderline Scale scores due to low n.
1d) Fragmentation	Positive correlation between conflict scores and MCMI-III Borderline Scale scores.	Small, negative but statistically insignificant relationship (r_s (8) = -0.134, n=10, p = 0.356, one-tailed).
1e) Looseness	Negative correlation between 'variance accounted for by Component 1' in 'Principal Components Analysis and MCMI-III Borderline Scale scores.	Mild to moderate, negative but statistically insignificant relationship (r_s (8) = -0.195, n=10, p = 0.295, one-tailed).
1f) Hostility	Positive correlation between PCI 'Hostility' scores and MCMI-III Borderline Scale scores.	Moderate, positive but statistically insignificant relationship (r_s (8) = 0.325, n=10, p = 0.180, one-tailed).
1g) Poorly elaborated self-construction	Negative correlation between 'percentage sum of squares' for the element 'Me Now' and MCMI-III Borderline Scale scores.	Moderate to large, negative relationship (r_s (8) = -0.438, n=10, p = 0.103, one-tailed). P value indicates *borderline* significance and effect size potentially indicates *practical*

		significance.
1h) Construction of current relationships in the same terms as early relationships	Negative correlation between standardised Euclidean distances between the elements 'Mother' and 'Father and 'Partner' and Therapist' with MCMI-III Borderline Scale scores.	For 'Mother'-'Partner', there was a moderate, negative but statistically insignificant relationship (r_s (7) = -0.301, n=9, p = 0.215, one-tailed). For 'Mother'-'Therapist', there was a large, negative relationship, significant at the 10% alpha level (r_s (8) = -0.536, n=10, p = 0.069, one-tailed). For 'Father'-'Partner', there was a moderate to large, negative relationship r_s (7) = -0.462, n=9, p = 0.105, one-tailed). The p value indicates borderline significance and the effect size potentially indicates practical significance. For 'Father'-'Therapist', there was a large, negative relationship, significant at the 10% alpha level (r_s (8) = -0.552, n=10, p = 0.062, one-tailed).
1i) Threat	Positive correlation between PCI 'Threat' scores and MCMI-III Borderline Scale scores.	Mild to moderate, positive but statistically insignificant relationship (r_s (8) = 0.279, n=10, p = 0.217, one-tailed).
3a) Belief that BPD is a part of the self	Negative correlation between Likert scale scores and BHS scores.	Mild, negative but statistically insignificant relationship (τ(8) = -0.174, p = 0.266, one-tailed).

3b) Belief that BPD is a treatable condition	Positive correlation between Likert scale score and BHS scores.	Mild, positive but statistically insignificant relationship $\tau(8) = 0.112$, p= 0.344, one-tailed).

Additional Content Analyses

To gain further qualitative information, additional content analyses were performed in relation to how participants see themselves presently ('Me Now') and how they view those who receive the diagnosis of BPD ('A Person Diagnosed with BPD'). Taking the element, "A Person Diagnosed with BPD", the poles of constructs that were given high ratings (i.e. '1' or '7') and thus were likely to indicate more extreme construing by the ten participants, were examined. As mentioned earlier, extreme ratings have been linked to higher levels of symptomatology.

A total of 44 constructs were rated extremely in relation to the element 'A Person Diagnosed with BPD'. Table 14 highlights the constructs elicited and the pole that the participant attributed to a person with the diagnosis of BPD (underlined). The frequency with which each category was used and percentage is also shown. As we can see, the most frequently used category applied to the element "A Person Diagnosed with BPD" was the 'Emotional' category (68.2%), with a particular focus on the 'Unbalanced' subcategory followed by the 'Personal' category (15.9%). As can be seen, none of the extremely rated constructs fall under the 'Moral' or 'Values/Interests' categories.

Within the 'Emotional' category, the individual with BPD is seen as "angry" and "emotional" (predominantly 'visceral' as opposed to 'rational') and yet "loving" "kind", "caring" and "sensitive" ('warm' rather than 'cold'). In this case, it seems that not being sensitive is linked with being "numb" or "hard". Paradoxically, within the 'Relational' category, individuals with BPD are viewed as 'Unsafe' and 'Not understanding', suggesting either interpersonal aggression and lack of sympathy for others or an inability to understand others.

The person with BPD is also associated with "Chaos", "Changeable", "Out of control", "Stressed", "Crazy", "Unstable", "Anxious" and "Tense". Of particular interest, is the fact that the person with BPD is seen categorically as "Ill" and "Unwell", reflecting a medically-based understanding of BPD. Perhaps unsurprisingly then, BPD is also associated with "Dark", "Hopeless" and "Failure".

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In the 'Personal' category, we can see that the person with BPD is considered "Sensitive" as opposed to "Toughness" (weak rather than strong), suggesting that one cannot be both sensitive and tough at the same time. They are also seen as lacking in direction ("Uncertain" and "Floundering"), rigid in their thinking ("extreme black or white thinking") and "passive". Again, the construct "Self-hating-Vain" appears to leave no room for a healthy sense of self-esteem. Specific emotions linked to 'A Person Diagnosed with BPD' are "Anxious", "Scared", "Depressed" and "Sad". Lastly, the person with BPD is regarded as "Incapable", "With suicidal images", "Lost" and "Incomplete", leaving overall, quite a negative picture.

Table 14. Content analysis of extremely rated construct poles applied to the element "A Person Diagnosed with BPD".

Construct	Frequency	Percentage
Emotional Category	30	68.2%
Visceral vs Rational		
Angry-Calm (two participants supplied this construct)		
Emotional-Unemotional		
Warm vs Cold		
Sensitive-Hard		
Loving-Unloving		
Sensitive-Numb		
Loving-Hateful		
Kind-Cruel		
Caring-Belligerent		
Balanced vs Unbalanced		
Well-Rounded-Chaos		
Changeable-Stable		
Not right/Has diagnosis-Normal		
In control-Out of control (this construct was supplied by two participants)		
Stressed-Calm		
Crazy-Settled		
Unstable-Stable		
Normal-Unwell		

Ill-Well Anxious-Calm Relaxed-Tense *Optimist vs Pessimist* Dark-Light Hopeless-Hopeful (construct supplied by two participants) Hopeful-Failure *Specific Emotions* Anxious-Not anxious/Happy Scared-Brave Happy-Depressed Depressed-Happy Happy-Sad		
Relational Category *Sympathetic vs Unsympathetic* Understanding-Not understanding *Peaceable -Aggressive* Unsafe-Safe	2	4.5%
Personal Category *Strong vs Weak* Toughness-Sensitivity *Decisive vs Indecisive* Driven-Uncertain Direction-Floundering *Flexible vs Rigid* Can see grey areas-Extreme black or white thinking	7	15.9%

Thoughtful vs Shallow Inquisitive-<u>Passive</u> *Self-Acceptance vs Self-Criticism* Confident-<u>Self-conscious</u> <u>Self-Hating</u>-Vain		
Intellectual/Operational Category *Capable vs Incapable* Capable-<u>Incapable</u>	1	2.3%
Concrete Descriptor Category *Others* <u>With suicidal images</u>-Without suicidal images	1	2.3%
Existential Category *Purposeful vs Purposeless* <u>Lost</u>-Found (construct supplied by two participants) *Fulfilment vs Emptiness* <u>Incomplete</u>-Complete	3	6.8%
TOTALS	44	100%

Taking the element "Me Now", the same process of content analysis was completed so that the poles of constructs (underlined) that were given high ratings (i.e. '1' or '7') were examined (see Table 15). In comparison with "A Person Diagnosed with BPD" (44 extremely rated constructs), a total of 14 constructs were rated extremely in relation to the element 'Me Now'. Table 15 highlights the fact that the most frequently used category of constructs is, again, the 'Emotional' category (50%), with most constructs falling under the 'Warm vs Cold' subcategory, closely followed by the 'Balanced vs Unbalanced' subcategory. After the 'Personal' category, the Moral category was most frequently used (21.4%). None of the extremely rated constructs fall under the Intellectual/Operational, Values/Interests, Existential and Concrete Descriptor categories.

The content analysis reveals that 'Me Now' is seen as "Nice" ('Good vs Bad'), "Caring" ('Altruist vs Egoist') and "Trustworthy" ('Sincere vs Insincere'). Interestingly, within the 'Emotional' category, participants see themselves as "Loving", "Kind" and "Caring", yet "Unable to feel emotions" and then later, we see "Emotional" and "Anxious" under the 'Balanced vs Unbalanced' subcategory and "Depressed" under the 'Specific Emotions' subcategory suggesting some kind of dilemma between feeling and not feeling. As with the 'Person Diagnosed with BPD', 'Me Now' is considered "Unsympathetic" to others within the 'Relational' category. Of particular importance is that under the 'Personal' category, we see "Self conscious" rather than "Self-Hating" and unlike the 'A Person Diagnosed with BPD' element, 'Me Now' is seen as flexible rather than rigid ("Willing to Change"). Furthermore, under the 'Intellectual/Operational' category, 'Me Now' is associated with "Openness to Learning".

In comparing the two content analyses ('A Person Diagnosed with BPD' vs 'Me Now'), it would appear that there is some sense of differentiation between the two elements. This is perhaps a reflection of a belief among participants that they have made progress since their initial diagnosis, or alternatively, as Fransella (1977) posits, there is a sense of differentiation of the self from the stereotype.

Table 15. Content analysis of extremely rated construct poles applied to the element 'Me Now'.

Construct	Frequency	Percentage
Moral Category *Good vs Bad* <u>Nice</u>-Not nice *Altruist vs Egoist* <u>Caring</u>-Nasty *Sincere vs Insincere* <u>Trustworthy</u>-Untrustworthy	3	21.4%
Emotional Category *Warm vs Cold* <u>Loving</u>-Hateful <u>Kind</u>-Cruel	7	50%

Caring-Belligerent		
Feeling-<u>Unable to feel emotions</u>		
Balanced vs Unbalanced		
<u>Emotional</u>-Unemotional		
<u>Anxious</u>-Calm		
Specific Emotions		
Happy-<u>Depressed</u>		
Relational Category	1	7.1%
Sympathetic vs Unsympathetic		
Sympathetic-<u>Unsympathetic</u>		
Personal Category	2	14.3%
Flexible vs Rigid		
<u>Willing to Change</u>-Dinosaur		
Self-Acceptance vs Self-Criticism		
Confident-<u>Self-conscious</u>		
Intellectual/Operational Category	1	7.1%
Cultured vs Uncultured		
<u>Openness to Learning</u>-Ignorant		
TOTALS	14	100%*

*Note: Totals may not equal exactly 100% due to rounding.

4.4   Case Examples

Two case examples (the participants with the highest scores on the MCMI-III Borderline Scale) will now be presented.

4.4.1   Jane

For ease of communication and confidentiality, I will refer to the first case example participant as Jane (pseudonym). Jane is a 27-year-old British (Mixed White British-Black Caribbean) woman who was first diagnosed with BPD 8 years ago, having been previously

diagnosed with PTSD. She informed me that she did not understand the diagnosis at first, having been told by a clinician while staying on an inpatient ward that she would either become a "revolving door patient or end up dead". She described herself as having rebelled against the diagnosis for about a year although she stated she agrees with it now, having become "more honest" with herself. She told me that she felt meeting other people with BPD helped her to accept her diagnosis.

Jane's Symptom Severity Measures (MCMI-III, BHS, PCI) and Beliefs About BPD Likert Scales.

- Jane's MCMI-III Borderline Scale score was 92, which, according to the MCMI-III scoring criteria, suggests the presence of BPD.
- Jane's BHS score was 17, indicating 'severe hopelessness', and is slightly higher than the mean for the ten participants.
- Jane's PCI Pre-Emption, Hostility and Threat scores were 14 (out of a possible 30), 8 (out of a possible 35) and 17 (out of a possible 30), respectively indicating moderate scores on Pre-emption and Threat and a fairly low score on Hostility.
- Jane answered "moderately agree" for the statement "BPD is a part of me" and "strongly agree" for the statement "BPD is a treatable condition" suggesting that while she feels the condition is a relatively stable fixture in her life, she believes that it can be managed to a certain extent.

Please see Appendix N for Jane's repertory grid. Jane completed a grid with the full twelve elements (including 'How Others See Me' and 'Me in the Future'). The following constructs were elicited from Jane:

Sensitive-Hard

Honesty-Dishonesty

Well-Rounded-Chaos

Emotional-Unemotional

Changeable-Stable

Lost-Found

Loving-Unloving

Capable-Incapable

Dark-Light

Anxious-Not Anxious/Happy

Incomplete-Complete

Unsafe-Safe

Table 16 shows the descriptive statistics for Jane's repertory grid.

Table 16. Descriptive statistics for Jane's repertory grid.

Descriptive Statistics – 'Jane'
Percentage sum of squares
-The most superordinate construct is 'Dark-Light' (10.95%) followed by 'Unsafe-Safe' (10.78%).
-The most salient element is 'Mother' (18.04%) closely followed by 'Person I Dislike' (16.49%).
-'How Others See Me (3.26%).
- 'Me Now' (2.27%)
Standardised Euclidean distances
'Me in the Past'–'Me Now' = 0.52 (similar)
'Me Now'-'Me in the Future' = 0.49 (similar)
'Ideal Self'-'Me in Future'= 0.74 (similar)
'Mother'-'Partner' = 1.34 (dissimilar)
'Mother'-'Therapist' = 1.40 (dissimilar)
'Father'-'Partner'= 0.56 (similar)
'Father'-'Therapist' = 0.42 (similar)
Variance of Component 1 (Principal Components Analysis)
62.31%
Conflict
45.7%

With regard to looseness of construing, the variance of Component 1 revealed by principal components analysis was 62.32%, which is slightly lower than the mean (66.10%) for the ten participants.

Examination of the standardised Euclidean distances shows that Jane sees herself as similar across the following elements ('Me in the Past-'Me Now' and 'Me Now'-'Me in the Future'), suggesting stability of identity over time. In comparison with the mean distances for the ten participants, Jane shows a slightly higher degree of similarity between self-elements.

Jane's overall percentage of conflict was 45.7%, which is slightly higher than the mean

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percentage of conflict for the ten participants. Of the overall percentage of conflict (45.7%), the elements that were characterised by the most conflict were 'Mother' (12.4%), 'Partner' (10.2%) and 'A Person I Dislike' (13%).

The percentage sum of squares for 'Me Now' is a very low 2.27% (2 SDs lower than the mean of 6.25%), suggesting a very low level of self-elaboration. In fact, of all of Jane's elements, 'Me Now' is the least elaborated, which would seem to indicate a high degree of identity confusion. The percentage sum of squares for 'How Others See Me' is 3.26%, which is somewhat lower than the mean for the ten participants (5.67%).

are the most dissimilar. Items that are close to the origin of the plot are less elaborated while items farthest from the origin are more extremely construed.

Figure 31. Representation of Jane's repertory grid.
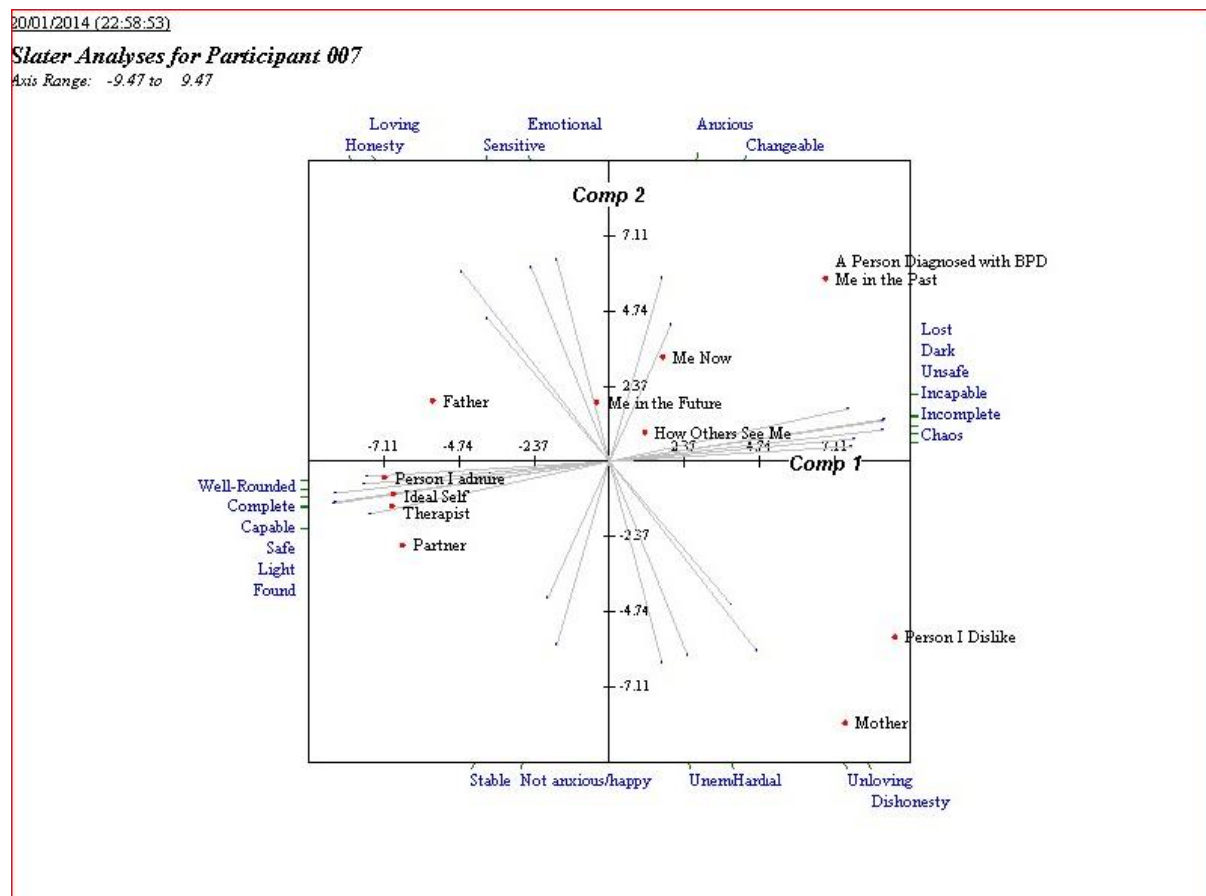
On inspection of Jane's plot, we can see that 'A Person Diagnosed with BPD' and 'Me in the Past' are associated by Jane with negative traits such as 'Lost', "Dark', 'Unsafe', 'Incapable', 'Incomplete' and 'Chaos' and to a lesser extent with 'Anxious' and 'Changeable, while 'Person I Admire', 'Ideal Self', 'Therapist' and 'Partner' are associated with more positive traits such as 'Well-Rounded', 'Complete', 'Capable', 'Safe', 'Light' and 'Found' and to a lesser extent with 'Stable' and 'Not anxious/Happy'. Thus, Jane construes that in the past

she was very similar to the 'typical' person who receives a diagnosis of BPD and both are construed negatively and as far away from others and how she really wants to be ('Ideal Self').

Being 'Sensitive' and 'Emotional' is associated with 'Loving' and 'Honesty' and to a lesser extent with 'Anxious' and 'Changeable'. Furthermore, it would seem that "Stable' and 'Not anxious/happy' to a certain extent are associated with 'Unemotional' and 'Hard' and to a lesser extent with 'Unloving' and 'Dishonesty', suggesting that for Jane, in order to become less distressed she would have to become less emotional, less honest, less loving and less sensitive. The fact that ideally she would like to remain honest and loving as she is presently indicates some degree of conflict.

We can see that 'Me in the Past' is closer to "A Person Diagnosed with BPD' than 'Me Now' and even further away from 'Me in the Future', suggesting that in some sense, she may feel that some improvement in her symptoms has taken place since her diagnosis and will continue to do so. However, as both 'Me Now' and 'Me in the Future' are in the same quadrant as 'A Person Diagnosed with BPD', it would seem that she still identifies herself as having BPD and as having BPD in the future. Comparing the elements 'Me in the Past' and 'Me Now', Jane seems to see herself as less sensitive, just as honest, more well-rounded, just as emotional, less changeable, less lost, just as loving, more capable, less dark, less anxious, more complete and less unsafe.

Looking more closely at her grid (See Appendix N), we can see that Jane would ideally like to be less sensitive, more well-rounded, more capable and more complete and that she sees herself as improving in these areas but perhaps not fully achieving the extent of change she would like ideally. Moreover, it would seem that she feels that she cannot change at all on the following constructs despite a wish to do so: 'Dark-Light'; 'Emotional-Unemotional'; 'Lost-Found', 'Unsafe-Safe' and 'Changeable-Stable'. Interestingly, there are three constructs ('Loving-Unloving', 'Anxious-Not Anxious/Happy' and 'Honesty-Dishonesty') with which Jane appears to feel confident and hopeful in that she feels she will either remain the same ('Loving-Unloving'), achieve her ideal ('Honesty-Dishonesty') or in fact, surpass her ideal ('Anxious-Not anxious/Happy').

The grid shows that Jane construes her therapist and father similarly and her partner and father similarly, which initially suggests that she may, in general, construe current relationships in the same terms as early relationships. However, this is not the case for her mother, whom she construes differently to her partner and therapist. Jane's relationship with

her mother appears to be difficult, given the high level of elaboration and proximity of the element 'Mother' to the construct poles 'Unloving' and 'Dishonesty' and to the element 'Person I Dislike'. Jane construes herself now as neither similar nor dissimilar to her mother. Her construction of her father appears to be less elaborated but her view of him seems more positive given that 'Father' is in the opposite quadrant to 'Mother' and in the same quadrant as 'Honesty' 'Loving', 'Emotional' and 'Sensitive'. Jane also construes her father as similar to herself now.

Content Analysis for Jane

Table 17 shows the results of the content analysis of the twelve constructs elicited by Jane. We can see that the 'Emotional' category is the most frequently used (58.33%), followed by the 'Existential' category (16.66%). The 'Moral', 'Relational' and 'Intellectual/Operational' categories were all used once (1%). The 'Personal', 'Values/Interests' and 'Concrete Descriptors' categories were unused.

Table 17. Content analysis of Jane's constructs.

Construct	Frequency	Percentage
Moral category *Sincere-Insincere* Honesty-Dishonesty	1	8.33%
Emotional Category *Visceral-Rational* Emotional-Unemotional *Warm-Cold* Sensitive-Hard Loving-Unloving *Balanced-Unbalanced* Well-Rounded-Chaos Changeable-Stable *Specific Emotions* Anxious-Happy *Optimist-Pessimist*	7	58.33%

Dark-Light		
Relational Category *Peaceable-Aggressive* Unsafe-Safe	1	8.33%
Personal Category	0	0%
Intellectual/Operational Category *Capable-Incapable* Capable-Incapable	1	8.33%
Values/Interests Category	0	0%
Concrete Descriptors Category	0	0%
Existential Category *Purposeful-Purposeless* Lost-Found *Fulfilment-Emptiness* Incomplete-Complete	2	16.66%
TOTALS	12	100%*

*Note: Totals may not equal exactly 100% due to rounding.

Jane's content analysis reveals that her construing is focused upon emotions, in particular, warmth towards others, the ability to balance/stabilise emotions and positive/negative outlook for the future ('Dark-Light'), which is the most salient of all of her constructs. In relationships, it would seem that she tends to construe people in terms of being safe or unsafe, suggesting a sense of interpersonal threat. The construct 'Lost-Found' implies an emphasis on finding her identity and place within the world.

4.4.2 Susan

Susan is a 27-year-old White British woman who was diagnosed with BPD at the age of 25

years. Prior to being diagnosed, Susan told me she had felt "confused" and that while BPD "made sense" of her difficulties, the downside to this was that it is a "negative label". She stated, "I agree with it but I don't agree with the way people act around you". She informed me that five days after receiving the diagnosis, she was called an "attention-seeker" by a member of staff. She described herself as being less angry now about the diagnosis because she has an understanding of it, which, she reported, has "helped in some very strange ways".

<u>Susan's Symptom Severity Measures (MCMI-III, BHS, PCI) and Beliefs about BPD Likert Scales.</u>

- Susan's MCMI-III Borderline Scale score was 95, which, according to the scoring criteria of the MCMI-III, warrants a diagnosis of BPD and is indicative of significant BPD symptomatology.
- Susan's BHS score was 20, which indicates "severe hopelessness" and is slightly higher than the mean.
- Susan's PCI Pre-Emption, Hostility and Threat Scores were 16 (out of a possible 30), 29 (out of a possible 35) and 26 (out of a possible 30), indicating a moderate score on Pre-Emption and high levels of both Hostility (1 SD higher than the mean) and Threat (5 SDs higher than the mean).
- Susan answered "moderately agree" with the statement "BPD is a part of me" and "uncertain" with the statement "BPD is a treatable condition" suggesting some lack of clarity about whether or not BPD is a stable fixture in her life.

<u>Susan's Repertory Grid</u>

Please see Appendix O for Susan's repertory grid. Susan completed a grid with the full twelve elements (including 'How Others See Me' and 'Me in the Future'). Susan elicited the following constructs:

Critical-Not critical

Supportive-Not supportive

Accepting-Rejecting

Happy-Unhappy

Empathy re BPD-No empathy re BPD

Caring-Uncaring

Sensitive-Not sensitive

Resilience-Passive

Calm-Chaotic

Able to Handle Conflict-Aggression

Listens-Ignores

Table 18 shows the descriptive statistics for Susan's repertory grid.

Table 18. Descriptive statistics for Susan's repertory grid.

Descriptive Statistics – 'Susan'
Percentage sum of squares -The most superordinate construct is 'Accepting-Rejecting' (12.94%) followed by 'Happy-Unhappy' (11.4%). -The most salient element was 'Mother' (14.87%) closely followed by 'Person I Dislike' (14.04%). -'How Others See Me (3.65%) - 'Me Now' (2.31%) Standardised Euclidean distances 'Me in the Past'–'Me Now' = 0.63 (similar) 'Me Now'-'Me in the Future' = 0.94 (neither similar nor dissimilar) 'Ideal Self'-'Me in Future'= 0.48 (similar) 'Mother'-'Partner' = 1.36 (dissimilar) 'Mother'-'Therapist' = 1.63 (dissimilar) 'Father'-'Partner'= 1.28 (dissimilar) 'Father'-'Therapist' = 1.51 (dissimilar) Variance of Component 1 (Principal Components Analysis) 68.03% Conflict 33.2%

The percentage sum of squares for the element 'How Others See Me' is 3.65%, which is slightly lower than the mean (5.67%). The percentage sum of squares for the element 'Me Now' (2.31%) is the least elaborated of all of her elements and 1 SD below the mean (6.23%) possibly indicating a high degree of identity confusion.

Examination of the standardised Euclidean distances shows that Susan sees herself as similar across the elements 'Me in the Past'-'Me Now' and as neither similar nor dissimilar

across the elements 'Me Now'-'Me in the Future', which may reflect uncertainty about whether or not she can or will change in future. However, 'Ideal Self' and 'Me in the Future' suggests some hope.

Susan construes her mother and therapist, mother and partner, father and therapist and father and partner dissimilarly suggesting that she does not tend to construe current relationships in the same terms as her earlier relationships.

The variance of Component 1 revealed by principal components analysis was 68.03%, which is slightly higher than the mean for the ten participants (66.10%).
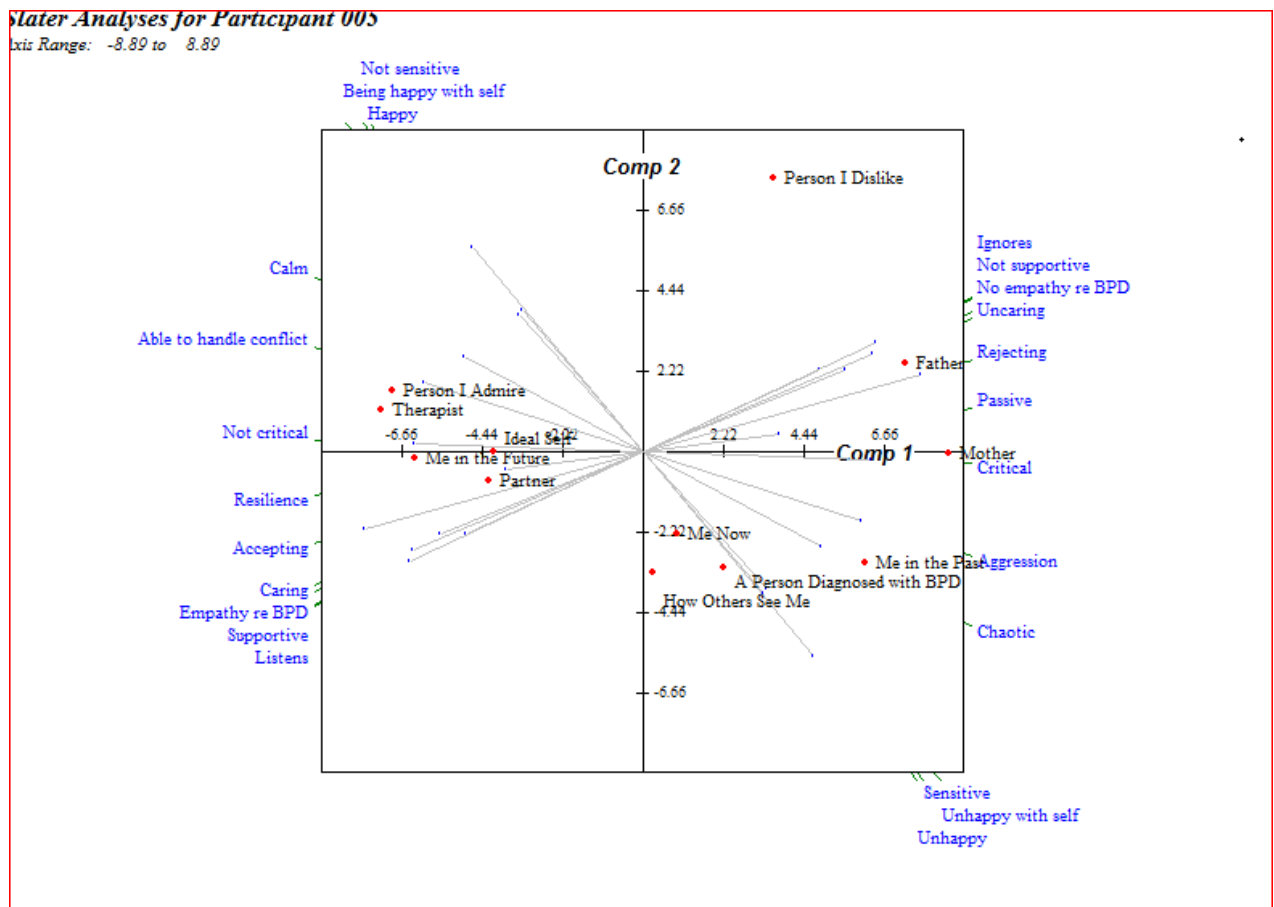
The overall conflict percentage within Susan's grid is 33.2%, which is the lowest score of the ten participants on this measure (1 SD below the mean). Of the overall percentage of conflict (33.2%), the elements that were characterised by the most conflict were 'Father' (11.8%) and 'A Person I Dislike' (14.8%).

A graphical plot of the relationships between Susan's constructs and elements was elicited using the 'Slater Analysis' function in Idiogrid and is displayed in Figure 32.

For Susan, 'A Person Diagnosed with BPD' is associated with 'Aggression', 'Chaotic' and to a lesser extent with 'Critical', 'Sensitive', Unhappy with Self' and 'Unhappy' and very different to 'Therapist', 'Partner', 'Ideal Self', Person I Admire' and 'Me in the Future', which are associated with 'Able to Handle Conflict', 'Calm', 'Not critical', 'Resilience' and to a lesser extent 'Accepting', 'Caring', 'Empathy re BPD', 'Supportive' and 'Listens'.

We can see that 'A Person Diagnosed with BPD' is close to 'Me in the Past' and even closer to 'Me Now' suggesting that either she feels that the diagnosis fits her more now than it did previously, that her symptoms have worsened over time, or lastly, this could merely be a representation of the fact that in the past she was undiagnosed whereas now she has the diagnosis. Both 'Me in the Future' and 'Ideal Self' fall within the opposite quadrant to 'A Person Diagnosed with BPD' suggesting that she views herself as recovering to a certain extent over time.

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Figure 32. Representation of Susan's repertory grid.

Comparing the elements 'Me in the Past' with 'Me Now', it would seem that Susan sees herself as having become somewhat less critical, more accepting, more happy, more empathetic towards BPD, more happy with herself, more caring, less sensitive, more resilient, more calm, more able to handle conflict, and more able to listen and would ideally like to continue to see improvements in these areas.

It would seem that Susan has a difficult relationship with her father, given the close proximity of the element 'Father' with 'Rejecting' 'Uncaring', 'No Empathy re BPD' 'Not supportive', 'Ignores' and 'Passive'. Similarly, 'Mother' is closely associated with 'Critical' and 'Passive'. However, the grid reveals that she does not view her therapist or partner in the same terms.

Susan sees herself in future as similar overall to her ideal self and we can see from her grid (See Appendix O) that on a number of constructs, she seems quite hopeful that she will achieve or, in some cases, surpass her ideal of becoming somewhat less critical, more supportive, more accepting, more empathetic with regard to BPD, happier, happier with herself, caring, calm, resilient, more able to listen and able to handle conflict. Interestingly,

however, the only construct with which she is less certain is 'Sensitive-Hard'. We see from her grid that Susan sees herself as somewhat sensitive (rating of '3'), would ideally like to be slightly less sensitive (rating of 2) but, in fact, sees herself in future as more sensitive (rating of '5') than she is presently. This may indicate a dilemma for her between feeling and not feeling.

Table 19 is a content analysis of the twelve elicited constructs for Susan. We can see that the 'Relational' category is the most frequently used (50%), followed by the 'Emotional' category (33.33%) and the 'Personal' category (16.66%). The 'Moral', 'Intellectual/Operational' 'Values/Interests', 'Concrete Descriptors' and 'Existential' categories were unused.

Table 19. Content Analysis of Susan's constructs.

Construct	Frequency	Percentage
Moral Category	0	0%
Emotional Category	4	33.33%
Warm vs Cold		
Caring-Uncaring		
Sensitive-Not sensitive		
Balanced vs Unbalanced		
Calm-Chaotic		
Specific Emotions		
Happy-Unhappy		
Personal Category	2	16.66%
Strong vs Weak		
Resilience-Passive		
Self-Acceptance vs Self-Criticism		
Being happy with Self-Not being happy with Self		
Relational Category	6	50%
Tolerant vs Authoritarian		

Accepting-Rejecting *Sympathetic vs Unsympathetic* Empathy re BPD-No empathy re BPD Listens-Ignores Supportive-Not supportive Critical-Not critical *Peaceable vs Aggression* Able to Handle Conflict-Aggression		
Intellectual/Operational Category	0	0%
Values/Interests Category	0	0%
Concrete Descriptors Category **Existential Category**	0	0%
TOTALS	12	100%*

*Note: Totals may not equal exactly 100% due to rounding.

The content analysis reveals that Susan's construing is largely focused upon relationships and, in particular, acceptance and rejection from others. There seems to be a focus on being understood, heard and validated as well as the ability to handle interpersonal conflict. Moreover, seemingly tied to this, is the ability to accept and validate oneself.

5   DISCUSSION

Before coming to any conclusions, it will be helpful to summarise the study's main quantitative and qualitative findings.

Hypothesis 1

Hypotheses 1a to 1i were concerned with the proposed characteristics of construing and whether these correlated with results from an existing BPD symptom severity measure (MCMI-III). As mentioned previously, p values of 0.10 or below were viewed as statistically

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significant, while those in the region of 0.10 and 0.15 were taken as indicating borderline significance. In addition, effect sizes above 0.40 were considered as potentially indicating practical significance. The most significant finding related to Hypothesis 1b ('*slot-rattling*') and reached significance at the 5% alpha level. Contrary to our prediction, similarity of construing of the elements 'Me Now' and 'Me in the Past' was correlated with greater BPD symptomatology. Aspects of Hypotheses 1h ('*construction of current relationships in the same terms as early relationships*') reached significance at the 10% alpha level. Specifically, similarity of construing of the elements 'Mother' and 'Therapist' and 'Father' and 'Therapist' was significantly correlated with greater BPD symptomatology. In addition, similarity of construing of the elements 'Father' and 'Partner' was correlated with greater BPD symptomatology and this finding reached *borderline* significance. A number of the other hypotheses also reached borderline significance. These were Hypothesis 1a ('*pre-emptive construing*') and Hypothesis 1g ('*poorly elaborated self-construction*').

Hypothesis 2

The content analysis conducted on elicited constructs revealed that the predominant category related, in contrast to Hypothesis 2, to *emotions*, or more specifically to the ability to regulate emotions (and to a lesser extent to warmth and sensitivity towards others, hopefulness vs hopelessness and mood). However, the second most common category related to the self; in particular to self-acceptance or self-criticism. As such, it can be said that Hypothesis 2 was, at least, partially accurate in that valuation of self appears to hold important meaning for participants. A striking example of this was the elicitation of the construct 'Self-hating-Vain'. Moreover, it would seem that valuation *by* as well as *of* others was particularly salient, with a strong emphasis on acceptance and rejection, tolerance and authoritarianism. Bearing in mind that many of those who are eventually diagnosed with BPD have a strong history of invalidation, this seems intuitive. Indeed, Winter et al. (2003) highlighted the fact that in group therapy, BPD clients had very little sense of self and defined themselves largely in terms of how others viewed them. Undoubtedly, the ability to value oneself is intrinsically linked with how others perceive of you. Perhaps unsurprisingly, the construct 'Trustworthy-Untrustworthy' was elicited, indicating that this is an important means through which to determine the degree of interpersonal safety of others ('Safe-Unsafe').

Hypothesis 3

A small majority of participants believed that BPD is in fact, part of their identity and most were uncertain as to whether or not BPD is a treatable condition, although correlations

performed on these beliefs about BPD and hopelessness (BHS) did not reach statistical significance. What has been highlighted though is the fact that there is uncertainty about the nature and stability of BPD in relation to the self. It seems appropriate at this point to revisit the participant who informed me that, in fact, she had been told that she no longer met the criteria for BPD. There appeared to be some confusion on her part and amongst the clinicians within her team as to whether the label should be removed. Furthermore, the finding that only half of the participants met the criteria for BPD according to the MCMI-III raises questions about the validity of the measure, the multiaxial model of the DSM and the fundamental assumptions upon which it is based. It is also feasible that this finding was due to improvements in patients' symptoms due to the effectiveness of their respective treatment programmes.

There will now follow a more in-depth discussion of the key findings.

Slot-Rattling

The finding that participants who displayed greater BPD symptomatology showed a consistency of self-construing over time (past and present) was unexpected. It is possible that this reflects a belief among participants that they are unable to change or alternatively, it may be a representation of Kellian hostility. Moreover, it could be argued that, in fact, examination of standardised Euclidean distances between self elements across time is not a valid measure of slot-rattling. Indeed, a large distance between the element 'Me Now' and 'Me in the Past' may more accurately be a measure of the clinical utility of treatment received and thus an indication of recovery. An alternative explanation for this finding requires us to remind ourselves that, according to Kelly (1955), slot-rattling is both primitive and simplistic, a superficial change not rooted in an elaborated system. Given the history of invalidation commonly experienced by those diagnosed with BPD, the inconsistent and erratic behaviour thought to characterise the disorder may indeed reflect slot-rattling. By presenting to the world a state of consistent inconsistency, we cannot be pinned down by others to any particular characteristic or trait and, as such, are less vulnerable to invalidation. However, it is feasible that this slot-rattling behaviour is not associated with comprehensive changes in core structures. Rather, it may be akin to the psychodynamic notion of the 'false self' (Winnicott, 1965), which seemingly allows the vulnerable inner core 'self' to remain hidden, protected, unchanged and intact. Thus, in rating the elements 'Me in the Past' and 'Me Now', participants may have referred to what they felt to be their 'true' inner core as opposed to the changeable slot- rattling 'selves'. Within this arena, slot-rattling may still explain the "affective instability" and "unstable and intense relationships" attributed

to those diagnosed with BPD if we consider that this divorce from the 'true' self may at times leave the individual unaware of their emotions and thus unable to regulate them. The focus of further research could utilise alternative measures for 'slot-rattling'. One alternative would be to investigate the construction of self across various *situations* (i.e. when I am feeling rejected vs accepted/loved, when I am being loving vs hateful, feeling vs not feeling) rather than *time* (past, present and future).

Construction of current relationships in the same terms as early relationships
A possible explanation for the significant and borderline significant findings in this area is that, as hypothesised, there is indeed a tendency to construe current relationships in terms of early relationships. As such, people may be considered as undifferentiated or all the same (i.e. always letting you down, rejecting, dangerous to get close to, etc). Linked to this and consistent with the slot-rattling result, is the possibility that people (including the self) are also construed as unchangeable. Within this context, it is understandable why there may appear to be "frantic efforts to avoid real or imagined abandonment" and why establishing trust is so important within therapeutic relationships developed with those diagnosed with BPD. For those in relationships with these individuals, it may be difficult to escape from the role that they have been assigned and they may experience their significant others as hostile (Kellian).

Pre-Emptive Construing
The borderline significant finding that pre-emptive construing was positively correlated with greater BPD symptomatology is supported by the content analysis of extreme ratings for 'A Person Diagnosed with BPD', which revealed that the individual with BPD is considered to be typified by a rigidity of thinking and an inability to see grey areas. It seems likely that pre-emptive construing represents an attempt to establish some certainty in the world. Such attempts, however, are often met with social disapproval and invalidation, making relationships dangerous territory in which the survival of the self and one's reality is compromised. Under such circumstances, it is not difficult to see how a mistrust of others and a dilemma between accepting the reality of others and rejecting one's own or vice versa, between passivity and aggression, between closeness and distance, arises. Again, within psychodynamic thinking, this has been referred to as the 'approach-avoidance dilemma' stemming from the oscillation between the need for and fear of intimacy and engulfment (Melges & Swartz, 1989).

Poorly Elaborated Self-Construction

The borderline significant finding that poor elaboration of the element 'Me Now' is positively correlated with greater BPD symptomatology is further supported by the fact that both of the case example participants score the highest MCMI-III scores while their least elaborated or salient element was 'Me Now'. This suggests that a sense of divorce or disassociation from the self is central to the experience of those diagnosed with BPD and may also account for the often-cited sense of numbness. If we consider that the thoughts, feelings, and emotions of those with BPD have in many cases been invalidated and the focus has historically been on survival, on adopting behaviours deemed most suitable for each situation, it follows that the result is a difficulty in reading, knowing or trusting one's own emotional states or 'oneself'. Thus, the individual may come to view the self as inconsistent, unpredictable and unfathomable.

Additional Content Analyses

Within both of the additional content analyses, it appears that emotionality or sensitivity is seen as both a positive and negative trait, suggesting a certain degree of conflict. While the individual with BPD is construed by participants as chaotic, changeable, angry, anxious, tense, crazy, and out of control, they are also considered to be loving, kind and caring. It is possible that this is a representation of how others view them in comparison with how they view themselves, respectively, or again, of the core ('true') versus social ('false') 'self'. Sensitivity seems to be associated with warmth but also with vulnerability or weakness. In most cases, individuals displayed a wish to be less sensitive in future although not being sensitive seems to be associated with being numb or hard. It may be that the 'emotion dysregulation' typical of BPD is at least partially the result of a slot-rattling between feeling and not feeling based upon a conflict between self and other, in which one is rejected (invalidated) when feeling and accepted (validated) when not feeling. Paradoxically, within interpersonal relations, the person with BPD is viewed as unsafe and not understanding. This may be a reflection of interpersonal aggression in the face of perceived threat posed by others, difficulties with comprehending the minds of others (sociality) or a combination of both.

The person with BPD is seen by participants as "Ill" and "Unwell", reflecting a medically-based understanding of BPD. When speaking with the ten participants, it seemed that whilst there was a wish to become well in future, there is simultaneously an acceptance that whilst improvements can be made, complete wellness is unlikely; a rather sad prospect, a belief that may account for the high levels of hopelessness revealed in this study. The outlook was

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not, however, completely hopeless, with a focus on effective management of the condition rather than cure, indicating that participants do, in fact, agree that personality disorders such as BPD are, as the multiaxial model purports, akin to a faulty immune system. For Jane and Susan (case example participants), it seems that whilst there may have been some initial resistance to the diagnosis, this was followed by an acceptance, perhaps even relief, that there is a name for their difficulties and thus the possibility of treatment.

The content analysis of extreme ratings for the element 'Me Now' revealed that participants construe themselves in the present as nice, caring, kind, trustworthy and loving yet we still see a lack of sympathy towards others. Again, this may represent a lack of understanding of others and/or willingness to understand the perspective of others ('sociality') as these maybe viewed as threatening to the self. Interestingly, we see the constructs 'Emotional' and 'Anxious' but also 'Unable to feel emotions', again perhaps representing a dilemma between feeling and not feeling. It would seem that overall, participants are in a better place now than they were prior to diagnosis and we see the construct 'Self-conscious' rather than 'Self-Hating' rated extremely for 'A Person Diagnosed with BPD'. Similarly, the presence of constructs 'Willing to change-Dinosaur' and 'Openness to Learning-Ignorant' indicate the introduction of more helpful experimentation in which there is a learning from experience and ultimately, a reduction in hostility. To utilise Kelly's man as scientist metaphor, rather than enforcing previously invalidated theories, there is now space for re-hypothesising (reconstruing following invalidation). Such findings certainly point to the effectiveness of the treatment received by the participants.

Limitations of the Study

Design

Correlational studies do not imply cause and effect and thus do not allow us to draw firm conclusions from our results. The results can be taken, however, as a stepping-stone to further research.

Sample

Correlational studies generally require large sample sizes but given the time constraints of the study, a low sample size was obtained. This is likely to have played a role in reducing the overall power of the study and thus its ability to detect significant relationship effects. In addition, the distributions of the symptom severity measures (MCMI-III and BHS) were not normally distributed (MCMI-III Borderline Scale and BHS) and this would also most certainly have influenced the study's ability to establish an association between symptom severity

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measures and proposed characteristics of construing.

Procedure

It is important to mention that during the lengthy recruitment phase of this study, a number of obstacles hindered the process. Specifically, one of the CMHTs that was approached explained that a number of their patients were unaware of their diagnosis of BPD and therefore recruitment would mean disclosing this information. Unfortunately, given the time constraints, I was unable to obtain a reason for the secrecy behind the diagnosis. However, the application of diagnostic labels without explicit transparency with the recipients, without doubt, raised obvious ethical concerns. It is probable that utilising the diagnosis within the closed and privileged circles of the mental health profession without informing those to whom they apply not only perpetuates a sense of stigma around BPD and reinforces mistrust of the mental health profession generally. Bearing this in mind, it is possible that participants chose not to participate due to a lack of trust in healthcare professionals.

Consideration should be given to the fact that the majority of the participants (all but one) were recruited from the Personality Disorder Service, within which a psychologically-based (DBT) approach to the understanding of BPD was adopted, although some of these participants were also registered with local CMHTs. It is not clear how many of the participants had received DBT and/or other treatment approaches. Thus, treatment differences may have influenced the outcomes.

Lastly, it is possible that the use of self-report measures (especially those with fixed choice questions) within this study may have led to a *social desirability bias*. This may be particularly relevant given the sensitivity to rejection and invalidation found among this client group.

<u>Issues of Reliability and Validity</u>

Symptom Severity Measures

As mentioned previously, Watson, Winter and Rossotti (1996) highlighted a number of issues with the original PCI (Chambers & O'Day, 1984). With regard to internal consistency, the coefficient alpha (Cronbach, 1951) was less than the recommended 0.60 for the 'pre-emption' and 'threat' subscales. Watson et al, 1996 subsequently removed items the coefficient alpha level, resulting in an improvement in scale reliability. However, the authors point out that in their revised 40-item PCI scale, they were unable to raise the alpha above

0.60 for the 'pre-emption' subscale. In relation to construct validity, the authors conducted a factor analysis on PCI items and found that items from the 'pre-emption' and 'threat' distributed across five of the total six factors. This suggests that the items were not, in fact, tapping into the Kellian constructs. When rating the content validity of the items, only four items were deemed to reflect 'pre-emption' in the Kellian sense. On the 'hostility' scale, the authors agreed that none of the items reflected the Kellian concept of hostility. Moreover, the authors agreed that only one item on the 'threat' scale ('*things very important to me are changing*') truly represented the Kellian concept of threat as an imminent and comprehensive change in core structures. The authors suggest that attempting to empirically measure Kellian processes of construing is challenging given that many of these are inaccessible to higher levels of awareness. Despite their modifications, they concede that further improvements are needed and thus the limitations of this measure should be taken into account.

Content Analysis

Steps were taken to increase reliability with the use of an additional rater and the level of inter-rater agreement was high (90%). Differences in rating highlight the fact that the rating process itself is dependent upon the current construct system of the rater and this has implications when considering internal validity.

Repertory Grids

It has been argued that one benefit of the repertory grid is that it enables us to establish the perceptions of others without researcher interference (Whyte & Bytheway, 1996). Given that the constructs were not supplied during the elicitation procedure and presumably this enabled the generation of unbiased constructs, it is assumed that there was a high degree of internal validity. However, the context within which grids are constructed is also important. The *elements* were supplied by the Main Researcher and this is likely to have influenced the direction of outcomes. Indeed, research has shown that the selection of elements used can yield significant effects (Wright & Lam, 2002). Similarly, the grid rating method chosen (in this case, the 'rating' as opposed to the 'ranking' method) is likely to have affected the results as has previously been demonstrated (Neimeyer & Hagans, 2002). It is also possible, that during the procedure, the Main Researcher may have unwittingly influenced outcomes by means of slight variations of procedure with each participant. However, attempts were made to ensure consistency in the way in which instructions and examples were delivered.

As Fransella, Bell and Bannister (2004) state it has been argued that the notion of reliability

runs counter to Kelly's concept of the person as a 'form of motion' rather than a 'static mind'. It would seem that the traditional construction of reliability has been one in which the focus is upon stability rather than change, of the persistence of certain traits within an individual. Having said this, Fjeld & Landfield (1961) found correlations of 0.80 between constructs elicited two weeks apart.

Current controversy: The Emergence of the DSM-5.

Whether we consider BPD to be a stable aspect of the personality, akin to a faulty immune system or as the reflection of unhelpful characteristics of construing that can be altered through experimentation; all inexorably affect those who receive the diagnosis. Is it ethical to ascribe labels to individuals without the hope that they will ever be removed; to ignore the complexities of the individual by clustering them into pre-determined and homogenous categories? What implications does this have on the prospect of recovery? Does this not perpetuate the invalidation and blame that is assumed to play such a crucial part in the etiology of the 'illness'? On the other hand, does removing a label one day only to reinstate it the next based on satisfying a number of arbitrary criteria constitute a more helpful approach or represent a form of social punishment for undesirable behaviours? Amidst the confusion, it is hardly surprising that individuals diagnosed with BPD might feel baffled and uncertain. What is evident is that questions need to be asked about the suitability of applying the medical model to mental distress and whether it should continue to hold a place within the assessment and treatment of the mentally distressed. The DSM and measures such as the MCMI-III are constructs in and of themselves, representing just one way of perceiving mental distress. What is needed perhaps is a dilation of our perceptual field, a loosening of our construing. Ultimately, however, this is dependent upon our own willingness to consider the alternatives and to reconstrue.

As previously mentioned, the DSM-IV has now been replaced by the DSM-5 (American Psychiatric Association, 2013). During the development of the DSM-5, attempts were made to address some of the apparent failings of the DSM-IV. One proposal was to establish six PD types as opposed to the DSM-IV's ten. Moreover, a *dimensional* as opposed to *categorical* model was proposed. Under a dimensional system, the comorbidity of various PDs and heterogeneity amongst those who receive diagnoses are more easily accounted for given that personality 'disorder' becomes a point on a continuum of general or 'normal' personality traits. Indeed, as Skodol (2012, p.321) points, out, "the configuration of dimensional ratings describe each person's personality, so many different multidimensional configurations are possible". Despite these suggestions, the ten PD types were retained and

the new hybrid dimensional-categorical model was not incorporated into the DSM-5's Main manual but rather placed in Section III for further study. One important change, however, is that the DSM-5 is no longer based upon the multiaxial model and now utilises a single axis system within which all mental disorders are categorised and, as such, the boundary between Axis I disorders (i.e. depression) and Axis II disorders (i.e. BPD) has been dispensed with.

Overall, it would seem that with the DSM-5 there has been an initial step in the 'right' direction; firstly, with the removal of the boundary between Axis I and Axis II disorders and secondly, with the inclusion of the hybrid dimensional-categorical model in Section III, which will hopefully stimulate further research. However, it is recognised that it is a work in progress and that fundamentally, it is still based upon a system of discrete categorisation of PDs. As Livesley (2011) states there are serious problems with the definition of the PD 'types', arguing that these are not based on empirical evidence. He asserts that whilst it would be convenient if PDs could be organised into discrete categories each linked to distinct etiological factors, nature has other, more complex ideas. Despite this, attempts to further capture, revise and fragment the complexities of human behaviour into an integrated, predictable diagnostic system continue unabated.

It has been suggested that psychiatry's lack of a meaningful response to criticisms levelled at its diagnostic system is the result of attempts at self-preservation of the field (Boyle, 2002; Pilgrim, 2007; Harper, 2013). In addition, as Gill, Mullin and Simpson (2013) point out, the medical model (and its diagnoses) lends itself to the current zeitgeist of evidence-based practice with diagnostic categories easily representing variables. Furthermore, Moncrieff (2010) reminds us that psychiatric diagnoses fulfil important social functions; the externalisation of our fears of chaos and 'madness' away from the rest of society (thus preserving it), of allowing us to ignore important questions about social inequality and distribution of power, of maintaining the pharmaceutical industry and lastly, of serving administrative functions in terms of service delivery. While it may seem that attempts to change the existing paradigm are futile, as Harper (2013) points out, there are already pockets of resistance that can be built upon and strengthened.

What can PCP contribute to the current controversy?

Making Sense of People's Problems

Diagnostic categories are created in an attempt to make sense of people's difficulties; to give meaning to universal human distress. While they may provide clinicians with a

shorthand means of communicating with each other, empirical validity and clinical utility issues are evident. It could be argued that a PCP approach to understanding human distress represents a viable alternative to the DSM-IV and DSM-5 with its attempt to access the personal construct system of the individual. Moreover, a PCP approach appears to foster a less stigmatising view of mental distress and for BPD specifically. Indeed, within a PCP approach (as with dimensional models) there are no discrete personality types. Rather, the focus is on problematic types of construing and their severity; on quantitative rather than qualitative distinctions.

From discussions with the two case example participants, while there appeared to be a sense of relief (linked perhaps to having the reality of their experiences validated), there was also a rejection of the label and its negative connotations. This finding seems to point to the need for a less didactic approach to meaning-making. Formulation, and in particular, PCP formulation, appears to satisfy both of these requirements, validating the experience of the individual on *their* terms in a collaborative approach within which te individual's personal meaning-making is recognised. Rather than representing a solid factual entity, formulation is an evolving, changeable process. It attempts to situate difficulties within their context rather than solely within the individual, thus removing blame. Furthermore, it places difficult experiences within a timeline, hypothesising about how an individual has come to the present place, how they remain there and how they may negotiate alternative ways of being and experiencing the world. Underlying this, is the assumption that recovery is possible.

Formulation, in theory, seems a logical alternative to diagnosis as a means for understanding human distress. However, as Johnstone (2006) states, formulation could potentially be as detrimental as psychiatric diagnosis if utilised in the wrong way. The attitude of the clinicians is all-important. This was keenly highlighted in the discussions with the case example participants, whose reports of the attitude of clinicians at the point of diagnosis revealed an undercurrent of blame and hopelessness for the future. In Linehan's (1993) DBT, the importance of the provision of a validating environment is emphasised. Similarly, a particular strength of the PCP model is that it encourages '*credulousnes*s'; the suspension of the therapist's beliefs and the attempt to see the world through the eyes of the client. Everything that the client imparts is considered 'true' from their unique perspective and, as Harter (1995, p.380), points out, there is "validation of the client's construing process itself". Within PCP, the problem is viewed as "the layman's formulation of the clinical issues' (Kelly, 1955, p.789), which is established during the assessment process. Subsequently, elaboration of the complaint from the perspective of the client and subsuming of the client's

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difficulties into the clinician's professional constructs ensues. However, these are *hypotheses*, not categorical 'truths', and as such, are subject to testing and experimentation.

Treatment and Clinical Implications

The clinical use of repertory grids allows the therapist to elicit rich and meaningful information that a diagnostic category cannot impart, encouraging us to suspend preconceived ideas that come with superimposed diagnostic templates. Furthermore, the grid offers a means for capturing the construing of the individual at that moment and a means for visualising change over time. As Winter (1992) points out, with the '*time-binding*' technique, problematic ways of construing are seen as having developed for a reason, as having an innate validity at the time they arose, but ultimately as no longer helpful for the client. PCP aims at achieving a balance between stability and change, between validation and invalidation of the current construct system; to explore alternative ways of construing in a non-threatening way. Some might argue that PCP brings nothing more to the BPD table than DBT does presently and indeed there are clear similarities between the two approaches. However, it would seem that the DBT approach is much more didactic. Indeed, Winter et al. (2003) note in their study comparing DBT vs PCP group sessions that the former were described by BPD participants in terms of a 'classroom' environment while the latter seemed to be experienced as an 'interpersonal laboratory'. Unlike many other cognitive-behavioural approaches, in PCP, with its 'man-as-scientist' metaphor; therapy is not corrective and the therapist becomes a co-scientist rather than a powerful director.

Taking the study's findings into consideration, how might a PCP therapist work with an individual displaying the following characteristics of construing: pre-emptive thinking, a poorly elaborated self-construction; a tendency to view current relationships in the same terms as early relationships and slot-rattling? In relation to pre-emptive thinking, clients could potentially be assisted through loosening techniques specifically relating to self and others. Loosening in this way may enable the client to envisage previously inconceivable possibilities and, as Winter (1992, p.258) puts it "may help release a client from the cul-de-sac of a pre-emptive construct". In so doing, the aim is dilation, increased permeability of constructs and elements; and ultimately, the development of an ability to see grey areas previously hidden from view by virtue of a tight, constricted perceptual field. Techniques such as enactment or informal role-play form a large part of PCP therapy and enable the client to experiment with alternative ways of interacting with others within a safe context.

Individuals who tend to display a poorly elaborated self may find that the process of

completing the repertory grid is enlightening in and of itself. In addition to this, clients can be encouraged to elaborate their self-constructions by completing a questionnaire such as the 'Role Rating Questionnaire' utilised by Neimeyer, Klein, Gurman and Greist (1983). Within this questionnaire, elements are solely aspects of the self and the aim is expansion of the various nuances of the identity. Resistance to change grids (Hinkle, 1965) highlight underlying dilemmas preventing movement and change in relation to the self (for example, with regard to continued self-harm in individuals with BPD) and thus may contribute to a deeper sense of self-knowledge. Similarly, self-understanding can be enhanced with the use of techniques such as '*fixed role therapy*' (Kelly, 1955; Epting, 1984; Winter, 1992). In this technique, the clinician initially asks the client to write a '*self-characterisation',* a character sketch of the self from the viewpoint of a sympathetic friend who knows them well and subsequently proposes an alternative '*as-if*' fixed-role sketch for the client to experiment with ('*enactment*'). However, underlying this is the assumption that its purpose is not to alter a faulty personality *structure* but rather enable the client to try out and potentially adopt new, more helpful ways of construing and being within a trusting therapeutic relationship. The PCP therapist adopts an 'invitational' or 'as if' approach (Kelly, 1964) to experimentation in order to reduce the threat posed by trying out new constructions, freeing the client to explore previously uncharted territory. Arguably, it is this emphasis on *possibility* rather than *certainty* that promotes therapeutic change. An important aspect of fixed role therapy is that the fixed role sketch should represent a person whose behaviour differs from the client's but not excessively so, the assumption being that this would prevent the superficial see-saw movement observed in slot-rattling.

With regard to viewing current relationships in the same terms as early relationships or as we have subsequently hypothesised, viewing others as undifferentiated, clients would be encouraged to engage in '*person binding'*, a tightening technique in which, as Winter (1992, p.262) describes, "a construct is viewed as convenient only for anticipating a particular person". Such binding techniques have been used with those with experiences of sexual abuse during childhood (Neimeyer, 1987). Furthermore, with regard to the "unstable and intense relationships" among those with BPD, joint completion of repertory grids been shown to be helpful in enabling the expression of negative feelings and increased tolerance of such feelings among partners (Ryle & Lipshitz, 1975). Within the therapeutic relationship, discussion with the client about the tendency to view the therapist in the same terms as early figures (referred to by Kelly, 1955 as '*secondary transference*') is assumed to be beneficial.

If we assume that slot-rattling is a defensive strategy employed following invalidation, it is

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likely that the environment of validation and respect provided by the PCP therapist in itself would be therapeutic. Furthermore, it is assumed that slot-rattling becomes less necessary as the individual develops a deeper and more consistent sense of themselves (self elaboration). It follows that with an increase in self-awareness, the ability to regulate emotion would also improve, allowing others to more easily predict their behaviour and ultimately to improved relationships. Moreover, fixed-role therapy offers the opportunity to experiment with behaviour change in a deeper, more meaningful way.

Further Research

It is noteworthy that all of the participants were female. Future research could perhaps investigate the characteristics of construing of male recipients of the diagnosis. In addition, studies that incorporate those with and without the diagnosis of BPD may also be a powerful means to investigate the proposed characteristics of BPD. Finally, following on from this study, further studies could focus on mapping certain grid characteristics onto specific symptoms rather than overall BPD symptom severity scores. This would reveal subtle differences so that for one individual, the main issue may be one of pre-emptive thinking while for another slot-rattling may be more of a problem. Such an approach would encourage clinicians to recognise the vast heterogeneity that exists among individuals with the diagnosis and could lead to a more person-centred treatment approach.

Conclusions

Given the correlational design of the study, it is impossible to make firm conclusions about causality although the study has yielded some interesting results and topics for discussion, which, it is hoped, will provide a useful contribution to the ongoing dialogue surrounding the conceptualisation of BPD. PCP offers a novel approach, counteracting the main flaws of the DSM-IV and it is believed that the utility of adopting the approach has been illustrated.

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TEST DIRECTIONS:

The following pages contain a list of statements that people use to describe themselves. They are printed here to help you describe your feelings and attitudes. Try to be as honest and serious as you can in marking the statements.

Do not be concerned if a few statements seem unusual; they are included to describe people with many types of problems. If you agree with a statement or decide that it describes you, fill in the ⓣ on the separate answer sheet to mark it True (● ⓕ). If you disagree with a statement or decide that it does not describe you, fill in the ⓕ to mark it False (ⓣ ●). Try to mark every statement, even if you are not sure of your choice. If you have tried your best and still cannot decide, mark the ⓕ for False.

Use a No. 2 pencil and make a heavy, dark mark when filling in the circles. If you make a mistake or change your mind, erase the mark fully and then fill in the correct circle. *Do not make any marks in this booklet.*

There is no time limit for completing the inventory, but it is best to work as rapidly as is comfortable for you.

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1. Lately, my strength seems to be draining out of me, even in the morning.

2. I think highly of rules because they are a good guide to follow.

3. I enjoy doing so many different things that I can't make up my mind what to do first.

4. I feel weak and tired much of the time.

5. I know I'm a superior person, so I don't care what people think.

6. People have never given me enough recognition for the things I've done.

7. If my family puts pressure on me, I'm likely to feel angry and resist doing what they want.

8. People make fun of me behind my back, talking about the way I act or look.

9. I often criticize people strongly if they annoy me.

10. What few feelings I seem to have I rarely show to the outside world.

11. I have a hard time keeping my balance when walking.

12. I show my feelings easily and quickly.

13. My drug habits have often gotten me into a good deal of trouble in the past.

14. Sometimes I can be pretty rough and mean in my relations with my family.

15. Things that are going well today won't last very long.

16. I am a very agreeable and submissive person.

17. As a teenager, I got into lots of trouble because of bad school behavior.

18. I'm afraid to get really close to another person because it may end up with my being ridiculed or shamed.

19. I seem to choose friends who end up mistreating me.

20. I've had sad thoughts much of my life since I was a child.

21. I like to flirt with members of the opposite sex.

22. I'm a very erratic person, changing my mind and feelings all the time.

23. Drinking alcohol has never caused me any real problems in my work.

24. I began to feel like a failure some years ago.

25. I feel guilty much of the time for no reason that I know.

26. Other people envy my abilities.

27. When I have a choice, I prefer to do things alone.

28. I think it's necessary to place strict controls on the behavior of members of my family.

29. People usually think of me as a reserved and serious-minded person.

30. Lately, I have begun to feel like smashing things.

31. I think I'm a special person who deserves special attention from others.

32. I am always looking to make new friends and meet new people.

33. If someone criticized me for making a mistake, I would quickly point out some of that person's mistakes.

34. Lately, I have gone all to pieces.

35. I often give up doing things because I'm afraid I won't do them well.

36. I often let my angry feelings out and then feel terribly guilty about it.

37. I very often lose my ability to feel any sensations in parts of my body.

38. I do what I want without worrying about its effect on others.

39. Taking so-called illegal drugs may be unwise, but in the past I found I needed them.

40. I guess I'm a fearful and inhibited person.

41. I've done a number of stupid things on impulse that ended up causing me great trouble.

42. I never forgive an insult or forget an embarrassment that someone caused me.

43. I often feel sad or tense right after something good has happened to me.

44. I feel terribly depressed and sad much of the time now.

45. I always try hard to please others, even when I dislike them.

46. I've always had less interest in sex than most people do.

47. I tend to always blame myself when things go wrong.

48. A long time ago, I decided it's best to have little to do with people.

49. Since I was a child, I have always had to watch out for people who were trying to cheat me.

50. I strongly resent "big shots" who always think they can do things better than I can.

51. When things get boring, I like to stir up some excitement.

52. I have an alcohol problem that has made difficulties for me and my family.

53. Punishment never stopped me from doing what I wanted.

54. There are many times, when for no reason, I feel very cheerful and full of excitement.

55. In recent weeks I feel worn out for no special reason.

56. For some time now I've been feeling very guilty because I can't do things right anymore.

57. I think I am a very sociable and outgoing person.

58. I've become very jumpy in the last few weeks.

59. I keep very close track of my money so I am prepared if a need comes up.

60. I just haven't had the luck in life that others have had.

61. Ideas keep turning over and over in my mind and they won't go away.

62. I've become quite discouraged and sad about life in the past year or two.

63. Many people have been spying into my private life for years.

64. I don't know why, but I sometimes say cruel things just to make others unhappy.

65. I flew across the Atlantic 30 times last year.

66. My habit of abusing drugs has caused me to miss work in the past.

67. I have many ideas that are ahead of the times.

68. Lately, I have to think things over and over again for no good reason.

69. I avoid most social situations because I expect people to criticize or reject me.

70. I often think that I don't deserve the good things that happen to me.

71. When I'm alone, I often feel the strong presence of someone nearby who can't be seen.

72. I feel pretty aimless and don't know where I'm going in life.

73. I often allow others to make important decisions for me.

74. I can't seem to sleep, and wake up just as tired as when I went to bed.

75. Lately, I've been sweating a great deal and feel very tense.

76. I keep having strange thoughts that I wish I could get rid of.

77. I have a great deal of trouble trying to control an impulse to drink to excess.

78. Even when I'm awake, I don't seem to notice people who are near me.

79. I am often cross and grouchy.

80. It is very easy for me to make many friends.

Go on to the next page

81. I'm ashamed of some of the abuses I suffered when I was young.

82. I always make sure that my work is well planned and organized.

83. My moods seem to change a great deal from one day to the next.

84. I'm too unsure of myself to risk trying something new.

85. I don't blame anyone who takes advantage of someone who allows it.

86. For some time now I've been feeling sad and blue and can't seem to snap out of it.

87. I often get angry with people who do things slowly.

88. I never sit on the sidelines when I'm at a party.

89. I watch my family closely so I'll know who can and who can't be trusted.

90. I sometimes get confused and feel upset when people are kind to me.

91. *My use of so-called illegal drugs has led to family arguments.*

92. I'm alone most of the time and I prefer it that way.

93. There are members of my family who say I'm selfish and think only of myself.

94. People can easily change my ideas, even if I thought my mind was made up.

95. I often make people angry by bossing them.

96. People have said in the past that I became too interested and too excited about too many things.

97. I believe in the saying, "early to bed and early to rise..."

98. My feelings toward important people in my life often swing from loving them to hating them.

99. In social groups I am almost always very self-conscious and tense.

100. I guess I'm no different from my parents in becoming somewhat of an alcoholic.

101. I guess I don't take many of my family responsibilities as seriously as I should.

102. Ever since I was a child, I have been losing touch with the real world.

103. Sneaky people often try to get the credit for things I have done or thought of.

104. I can't experience much pleasure because I don't feel I deserve it.

105. I have little desire for close friendships.

106. I've had many periods in my life when I was so cheerful and used up so much energy that I fell into a low mood.

107. I have completely lost my appetite and have trouble sleeping most nights.

108. I worry a great deal about being left alone and having to take care of myself.

109. The memory of a very upsetting experience in my past keeps coming back to haunt my thoughts.

110. I was on the front cover of several magazines last year.

111. I seem to have lost interest in most things that I used to find pleasurable, such as sex.

112. I have been downhearted and sad much of my life since I was quite young.

113. I've gotten into trouble with the law a couple of times.

114. A good way to avoid mistakes is to have a routine for doing things.

115. Other people often blame me for things I didn't do.

116. I have had to be really rough with some people to keep them in line.

117. People think I sometimes talk about strange or different things than they do.

118. There have been times when I couldn't get through the day without some street drugs.

119. People are trying to make me believe that I'm crazy.

120. I'll do something desperate to prevent a person I love from abandoning me.

Go on to the next page

121. I go on eating binges a couple of times a week.

122. I seem to make a mess of good opportunities that come my way.

123. I've always had a hard time stopping myself from feeling blue and unhappy.

124. When I'm alone and away from home, I often begin to feel tense and panicky.

125. People sometimes get annoyed with me because they say I talk too much or too fast for them.

126. Most successful people today have been either lucky or dishonest.

127. I won't get involved with people unless I'm sure they'll like me.

128. I feel deeply depressed for no reason I can figure out.

129. Years later I still have nightmares about an event that was a real threat to my life.

130. I don't have the energy to concentrate on my everyday responsibilities anymore.

131. Drinking alcohol helps when I'm feeling down.

132. I hate to think about some of the ways I was abused as a child.

133. Even in good times, I've always been afraid that things would soon go bad.

134. I sometimes feel crazy-like or unreal when things start to go badly in my life.

135. Being alone, without the help of someone close to depend on, really frightens me.

136. I know I've spent more money than I should buying illegal drugs.

137. I always see to it that my work is finished before taking time out for leisure activities.

138. I can tell that people are talking about me when I pass by them.

139. I'm very good at making up excuses when I get into trouble.

140. I believe I'm being plotted against.

141. I feel that most people think poorly of me.

142. I frequently feel there's nothing inside me, like I'm empty and hollow.

143. I sometimes force myself to vomit after eating.

144. I guess I go out of my way to encourage people to admire the things I say or do.

145. I spend my life worrying over one thing or another.

146. I always wonder what the real reason is when someone is acting especially nice to me.

147. There are certain thoughts that keep coming back again and again in my mind.

148. Few things in life give me pleasure.

149. I feel shaky and have difficulty falling asleep because painful memories of a past event keep running through my mind.

150. Looking ahead as each day begins makes me feel terribly depressed.

151. I've never been able to shake the feeling that I'm worthless to others.

152. I have a drinking problem that I've tried unsuccessfully to end.

153. Someone has been trying to control my mind.

154. I have tried to commit suicide.

155. I'm willing to starve myself to be even thinner than I am.

156. I don't understand why some people smile at me.

157. I have not seen a car in the last ten years.

158. I get very tense with people I don't know well because they may want to harm me.

159. Someone would have to be pretty exceptional to understand my special abilities.

160. My current life is still upset by flashbacks of something terrible that happened to me.

Go on to the next page

161. I seem to create situations with others in which I get hurt or feel rejected.

162. I often get lost in my thoughts and forget what's going on around me.

163. People say I'm a thin person, but I feel that my thighs and backside are much *too big.*

164. There are terrible events from my past that come back repeatedly to haunt my thoughts and dreams.

165. Other than my family, I have no close friends.

166. I act quickly much of the time and don't think things through as I should.

167. I take great care to keep my life a private matter so no one can take advantage of me.

168. I very often hear things so well that it bothers me.

169. I'm always willing to give in to others in a disagreement because I fear their anger or rejection.

170. I repeat certain behaviors again and again, sometimes to reduce my anxiety and sometimes to stop something bad from happening.

171. I have given serious thought recently to doing away with myself.

172. People tell me that I'm a very proper and moral person.

173. I still feel terrified when I think of a traumatic experience I had years ago.

174. Although I'm afraid to make friendships, I wish I had more than I do.

175. There are people who are supposed to be my friends who would like to do me harm.

Personal Construct Inventory

Instructions: Please read the following statements and decide to what extent you agree or disagree with each.

If you agree strongly with the statement then fill-in the space labeled 1 on your answer form.
If you agree moderately, then fill in the space labeled 2.
If you are uncertain or both agree and disagree then fill in the space for 3.
If you moderately disagree with the statement, fill in the space for 4.
If you strongly disagree with the statement, fill in the space for 5.

There are or right or wrong answers. Work quickly as you can but be as accurate as you can.

1. I suspect I will be a very different person in a few years.
2. I almost never lose an argument
3. Almost all of a person's behavior can be predicted from knowledge of a few basic characteristics of the person.
4. I have not been my true self much lately.
5. My understanding of many things seems to be decreasing.
6. Lately I have not been acting in the ways I know I should.
7. My thought is often hazy and not clearly formed.
8. I am not very certain of what sort of person I will be in a few years.
9. I am lately more and more confused.
10. Most of the talking that people do really concerns nothing but a few issues.
11. I suffer from deep feelings of guilt.
12. People can be many things and are often unpredictable.
13. A number of things, events and people seem so meaningless to me
14. I will basically be the same person in a few years.
15. The events of my life have a very clear-cut meaning to me.
16. I admit that I enjoy winning even if I have to cheat.
17. I find poetry to be vague and a waste of time.
18. All things are because of laws. Nothing is due to chance or free will.
19. I have lately done a number of things that were not 'like me'.
20. I am generally unsuccessful at predicting people's behavior.
21. Things very important to me are changing.
22. I often give in to other's views even though they are not my own.
23. Life's confusing and chaotic to me.
24. Playing by the rules is more important than winning.
25. The important things in life never change.
26. People are generally confusing to me.
27. I am not a very systematic person.
28. I feel like my foundations are shifting.
29. Much of what people say is nothing but rubbish.
30. I rarely feel guilty.

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31. My future is quite certain and I do not anticipate many surprises.
32. People are rarely both good and bad. They tend to be either good or bad.
33. I am a highly organized person.
34. I generally act on my true feelings and thoughts.
35. I often fear there is something I should know but I do not know what it is.
36. Winning is everything.
37. My mind wanders easily.
38. Nothing is either black or white. All things tend to be shades of grey.
39. I usually do just as I feel I should do.
40. My way of doing things will possibly be very different in the future.
41. I have a great fear of the unknown.
42. Power is really more important than truth.
43. I feel out of tune with those I admire.
44. I figure most people out quickly.
45. I often seem to think in a disorganised fashion.
46. I feel empty inside.
47. Often I just do not know what to say.
48. I think most things that are interesting cannot be described exactly.
49. I would make a great salesman/saleswoman, regardless of the quality of my product.
50. I have not been acting like the person I really am deep inside.
51. There is usually only one good way to do something.
52. I enjoy manipulating people.
53. I anticipate having mostly different friends in the coming years.
54. Often I think of something and then it slips from my mind.
55. I am just not what I could and should be.
56. One should always be very precise whenever they say something to others.
57. Things have not been adding up well in my life lately.
58. I am highly flexible and change with the events around me.
59. I have done many things that I now regret.
60. I often do not tell all I know if it can help me win an argument.
61. I prefer a lot of structure in classes or work activities.
62. I fear that I cannot generally trust myself.
63. I prefer to keep close to a schedule.
64. I am rarely anxious.
65. I do not mind distorting the truth to get my way. Business is business.
66. Knowing one thing about a person rarely tells you another. You have to wait and see.
67. I often do not do what I know I should do because others advise me to do otherwise.
68. Only a fool plays by the rules.
69. My mind often goes blank.
70. I am often surprised by people.
71. My health will probably be changing in the near future.
72. I regret having let a number of people down.
73. Always saying things clearly is very important.
74. I am often very anxious and confused.
75. When I am wrong, I freely admit it, even to people I do not like.
76. I feel there will be some definite changes in my love life.

77. Loose of 'fuzzy' thinking is not necessary for creativity.
78. I trust myself to do the best I can do.
79. Quite often I am not sure of who I am.
80. I often begin a sentence and do not finish it.

Thank you for your participation.

APPENDIX C: Beck Hopelessness Scale

BHS®

Date:_____

Name:_____ Marital Status:_____ Age:_____ Sex:_____

Occupation:_____ Education:_____

This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the **past week including today,** darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1. I look forward to the future with hope and enthusiasm. Ⓣ Ⓕ

2. I might as well give up because there is nothing I can do about making things better for myself. Ⓣ Ⓕ

3. When things are going badly, I am helped by knowing that they cannot stay that way forever. Ⓣ Ⓕ

4. I can't imagine what my life would be like in ten years. Ⓣ Ⓕ

5. I have enough time to accomplish the things I want to do. Ⓣ Ⓕ

6. In the future, I expect to succeed in what concerns me most. Ⓣ Ⓕ

7. My future seems dark to me. Ⓣ Ⓕ

8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person. Ⓣ Ⓕ

9. I just can't get the breaks, and there's no reason I will in the future. Ⓣ Ⓕ

10. My past experiences have prepared me well for the future. Ⓣ Ⓕ

11. All I can see ahead of me is unpleasantness rather than pleasantness. Ⓣ Ⓕ

12. I don't expect to get what I really want. Ⓣ Ⓕ

13. When I look ahead to the future, I expect that I will be happier than I am now. Ⓣ Ⓕ

14. Things just won't work out the way I want them to. Ⓣ Ⓕ

15. I have great faith in the future. Ⓣ Ⓕ

16. I never get what I want, so it's foolish to want anything. Ⓣ Ⓕ

17. It's very unlikely that I will get any real satisfaction in the future. Ⓣ Ⓕ

18. The future seems vague and uncertain to me. Ⓣ Ⓕ

19. I can look forward to more good times than bad times. Ⓣ Ⓕ

20. There's no use in really trying to get anything I want because I probably won't get it. Ⓣ Ⓕ

APPENDIX D: Beliefs about BPD Likert Scales.

To what extent do you agree with the following statements?

Number 1 means strongly agree

Number 2 means moderately agree

Number 3 means uncertain

Number 4 means moderately disagree

Number 5 means strongly disagree

1. BPD is a treatable condition

2. BPD is a part of my personality

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Student Number: 10280099

APPENDIX E: Research Ethics Committee Approval

NHS
Health Research Authority

NRES Committee East of England - Hertfordshire

Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597733
Facsimile: 01223 597645

16 January 2013

Miss Lauren White
Trainee Clinical Psychologist
University of Hertfordshire
Health Research Building, College Lane Campus
Hatfield
Hertfordshire
AL10 9AB

Dear Miss White

Study title: **Borderline Personality Disorder: A Personal Construct**
                          Approach.
REC reference: **12/EE/0497**
Protocol number: **n/a**
IRAS project ID: **113500**

Thank you for your letter of 17 December 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Anna Bradnam, nrescommittee.eastofengland-norfolk@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

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Student Number: 10280099

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of insurance or indemnity - Gallagher Health		06 August 2012
Investigator CV - Lauren White (Student and CI)		03 October 2012
Investigator CV - David Winter (Supervisor)	v1 Oct 2012	
Letter from Sponsor – Letter from Prof John Senior		31 October 2012
Other: Project Checklist	1	19 October 2012
Participant Consent Form	2	17 December 2012
Participant Information Sheet	2	17 December 2012
Protocol	2	17 December 2012

Questionnaire: BHS	(validated)	
Questionnaire: Personal Conduct Inventory	1	12 October 2012
Questionnaire: Millon Clinical Mutiaxial Inventory-III – hand-scoring Test Booklet (MCMI-III)	(validated)	
REC application IRAS Part A&B	113500/3788 27/1/181	31 October 2012
Response to Request for Further Information – Letter from Lauren White		17 December 2012

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure.   If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review
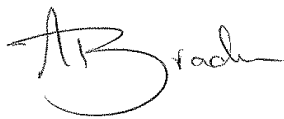
12/EE/0497	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

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Portfolio Volume 1. Borderline Personality Disorder: A Personal Construct Approach.
Student Number: 10280099

Yours sincerely

Dr Steve Eckersall
Chair

Email:nrescommittee.eastofengland-norfolk@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Emailed to: Lauren White   l.white6@herts.ac.uk

                          John Senior, University of Hertfordshire j.hollinshead@herts.ac.uk

                          Mr Tim Gale, Hertfordshire Partnership NHS Foundation Trust tim.gale@hertspartft.nhs.uk

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Student Number: 10280099

APPENDIX F: Research Ethics Committee Amendment Approval

NHS
Health Research Authority

NRES Committee East of England - Hatfield

Room 002, TEDCO Business Centre
Rolling Mill Road
Jarrow
Tyne and Wear
NE32 3DT

Tel: 0191 4283467

03 October 2013

Miss Lauren White
Trainee Clinical Psychologist
University of Hertfordshire
Health Research Building
College Lane Campus
Hatfield
Hertfordshire
AL10 9AB

Dear Miss White

Study title: **Borderline Personality Disorder: A Personal Construct Approach.**
REC reference: **12/EE/0497**
Amendment number: **Amendment 1, 15/09/2013**
Amendment date: **25 September 2013**
IRAS project ID: **113500**

Thank you for submitting the above amendment, which was received on 01 October 2013. I can confirm that this is a valid notice of a substantial amendment and will be reviewed by the Sub-Committee of the REC at its next meeting.

Documents received
The documents to be reviewed are as follows:

Document	Version	Date
Protocol	3	15 September 2013
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1, 15/09/2013	25 September 2013
Participant Information Sheet	3	15 September 2013

Notification of the Committee's decision
The Committee will issue an ethical opinion on the amendment within a maximum of 35 days from the date of receipt.

R&D approval
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval for the research.

A Research Ethics Committee established by the Health Research Authority

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

| 12/EE/0497: | Please quote this number on all correspondence |

Yours sincerely

Miss Christie Ord
REC Assistant

E-mail: nrescommittee.eastofengland-hatfield@nhs.net

Copy to: *Dr Tim Gale, Hertfordshire Partnership Foundation NHS Trust*

                John Senior, University of Hertfordshire
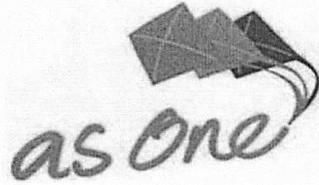
Hertfordshire Partnership **NHS**
NHS Foundation Trust

as One

Ms Lauren White
Trainee Clinical Psychologist
University of Hertfordshire
Health Research Building
College Lane Campus
Hatfield
AL10 9AB

R&D Department
Department of Psychiatry
QEII Hospital
Howlands
Welwyn Garden City
AL7 4HQ

Tel. 01707 369058
Fax. 01707 365169
e-mail t.gale@herts.ac.uk

11th March 2013

Dear Ms White,

Research Study: **Borderline personality disorder: A personal construct approach**
REC reference: **12/EE/0497**

I have received the documentation in support of the above project. Following a review by The R&D Department, I am pleased to tell you that the study now has R&D approval on behalf of Hertfordshire Partnership NHS Foundation Trust.

Approval is given on the understanding that you will notify the R&D Office of any further amendments to the study design, that you will carry out the study as specified in the final version of the protocol, and that you will comply fully with the HPFT R&D Policy (copy sent by e-mail).

With kind regards

Tim Gale Ph.D.
Manager, Research and Development Department
Visiting Professor, Dept Psychology, UoH

RESEARCH STUDY INFORMATION FOR CLINICIANS

As part of my Major Research Project ('Borderline Personality Disorder: A Personal Construct Approach'), I am hoping to recruit approximately 20 participants from the Personality Disorder Service. It is hoped that this research will help us, as clinicians, to better understand Borderline Personality Disorder and hence has implications for treatment.

I would be grateful if you could pass an information pack to clients you think may be suitable for participation. The information packs include information about the research and also an opt-in form and stamped addressed envelope.

INCLUSION CRITERIA:
- Clients will have received a primary diagnosis of BPD for at least one year.
- Clients will be currently under the records of the Personality Disorder Service.

EXCLUSION CRITERIA:

1) Clients who are currently experiencing crisis or recently experienced crisis or admission (to be determined by resident Psychologists at the Personality Disorder Service).
2) Clients who have been diagnosed for less than one year.

Many thanks for your assistance.

A Personal Construct Model of Borderline Personality Disorder (Winter et al., 2003)

DSM Diagnostic Criteria	Possible Characteristics of Construing
i) A pattern of unstable and intense relationships characterised by alternating between extremes of idealisation and devaluation.	Tendency to pre-emptive construing; slot-rattling; superordinacy of constructs concerning validation of self and others; fragmentation; low sociality.
ii) Impulsiveness in at least two areas that are potentially self-damaging.	Foreshortening of the CPC cycle.

iii) Affective instability.	Slot-rattling; loose construing.
iv) Inappropriate or intense anger or lack of control of anger.	Dearth of validation and failure to reconstrue following invalidation.
v) Recurrent suicidal threats, gestures or behaviours, or self-mutilating behaviours.	Lack of verbalisation of constructions or demands expressed in suicidal behaviour; hostility.
vi) Marked or persistent identity disturbance.	Poorly elaborated or fragmented self-construction.
vii) Chronic feelings of emptiness and boredom.	Failure to be aggressive (Kellian) and complete new experience cycles.
viii) Frantic efforts to avoid real or imagined abandonment.	Dependency path characterised by threat; construction of current relationships in the same terms as early relationships.

AIMS AND OBJECTIVES:

The aim of this study is to test out the characteristics of construing proposed by Winter., et al, 2003 by investigating whether these correlate with existing measures of personality disorder symptom severity. This will form the main research question.

As an additional research question, the usefulness of the diagnosis itself will be investigated by asking clients with a diagnosis of BPD whether they believe their "condition" is treatable or not and investigating whether this correlates with increased hopelessness and symptom severity. This has clear clinical implications.

Hypothesis 1. Participants who show greater BPD symptoms severity will also show more strongly characteristics of construing as proposed by Winter et al, 2003. (i.e. slot-rattling, loose construing, hostility, etc).

Hypothesis 2. Clients who have received a diagnosis of BPD who believe that: a) their condition is an intrinsic part of them; and b) that it is untreatable, will be more likely to show higher levels of hopelessness.

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Student Number: 10280099

INVITATION TO PARTICIPATE IN RESEARCH STUDY/ INFORMATION SHEET ABOUT THE RESEARCH

We would like to invite you to take part in our research study. Before you decide whether you would like to take part, we would like you to understand why the research is being done and what you will be asked to do.

Part 1 will tell you more about the research study and what you will be asked to do if you decide to take part. Part 2 will talk in more detail about the research and the conduct of the study. If you would like to speak to someone about this research before deciding whether you would like to participate, please contact the Main Researcher, Lauren White on l.white6@herts.ac.uk or on 01442 275 492.

PART 1
MAIN PURPOSE OF THE STUDY
The aim of this study is to learn more about the way that people who have been diagnosed with Borderline Personality Disorder (BPD) think about themselves, other people and their diagnosis.

WHY HAVE I BEEN INVITED?
You have been invited because, as a person who has received a diagnosis of BPD, we are interested in the way in which you think about yourself in relation to other people and how you feel about BPD.

DO I HAVE TO TAKE PART?
You do not have to take part and your decision as to whether you take part in this study or not will not affect your ongoing treatment at the Community Personality Disorder Clinic in any way.

WHAT WILL HAPPEN TO ME IF I TAKE PART?
You will be asked to send back the attached opt-in slip with details of your name and the best telephone number to contact you on. Once we have received this, the Main Researcher will contact you to arrange the most convenient time for you to come along to take part. At this stage, we will also ask you to complete an initial questionnaire that we will post to your home address and we will ask you to bring this with you on the day.

On the day, we will ask you to complete two other shorter questionnaires and also ask you some questions about yourself and other people you know. We will also ask you a few questions about how you feel about BPD.

The Main Researcher is able to offer a £10 gift voucher to participants.
(Please be advised that if you currently receive state benefits, gift tokens can be treated as income by Job Centres and therefore should be declared).

PART 2
MORE ABOUT THE RESEARCH

Personal Construct Psychology is an approach in which people are seen as "scientists" who attempt to make sense of the world by anticipating events. The theory states that we anticipate events or 'construe' by organising ideas and concepts into opposites, such as 'good' and 'bad', in accordance with past experiences.

We are aiming to find out more about the way that people with a diagnosis of BPD make sense of, or construe, themselves, the world and other people. It is hoped that this will help us to gain more insight into some of the difficulties experienced by people with BPD and thus inform and improve treatment.

A second aspect of the study is that we aim to determine the extent to which people with a diagnosis feel that BPD is a part of themselves and how much people believe that BPD is treatable.

WHAT WILL WE ASK YOU TO DO
When the Main Researcher calls you to arrange a suitable appointment time, they will also ask if it is OK to send you a questionnaire to fill out by post and bring with you on the day. This questionnaire will ask you a number of questions about how you feel about yourself and your mood, thoughts and feelings.

On the day, we will ask you to complete two shorter questionnaires. The first is a true-false questionnaire that will ask you questions about how hopeful you feel about the future. The second will ask you to describe the extent to which you agree with a list of statements about yourself and other people by choosing from a scale (i.e. strongly agree or strongly disagree).

Lastly, we will hand you three cards at a time representing different people (such as myself, my best friend, someone I admire, someone I dislike) and ask you to tell us in which way two of them are different from the third. When you give us the name of a word that describes a difference, we will ask you what the opposite of that word is to you. We will continue to do this using three different cards at a time and then finally ask you to rate each person according to some of the words you came up with. *You will not be required to write anything down in this part of the study. The Main Researcher will write down all your responses.*

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?
The Psychology Team at the Community Personality Disorder Service will be aware of your participation in the project. However, the details of your answers will be kept anonymised and you will be allocated a code number so at no point will your name be put onto your questionnaires. The data will be kept securely in a locked storage space on the premises of the Community Personality Disorder Clinic and only the Main Researcher and Research Supervisors will have access to these records. In the event that a participant revealed information that suggested that they or another person were at risk,

the Main Researcher would be obliged to break confidentiality, for example, by informing the participant's Care-Co-Ordinator and GP.

WHAT IF SOMETHING GOES WRONG?

If you have a concern about any aspect of this study, you should ask to speak to the Main Researcher, who will do their best to answer your questions (Lauren White, 01442 275 492). If you remain unhappy and wish to complain formally, you can contact the Patient Advice and Liaison Service (PALS) (01727 804 629). If you wish to have further independent advice you can contact the Hertfordshire and Bedfordshire Independent Complaints and Advocacy Service (0300 456 230).

WHO HAS REVIEWED THE STUDY?

All research in the NHS is reviewed by a Research Ethics Committee, to protect your interests. This study has been reviewed and considered suitable by the National Research Ethics Service Committee, East of England, Hertfordshire.

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Portfolio Volume 1. Borderline Personality Disorder: A Personal Construct Approach.
Student Number: 10280099

OPT-IN FORM FOR PARTICIPATION IN THE RESEARCH

('Borderline Personality Disorder: A Personal Construct Approach').

Please complete and return this form in the enclosed stamped and addressed envelope indicating with a tick whether you would like to a) take part in the study or alternatively b) if you would like to be contacted to find out more information. Thank you for your co-operation.

- o I confirm that I am interested in participating in the research study

- o I am unsure as to whether I would like to take part in the research at
  this stage but would like someone to contact me to provide further information.

Name:
………………………………………………………………………

Best daytime contact telephone
no:…………………………………………

I am/am not happy for a message to be left on this number (please delete as appropriate).

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Student Number: 10280099

University of Hertfordshire UH

CONSENT FORM FOR PARTICIPATION IN RESEARCH

Borderline Personality Disorder: A Personal Construct Approach
Main Researcher: Lauren White, Trainee Clinical Psychologist.

Please tick and initial boxes

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐

I agree to take part in the above study. ☐

I agree that my data gathered in this study may be stored (after it has been anonymised) in a confidential location within the Trust. ☐

I agree to my anonymised data being used for future research. ☐

I agree to the use of anonymised quotes in publications. ☐

I understand that relevant sections of my medical notes may be looked at by the Main Researcher and my data collected during the study may be looked at by the Main Researcher, Supervisory Researchers and Research Tutor at the University of Hertfordshire, from regulatory authorities or from the NHS Trust where it is relevant to my taking part in this research. I give permission for these individuals to access my records. ☐

Name of Participant:...

Date:...........................

Signature...

Name of Researcher..

Date: ....

Signature...

Version 2. 17/12/12.
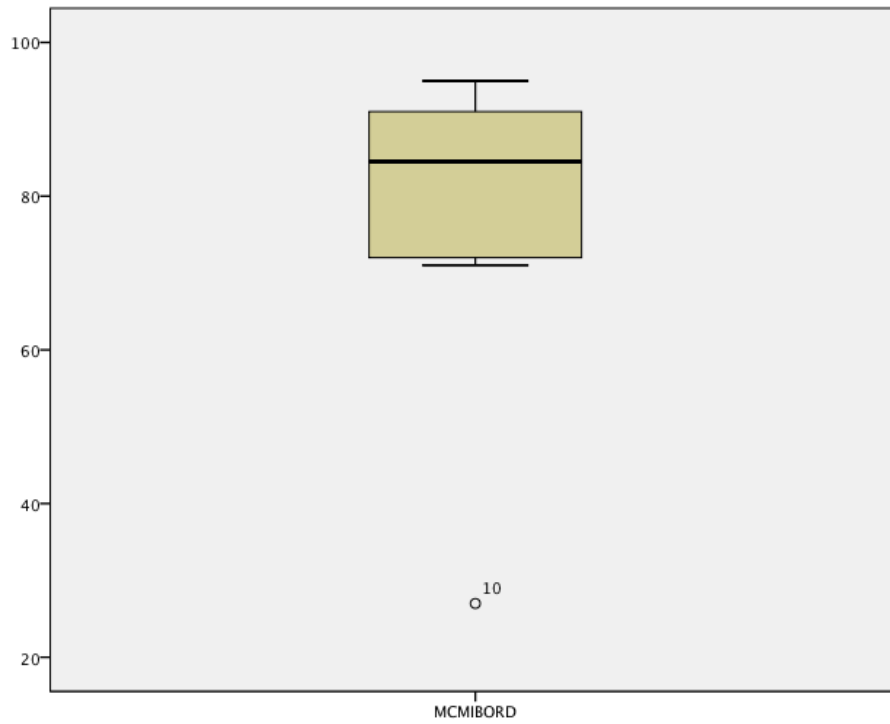
Figure 3: Boxplot of Millon Clinical Multiaxial Inventory, Third Edition, Borderline Scale scores
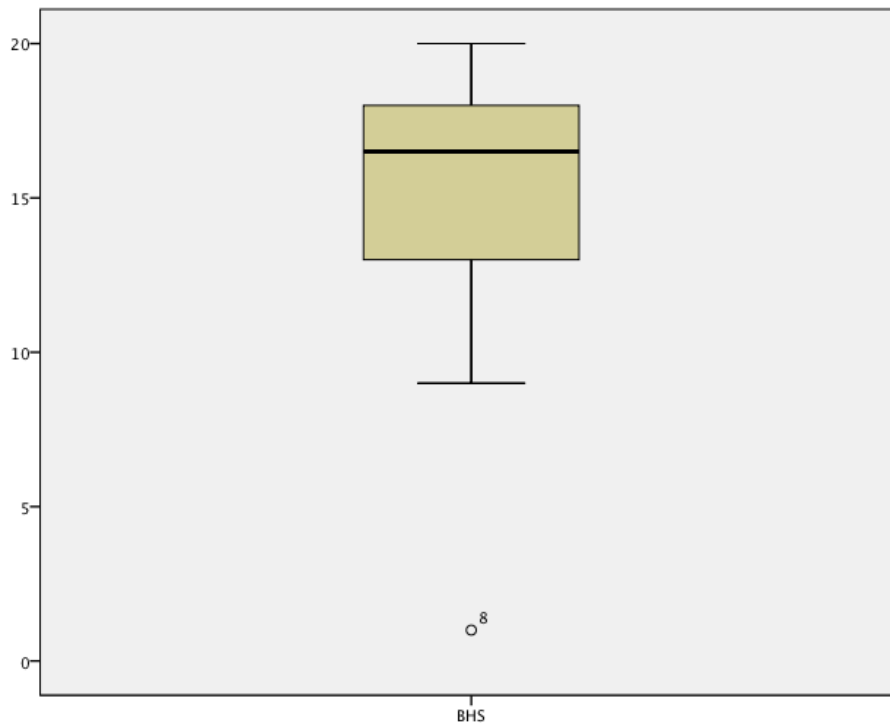
Figure 4: Boxplot of Beck Hopelessness Scale scores

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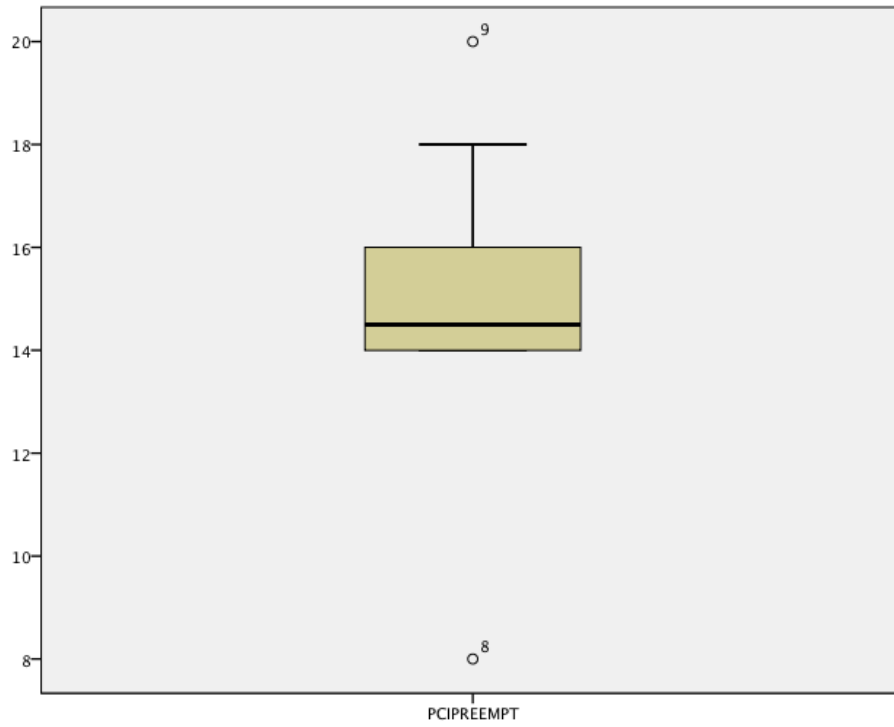
Figure 5: Boxplot of Personal Construct Inventory Pre-Emption scores
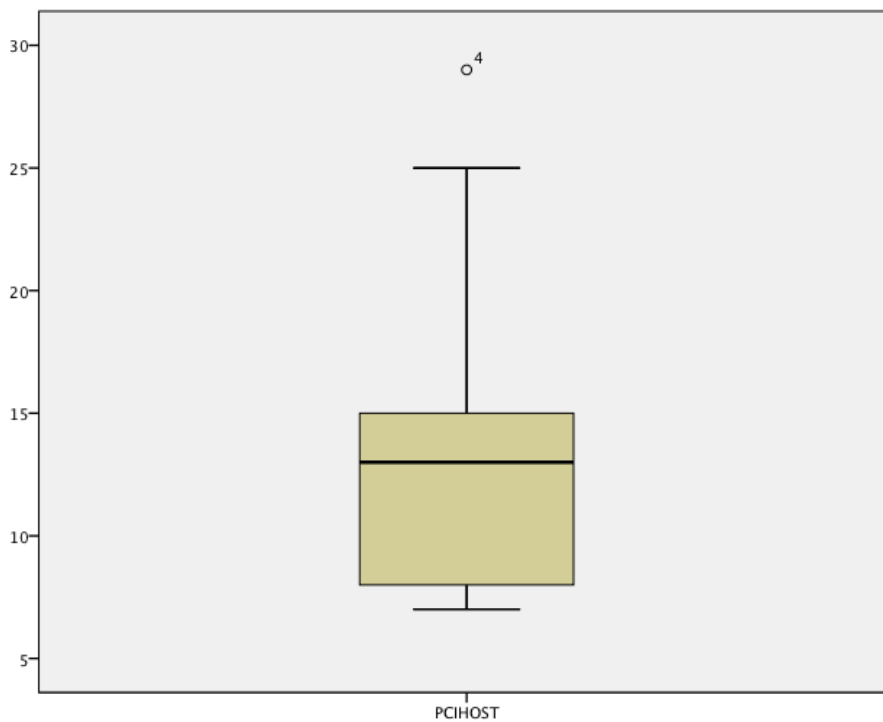
Figure 6: Boxplot of Personal Construct Inventory Hostility scores

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Figure 7: Boxplot of Personal Construct Inventory Threat scores

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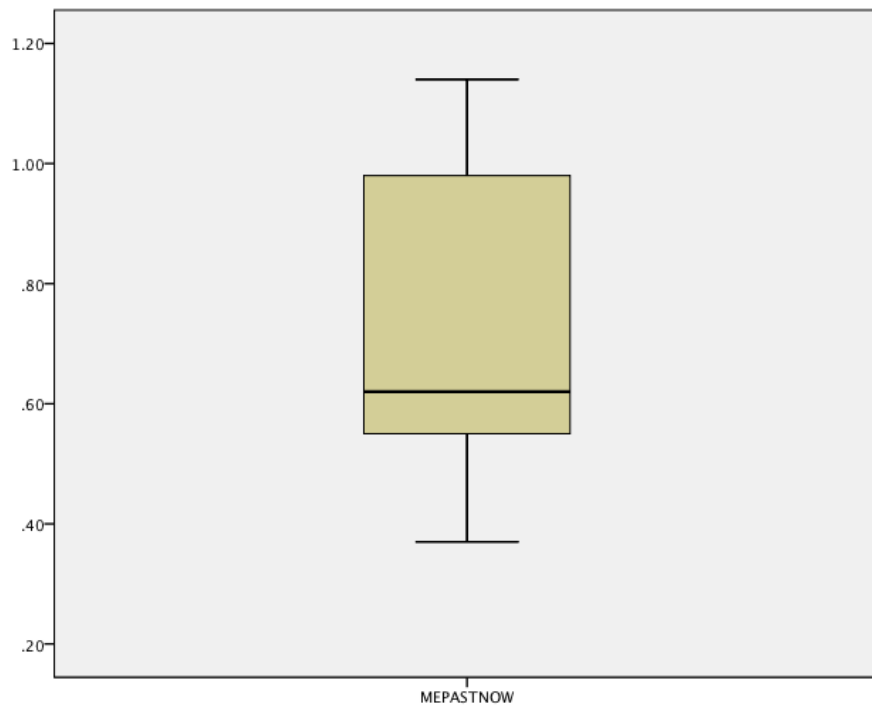
Figure 8: Boxplot of standardised Euclidean distances between 'Me in the Past' and 'Me Now'
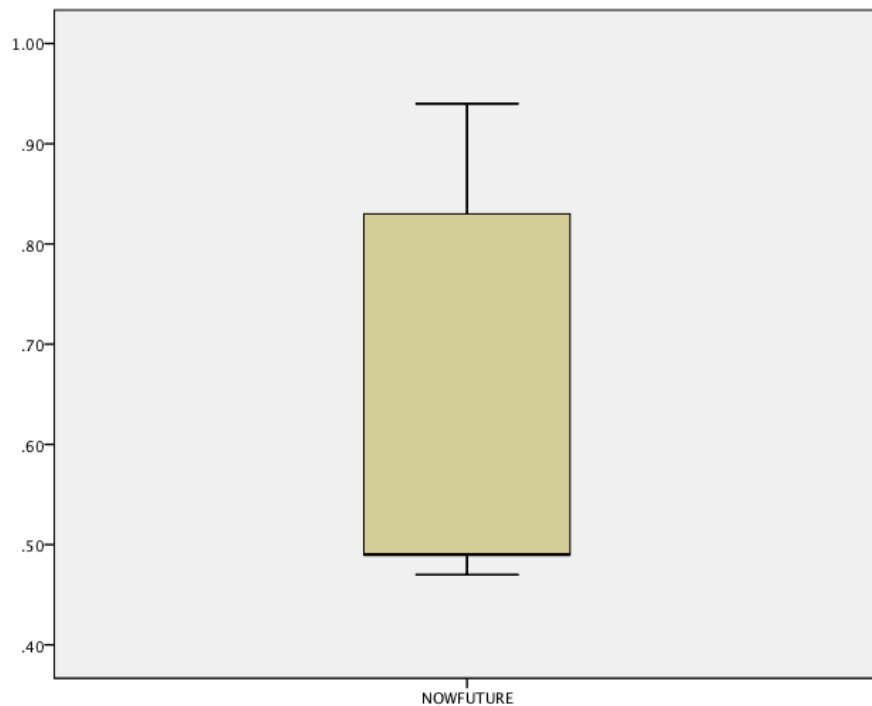
Figure 9: Boxplot of standardised Euclidean distances between 'Me Now' and 'Me in Future'

Figure 10: Boxplot of percentage sums of squares for 'How Others See Me'
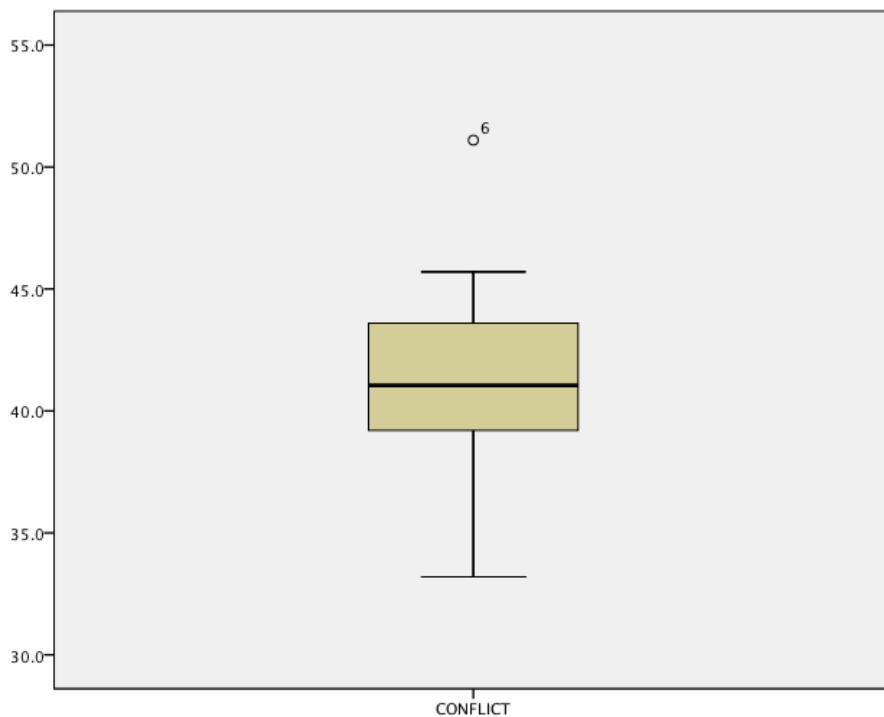
Figure 11: Boxplot of conflict scores

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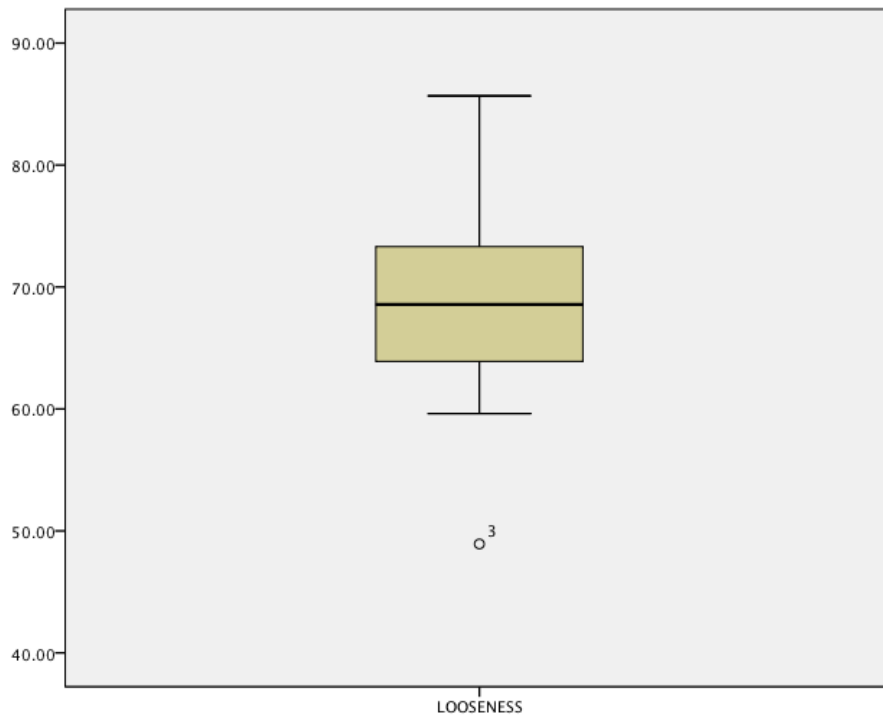
Figure 12: Boxplot of variance of component 1 scores (principal components analysis)
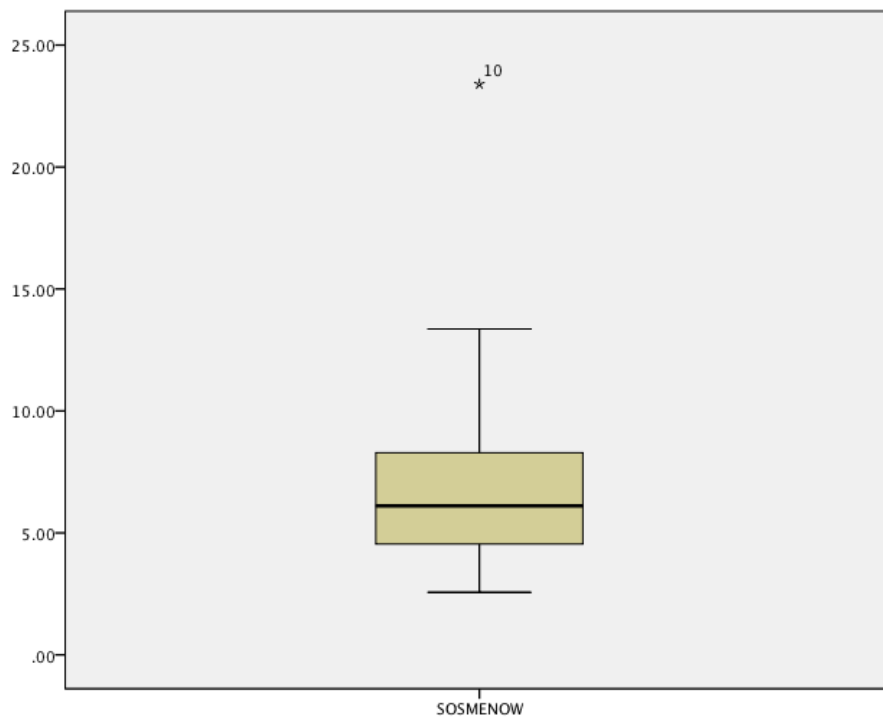
Figure 13: Boxplot of percentage sum of squares for 'Me Now'

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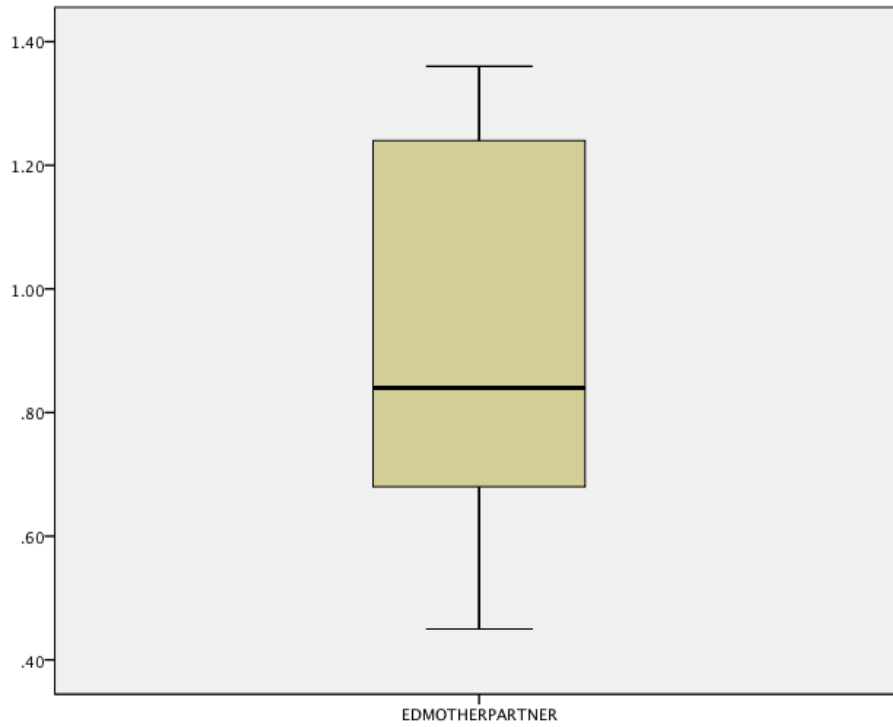
Figure 14. Boxplot of standardised Euclidean distances between 'Mother and 'Partner'
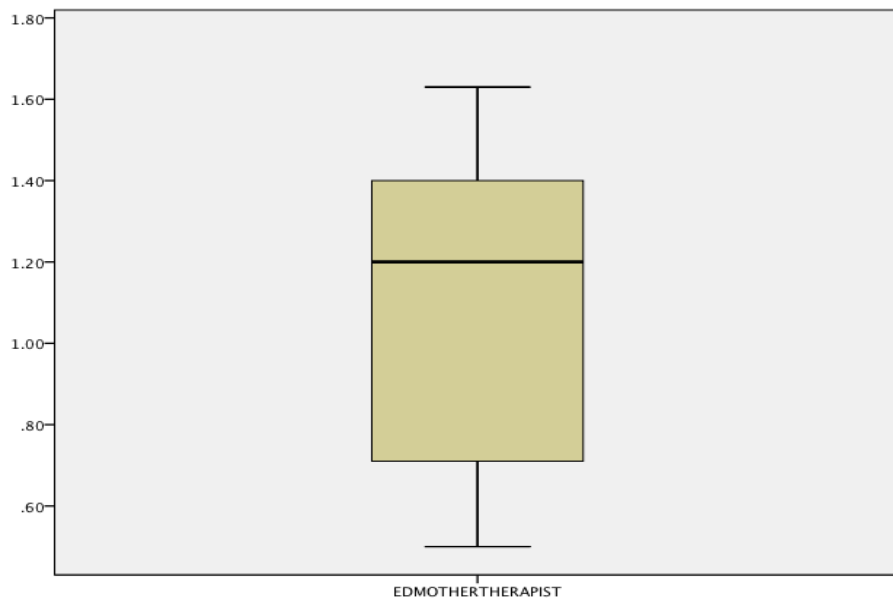
Figure 15: Boxplot of standardised Euclidean distances between 'Mother' and 'Therapist'

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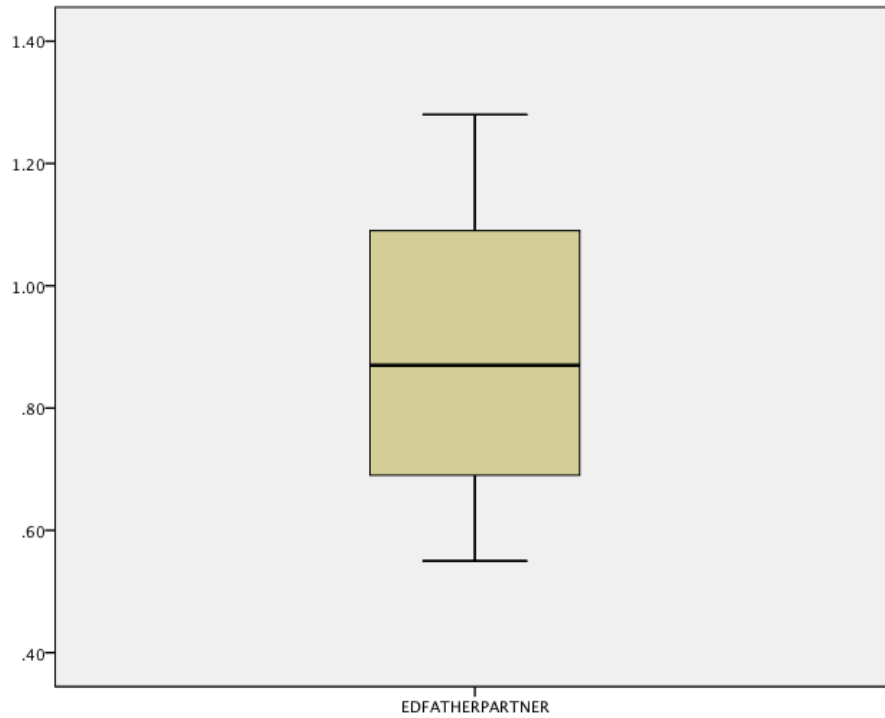
Figure 16: Boxplot of standardised Euclidean distances between 'Father' and 'Partner'
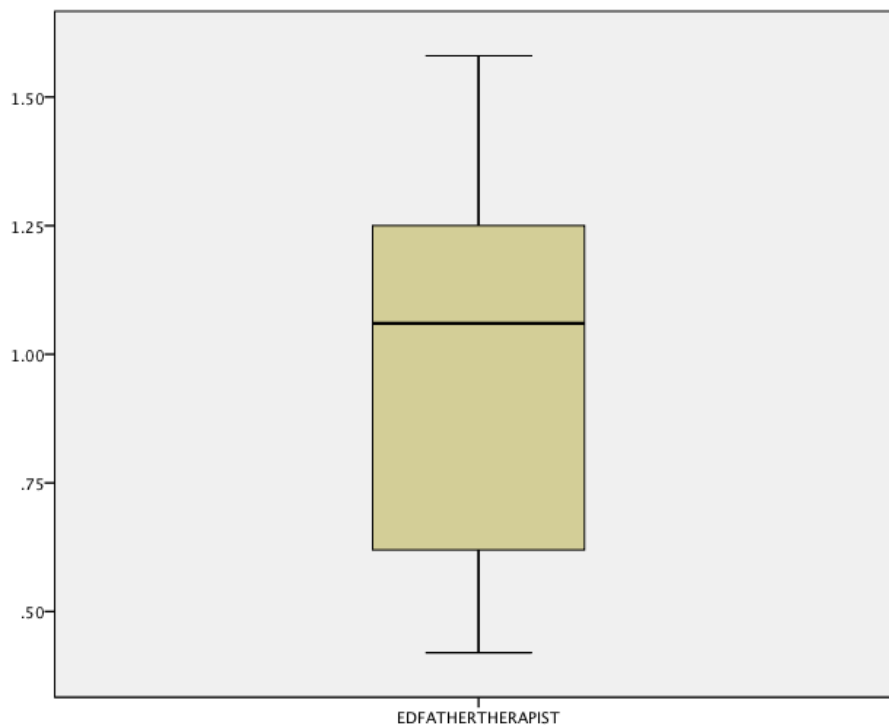
Figure 17. Boxplot of standardised Euclidean distances between 'Father' and 'Therapist'

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ELEMENTS

Mother	Father	Me in the Past	Me Now	Ideal Self	Partner	Therapist	Person I Admire	Person I Dislike	A Person Diagnosed with BPD	Me in the Future	How Others See Me	CONSTRUCTS	
1	7	7	6	4	4	5	7	1	7	5	2	Sensitive	Hard
2	6	6	6	7	6	6	6	1	6	7	7	Honesty	Dishonesty
1	5	1	3	7	6	6	6	1	1	5	2	Well-Rounded	Chaos
1	7	7	7	5	5	5	5	2	7	7	7	Emotional	Unemotional
1	4	7	5	4	4	4	4	6	7	7	7	Changeable	Stable
6	2	7	5	2	1	1	1	6	7	5	3	Lost	Found
1	7	7	7	7	7	7	7	1	7	7	7	Loving	Unloving
2	7	1	3	7	7	7	7	1	1	5	4	Capable	Incapable
6	1	7	5	1	1	1	1	7	7	5	5	Dark	Light
1	6	7	6	4	1	3	3	3	7	2	3	Anxious	Not anxious/Happy
1	5	1	4	7	6	7	7	2	1	5	3	Complete	Incomplete
6	1	7	5	1	1	1	1	7	7	5	4	Unsafe	Safe

Mother	Father	Me in the Past	Me Now	Ideal Self	Partner	Therapist	Person I Admire	Person I Dislike	A Person Diagnosed with BPD	Me in the Future	How Others See Me	CONSTRUCTS	
7	7	5	3	2	2	2	1	4	5	2	4	Critical	Not critical
4	2	5	5	6	6	7	7	1	3	6	4	Supportive	Not supportive
1	1	2	3	5	6	7	7	1	4	7	6	Accepting	Rejecting
3	4	1	2	5	4	7	7	7	2	7	2	Happy	Unhappy
2	1	2	6	7	6	7	5	2	6	7	5	Empathy re BPD	No Empathy re BPD
4	5	3	4	6	5	7	7	7	3	7	4	Being happy with self	Not being happy with self
2	3	4	5	6	6	7	7	2	5	7	6	Caring	Uncaring
5	4	5	3	2	1	1	1	1	5	5	6	Sensitive	Not sensitive
3	5	5	6	7	7	7	7	5	6	7	6	Resilience	Passive
2	5	2	4	6	5	7	7	6	3	7	5	Calm	Chaotic
2	2	2	4	6	6	7	7	6	4	7	5	Able to handle conflict	Aggression
2	2	4	5	6	7	7	7	1	5	7	5	Listens	Ignores

ELEMENTS