A comparative study of the reconstruction of self among depressed and non-depressed older adults.

Volume 1.

Portfolio of academic, clinical and research work submitted in part fulfilment of the degree of

Psych D. Clinical Psychology

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April 1998.
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Acknowledgements.

Thanks are due to Adrian Coyle for his supervision of this research. His expertise in qualitative research methodology has been invaluable to the design and analysis of both studies. I would also like to thank my field supervisor Lynn Beech for providing a stimulating clinical placement out of which the research studies emerged, and also for assisting practically in conducting the studies. I would also like to thank Jonathan Foulds for his supervisory input.

Various people have provided assistance regarding the use of repertory grids. I would like to thank David Sperlinger and Julia Houston for providing advice on analysing and interpreting repertory grid data. I am also grateful to Dr Debbie Stinson for her assistance in recruiting participants.

I would like to thank the clinical psychologists who have supervised clinical placements throughout the course - Brian Glaister, Tessa Lippold, Ann Kimber, Lynn Beech, Noelle Blake, Danka Gordon and Maggie Hilton, and to Mary John for her support and encouragement as clinical tutor.

Finally, I would like to thank everyone who has provided personal support and encouragement, in particular my family, Sue and Andrew.
ACADEMIC DOSSIER.
What is rehabilitation?
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Rehabilitation refers to the process of intervention applied to individuals with long term disabilities. It is a broad concept which has been interpreted in a number of ways both at the theoretical level, and at the practical level of implementation. Although the concept originated in physical medicine, it represents a movement away from the application of a pure medical model to the treatment of psychiatric disorders.

Rehabilitation differs from the traditional medical model of treatment in a number of ways. An important difference is that in rehabilitation the disorder is conceptualised as a disability rather than an illness. It follows from this that treatment is long term and that the goal of treatment is not to "cure" the individual's disorder. Instead the objective is to help the individual to cope in an adaptive way; by maximising the functioning of residual skills and abilities, and by minimising handicap resulting from disability. The ultimate outcome of intervention is the prevention of deterioration and/or the reoccurrence of a psychiatric disability.

A medical or curative model has been found to be inappropriate as a complete treatment for psychiatric disorders, particularly those which come to be described as "chronic". The medical model concerns the observation of symptoms, diagnosis and a specified intervention based on that diagnosis. In psychiatry, the application of this model implies that something physical is wrong, which can be treated with physical (generally pharmacological) means. However, where psychiatric disorders are concerned, diagnosis predicts little about prognosis, symptoms, or interventions (Summers & Hersch, 1983). Although medication plays an extremely important role in maintaining the client's mental health, it is a limited component of a wider programme of rehabilitation.
There are a number of disadvantages to the exclusive use of the medical model in psychiatry. It implies that a cure is possible which is clearly inappropriate for those whose psychiatric disabilities are long term. The model also implies that the client is "sick", which may encourage him to adopt a passive role as the recipient of treatment rather than empowering him to become an active participant in treatment. The detrimental effect of an individual assuming a sick "role" over the long term has been well documented.

A number of models have been developed to guide the way that rehabilitation is implemented with individual clients. These models include the disability model (Wing 1978, 1981), the skills model (Anthony, 1977), the needs model, and the roles model. Each model identifies a different focus for intervention. However, there is no right or wrong way of planning and carrying out a programme of rehabilitation and it is not necessary to use any one approach exclusively.

Before the models are explored it is first necessary to describe the context in which they emerged. The factor which has influenced rehabilitation models the most has been the movement away from treating people in institutions which has taken place throughout the second half of this century. In 1954 the number of psychiatric inpatients totalled 148,000 in Britain. Not only did the hospital population mushroom, but it was observed that a large number of patients were slowly deteriorating not just as a result of their illness, but because of the effects of living in a depersonalising, socially depriving, custodial environment. The psychiatrist Barton (1959) was the first to describe the "institutional syndrome", while sociologists raised public awareness of the detrimental effects for people living in "total institutions" (Goffman, 1961).

The deinstitutional movement was in the first instance a humanitarian response to the inadequate conditions of the overcrowded asylums, but
also gained momentum due to advances in pharmacological treatment which facilitated better patient management, and by financial contingencies (i.e. the cost of having such a large hospital population).

De-institutionalisation gave rise to community care, which became government policy with the Community Care Act (Department of Health, 1990). The tenets of community care are that people with psychiatric disabilities can receive appropriate treatment in their home or another community setting, and do not need to be exposed to the negative consequences of hospitalisation. However, it is important to remember that many individuals will require long term support irrespective of whether they have become institutionalised. A second important point is that the process of resettling a hospital patient into the community is not synonymous with rehabilitation. Those who are severely impaired will need a considerable amount of rehabilitation if they are to cope with living in the community. Often the reactions of ‘ordinary’ members of the community to neighbours with psychiatric disabilities is adverse, and the assumption that care in the community will lead to care by the community is a false one. Care in the community does not present a cheaper alternative to hospital treatment.

A third factor which has influenced rehabilitation is the philosophy of normalisation (Wolfensberger, 1972, 1980). Normalisation is a guiding principle which promotes the “use of culturally valued means in order to enable people to live culturally valued lives”.¹ The philosophy recognises that vulnerable groups within society tend to become devalued, which causes additional difficulties to such individuals. The goal is the enhancement of the social role given to people with long term mental illness. Normalisation has given rise to a range of measures aimed to reduce stigma. For example group homes in the community do not put up big signs announcing the presence of people with psychiatric disabilities,

¹ Wolfensberger, 1980.
and where possible individuals are helped to use ordinary services such as transport as opposed to services provided by health or social services. The term “normalisation” has led to the misconception that its goal is to make disabled people “normal”.

It is within this context of a movement away from institutional treatment towards community care, with an emphasis of enabling psychiatrically disabled people to adopt a culturally valued role, that the models of rehabilitation have been developed. The first model of rehabilitation to be considered is the disability model which provides a useful framework for conceptualising psychiatric disorders as disabilities.

The disability model (Wing, 1978, 1981) was developed due to the recognition that a core of psychiatric patients had chronic impairments which were not responsive to medication or social approaches of treatment. Another group of patients was also recognised who remained ‘disabled’ even after the active phase of their disorder had passed. A majority of these patients were diagnosed with major forms of mental disorder such as schizophrenia or bipolar mood disorder. In such cases where the individuals difficulties are enduring over the long term, it is helpful to think of the client as psychiatrically disabled. Wing has developed a model which outlines three levels of disability.

The primary level of disability refers to the impairments which are intrinsic to the disorder. These include acute symptoms such as hallucinations and delusions, and handicaps which clients commonly present over time, such as lethargy, odd unacceptable behaviours, lack of awareness of handicaps, and disturbance in social relationships. Even if such features are not present, the possibility of a relapse is itself a form of handicap. At the second level of disability are the adverse personal reactions which result from the way that significant others react to the individual’s illness. These personal reactions can include negative attitudes toward self
including lack of self esteem and confidence, lowered motivation, poor coping abilities, and denial of “illness”.

The third level of disability refers to social disadvantages which result from psychiatric impairments, and can also amplify disabilities at the primary and secondary levels. Factors here include deprived or hostile environments either within the family or elsewhere, lack of vocational skills, stigma, poverty, unemployment or homelessness.

This model is useful because it forces us to look beyond the presenting 'symptoms' towards the system of relationships and environmental factors which surround the individual, and contribute to his level of functioning. The approach encourages an individualised approach to treatment, because it leads to an understanding of each client’s unique combination of problems. Furthermore the concept of disability is useful because it implies that the aim of treatment should be to help the individual adapt, or that the environment should be adjusted to compensate for the individual’s skill deficits. The disadvantage of the disability model is that although it does identify a large range if issues which contribute to the client's disability, it does not lead to specific intervention procedures. The amount of issues that this model does identify can also appear rather overwhelming to both the client and to professionals working with the client. The model does not provide guidelines regarding which issue should be addressed first.

The skills model of rehabilitation is based on the idea that patients have lost, or never developed, the skills necessary to cope with life outside psychiatric institutions. Therefore the focus of treatment is skill development rather than symptom remission. The term 'skills' refers to behaviours which are observable, measurable, and teachable, and which facilitate adaptive functioning within the individual's environment. According to Anthony (1977), "The goal of a rehabilitation approach should be to provide the disabled person with the physical, intellectual
and emotional skills needed to live, learn, and work in the community with the least possible amount of support from agents of the helping professions.” 2

This model acknowledges that different environments require a different level of skills. In the skills training approach, a diagnosis should determine the discrepancy between the client's present level of functioning, and the level of functioning needed in the present environment. The discrepancy is the focus of rehabilitation treatment. An example of the skills model in practice is the Centre of Psychiatric Rehabilitation in Boston, which was founded in 1979 with Anthony as the director. A collaborative partnership is established with clients who are encouraged to identify their own goals of treatment. The goals are broken down into small objectives which are taught in a step by step programme. There has been research to evaluate the efficacy of the skills building approach (Anthony and Margules, 1974), which has shown that clients can learn a variety of physical, emotional, and intellectual skills regardless of their symptomatology. Furthermore, the outcome of a training programme is significantly better if the skills are integrated into everyday use in the community.

The fact that despite extensive skills training, some clients continue to have skills deficits and that their symptoms still recur has lead to an acknowledgement that environmental changes are also needed to support and accommodate a person's psychiatric disabilities. The original optimism that skills would develop naturally if a client was encouraged to progress through a hierarchy of increasingly demanding rehabilitation environments has in many cases not proved to be valid. Often clients continue to need a large degree of support to be provided within the environment through sheltered work and accommodation.

The advantages of the skills model are that it is applicable to all individuals with psychiatric disabilities and it encourages a positive approach to the treatment of even the most impaired clients. In addition, because the focus is on remediating the individual's specific skill deficits, it follows that treatment programmes will be individualised. The model has been criticised because it places too much emphasis on practical functional skills at the expense of psychological and emotional issues which also need to be addressed. It also assumes that people will use the skills they possess. There are a range of factors which influence the extent to which people use skills including motivational factors and fluctuations in level of functioning due to psychiatric disability. Psychiatric disorders often tend to be unstable and cycles of improvement followed by deterioration are common. It is not appropriate to expect clients to steadily progress through a rehabilitation progress, achieving increasing levels of independence. The skills training model should only be one aspect of a broader overall approach.

Needs approaches to rehabilitation (Wing, 1981; Shepherd, 1984; Brewin, Wing, Mangen, et al. 1987) are relatively recent in their development and are hampered by the lack of a clear definition for the concept of 'Needs'. In rehabilitation the needs model reflects a desire to individualise treatment and avoid block treatments associated with institutions. An important difference between the skills and needs models is that while the focus of intervention in the skills model is to identify and remediate skills deficits per se, in the needs model the focus would be to ask what skills does the individual need in order to make the best use of residual capacities and maximise functioning in every day life? Ekdawi and Conning (1993) provide an anecdote to illustrate this distinction, of a client who after being taught some skills in cooking continued to have his meals at his local cafe. While cooking for himself would meet his need for nutrition, eating at the cafe met both his nutritional needs and an important social need because it gave him contact with other people.
In identifying needs it is essential to discover what the individual values. There is a danger that well meaning professionals will impose their view of what the client needs. Several studies (Khwaja, 1985; Thapa & Rowland, 1989) have found that staff and clients often disagree on what the clients needs are, and also differ on the importance they place on different areas of need. The term 'need' has been variously used in the past. It is sometimes used interchangeably with the notion of a 'problem', while at other times it has referred to either 'something demanded' or 'a want'. Brewin (1987) proposed a rather contentious suggestion that a need should only be identified if there is a standard form of care that will be expected to meet it.

It is clear that the needs model of rehabilitation has much utility in the treatment of individuals with psychiatric disabilities. It forces professionals to adopt a more person centred perspective of the whole of the client's life, and encourages them not to impose an agenda of needs which is discrepant to the client's own priorities. There is a greater likelihood that a client will practice newly acquired skills if they meet valued needs. In forcing professionals to consider the targets of treatment in this way, it is more likely that they will identify objectives which are achievable and which will lead to the maximum amount of positive change for the client. However, it is also clear that an operational definition of the concept of needs is required, in order to allow adequate tools to be developed for staff to be able to identify and measure the needs of individual clients.

The importance in rehabilitation of helping the individual to develop talents, confidence and self esteem through success in social roles has been emphasised often (Bennett, 1978; Wing, 1980; Shepherd, 1984). In society, status is determined by the normative roles people hold in different spheres (e.g. occupational, domestic roles). Often people with psychiatric disabilities adopt the low status 'sick' role because they are
unable to meet the expectations placed on other roles such as employee, husband, wife, or parent.

There are a number of advantages to developing a rehabilitation approach which emphasises the roles an individual holds. Such an approach would enable clinicians to develop an understanding of the individual’s disabilities and skill deficits, and would also provide a framework within which needs could be identified. In other word, an assessment of the various roles an individual holds, or would like to hold including work and relational roles, would inform professional about which areas support should be provided. Such an assessment should consider what skills or abilities are needed by each role, which skills the individual can perform, which skills he can learn, and which skills he is unable to learn and therefore will need support from family of carers.

These roles may be many and varied, may or may not be beneficial, and their benefit may vary over time. For example it may be difficult for an individual experiencing a re-occurrence of their illness to fulfil an occupational role but important at that time to adopt the patient role and comply with hospitalisation or medication. Levels of support needed tend to fluctuate over time leading individual’s to become temporarily unable to fulfil certain roles while maintaining their performance in others. Rehabilitation services need to be sensitive to these differences and if necessary, remove the individual from roles they are not coping with while continuing to support other roles. Alternatively the individual may be helped to cope with a role by reducing the expectations of others including employers, spouses, and parents.

Although there is not a well defined comprehensive roles model, rehabilitation services can be organised around enabling individuals to achieve and hold valued social roles. For example sheltered work projects can benefit clients in a number of ways. Work can help people with psychiatric disabilities to become less socially withdrawn and
generally improve their social behaviour. Aspects of the work itself can help individuals to utilise and exercise various cognitive skills. Other benefits include improved self esteem, and the provision of important social contacts outside of the family or domestic environment.

In summary, rehabilitation is an approach to treating individuals with long term psychiatric disabilities which aims not to cure the individual, but to help the "psychiatrically disabled person to make the best use of his or her residual abilities in order to function at an optimum level in as normal a social context as possible".3

Each of the models of rehabilitation has a different focus for intervention, but it is not necessary or indeed appropriate to adopt any single approach in the treatment of complex long term psychiatric disorders. The disabilities model provides a useful way of conceptualising different levels of disability, which encourages clinicians to adopt an understanding of the client's difficulties which is much wider than at the symptom level of understanding. The skills model advocates addressing client's skill deficits rather than aiming for symptom remission, in order to maximise functioning with the least amount of professional support. The needs model encourages an individualised and person centred approach to treatment, by focusing practical support to areas which the client identifies as important needs. Finally, the roles model incorporates the importance of identifying disabilities, skill deficits and needs into an approach in which clients are supported to develop abilities, confidence and self esteem through success in social roles.

3 Bennett, 1978.
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Discuss the use of a gentle teaching approach with people with learning disabilities who show challenging behaviours. Are any of the techniques used in gentle teaching common to those used in applied behaviour analysis?
Discuss the use of a gentle teaching approach with people with learning disabilities who show challenging behaviours. Are any of the techniques used in gentle teaching common to those used in applied behaviour analysis?

Gentle teaching was developed during the early 1980’s by a small group of academics at the university of Nebraska medical centre in America. It can be broadly described as a non aversive approach to reducing challenging behaviour which utilises traditional behavioural techniques, but within an explicit value base which stresses the importance of bonding and friendship to human growth and development. The proponents of gentle teaching (GT) have sought to emphasise the differences between GT and Applied behaviour analysis, and there has been an at times vitriolic debate between advocates of each approach which continues today.

This debate, known as the ‘aversives debate’ has polarised the two approaches over the issue of punitive or aversive techniques in behaviour modification. In the USA gentle teaching became increasingly popular due to a reaction against the use of such techniques with ‘challenging mentally retarded patients’, (examples of grossly punitive practices include the use of chemical and physical restraints, mechanical restraints to prevent self injurious behaviour, and aversive procedures such as contingent electric shocks). McGee, Menolascino, Hobbs, and Menousek, (1987) have argued that “punishment practices are similar to the torture of political prisoners….the rationales are different, but the means are similar - a calculated, deliberate assault on human dignity through isolation, control over the person, degradation, and finally, submission.” (McGee et al. 1987, p. 9). This stark characterisation of behaviour modification provoked a furious response. For example, Mudford, (1985) countered that “the ill researched, vitriolic attack on mainstream behaviour analysis/therapists….is definitely incorrect and possibly libellous.” (Mudford, 1985, p. 268). Other counter criticisms of GT have included
that it is scientifically unfounded, naive, behaviourism dressed up in
different clothing, and jingoistic rhetoric.

In GT the focus of intervention is the interaction between the client with
challenging behaviour and the care givers. It is based on the assumption
that the "purpose of all human development is the need for all people to
learn to live together". (McGee et al. 1987, p. 29). GT has been
influenced by the literature on attachment theory (Bowlby, 1958, 1969;
Ainsworth, 1964), identifying the importance of 'bonding' which promotes
proximity and contact seeking between two people. McGee et al. (1987)
point out that often for people with learning disabilities and behavioural
problems "bonding has either never existed or has been diminished for
any number of personal, social, or psychological reasons". (McGee et al.
1987. P. 18). This can result in disruptive or destructive behaviour as the
client attempts to make sense of and communicate with "an

The primary aims of GT are for care givers to demonstrate to the client
that human relationships can be rewarding, to establish a bonded
relationship with the client, and to encourage him to reciprocate so that a
situation of mutual interdependence is achieved. GT does not advocate
the application of isolated techniques in order to achieve the goal of
interdependence. It argues that all learning and behaviour change is
achieved through interactional processes, and therefore GT is best
implemented by analysing the caregiver's values and style of interaction,
and helping them to move towards a 'posture of solidarity'. In other
words, GT requires the care givers to change as a prerequisite to client
change. This concept of 'mutual change' is a fundamental aspect of GT.

The concept of 'Postures' refers to the set of personal values, attitudes,
beliefs, and moral judgements which significantly influence an individual's
actions and interactions with others. GT sees postures as more important
than specific techniques, because techniques are just a means of
achieving a goal, whereas postures determine which goals are selected. Posture also influences which techniques are selected to achieve a goal, and the manner in which the technique is implemented. "The ongoing challenge in gentle teaching is for care givers to recognise that their personal values need to surface and need to be critically examined. This questioning is a lifelong process." (McGee et al. 1987. P. 31). This emphasis on systemic factors is a fundamental distinction between GT and Applied behaviour analysis. One of the commonest weaknesses of behavioural techniques is that they are inconsistently applied by care givers whose attitudes are incongruent with positive approaches to behaviour modification. McGee et al. point out that "techniques cannot be implemented in a vacuum." (1987, p.31).

In GT, a distinction is made between authoritarian and democratic value systems. Punishment is characteristic of authoritarian value systems, in which there is a strong need to dominate and control people with learning disabilities. In democratic value systems, all human beings are unconditionally valued. The value of individuals does not depend on obedience, conformity, and submission. Four interactional postures have been identified. The overprotective posture describes a style of caregiving in which the client's needs are smothered which inhibits further development, and leads the client to become a victim in an increasingly unequal relationship. Authoritarianism is a posture in which repressive and punitive styles of interacting are used to achieve compliance. Coldness is a posture which also focuses on compliance but there is also an element of disregard and disinterest towards the client, and interactions are mechanistic with clients being regarded as sets of stimuli and responses with no feelings or spirit.

The posture advocated by GT is solidarity, which emphasises the 'mutuality of shared humanness'. Solidarity implies that each person is valued, is supported in participating in meaningful interaction with others, and can reciprocally meet other people's need for social interaction. The
initial stage of this posture is for an equitable relationship to be formed. Interactional equity results in bonding and interdependence. The posture of solidarity does not seek to control, dominate or force others into compliance. Challenging behaviours such as aggression are not eliminated, but rather new behaviours and interaction skills are taught and encouraged.

What are the techniques used within a Gentle Teaching treatment approach? McGee (1985) has identified nine techniques used in his work which include environmental control, stimulus control, errorless learning, and shaping and fading. These are not new methods of treating clients with challenging behaviour. McGee admits that the specific applications are based on behavioural techniques, but he stresses that it is the purpose for which the technology is applied that is different. In GT the purpose is strongly influenced by a humanistic philosophy, whereas applied behaviour analysts are characterised by advocates of GT as unfeeling technicians, applying the tools of control and coercion to achieve their own goals, irrespective of the rights and needs of the individual client.

Is this a fair characterisation? Non aversive methods of behaviour modification are not unique to the advocates of GT. Behaviourists have also opposed punishment, for example Skinner, (1953) advocated the use of alternatives to punishment, and he supported his argument by citing the negative effects of punishment. During the 1970's and 80's, there was a growing recognition of the importance of ecological variables within traditional behaviourism. In particular the work of LaVigna and Donnelan, (1986) was influential in promoting positive forms of behaviour change without using aversive contingencies.

Jones and McCaughey, (1992) argue that the focus on wider ecological variables such as environmental and interpersonal factors, is a strength of GT above traditional behavioural approaches. In applied behaviour
analysis, challenging behaviour has been seen as learned behaviour which can be understood by investigating the relationships between the behaviour, its antecedents, and its consequences. Throughout the 1980's there was a growing interest in functional analysis, and notable examples of work carried out in this area include Iwata's demonstration that challenging behaviour can serve different functions, (Iwata, Dorsey, Slifer, Bauman and Richman, 1982). This has led to the view that challenging behaviour typically serves four functions; attention, avoidance, tangible reinforcement, and self stimulation. Furthermore, Durand, (1990) has explored the communicative function of challenging behaviour.

McGee has identified that "considerable change in behaviours can result from a focus on antecedent conditions as opposed to consequences", (1985, p. 7-8). There is a difference between GT and applied behaviour analysis in their respective foci on antecedent factors, and consequent factors and functions of behaviour. In GT, the primary aim of treatment would be to provide all of the environmental ingredients which it assumes to be essential to meet the individual's inherent need for affection, warmth, and interactional interdependence, (bonding). In applied behaviour analysis, treatment of challenging behaviour would involve the manipulation of the operant contingencies identified as maintaining the undesired behaviour. This entails the application of a technology in order to achieve change in (usually) one dimension of offending behaviour. It is not necessary to include the use of aversive or punitive contingencies in this approach. However even if a positive approach is adopted, this treatment does not necessarily serve the individual client's interests, and it could be argued that the underlying agenda is inherently controlling, i.e. it seeks to achieve client compliance. Often in service settings, the value of clients is linked to compliance to the rules contrived by the system. GT emphasises the need to unconditionally value all human beings irrespective of the behaviour they present.
McGee, (1985) has reported that that GT has been successfully used with over 600 clients in a variety of settings including a psychiatric institute, group homes, workshops and client's own homes. Those treated in this study include clients with varying levels of learning disabilities who presented behaviours such as aggression and self injury, and clients with diagnoses such as depression and schizophrenia. This study has been criticised (Mudford, 1985) because the outcome results are based on informal observational data, and because a proper experimental methodology was not used. It is not possible to draw firm conclusions that the improvements observed were due to GT and not to other extraneous variables.

Other studies have failed to replicate these results, and have contradicted McGee's assertion that GT can be effectively utilised with every client. Jordan, Singh and Repp (1989) found a mildly aversive procedure was more effective than GT in reducing self injury in a study of three clients. Paisley, Whitney and Moore (1989) found GT to be the least effective of three procedures, (which also included differential reinforcement of incompatible behaviour, and graduated guidance), when administered to two self injuring clients. However, both of these studies also suffered from methodological flaws, and it has been argued that GT was not properly implemented in either study. In a study conducted by Barrera and Teodoro, (1990) in which McGee acted as a consultant to ensure GT was properly implemented, it was found that this intervention led to an increase in self injurious behaviour in the one subject. Two other studies have produced results suggesting a favourable outcome for GT, (Jones, 1991; McGee & Gonzalez, 1990).

There are a number of complicated issues associated with endeavours to empirically evaluate the efficacy of GT. For example, how do the authors know if they have properly implemented the treatment? GT has not been operationally defined, although there has been a detailed account of the philosophy, theory, and value base of GT (McGee et al. 1987).
Implementing GT does not simply entail applying a set of procedures and techniques in a mechanistic way. It requires a transformation of the entire service, including change at a cultural level. It is questionable as to whether it is possible to achieve a 'pure' gentle teaching milieu. There will always exist differences between individuals in every system in terms of ideology and value base. This gives rise to the possibility of a circular argument that if the treatment fails, it is because the treatment hasn't been used properly.

If we accept that it is possible to implement 'pure' GT treatment, there are a number of issues surrounding how it should be evaluated. The success of GT depends on its ability to help care givers make attitudinal changes, and changes in their behaviour and style of interaction with clients. Ideally, a lifelong commitment by care givers to enable true 'parental' or therapist bonds to develop is required. Under GT, staff should be motivated to respond to small changes in client's social responsiveness rather than to reductions in challenging behaviour. Therefore, to evaluate GT on the basis of modifications in client behaviour alone would not accurately reflect the wider changes achieved within the system as a whole.

More recent papers written by advocates of GT have sought to move away from the influences of behavioural approaches and humanistic psychology. For example, McGee and Menolascino, (1991), have stated that "The challenge is not to find non-aversive behavioural techniques, but to formulate and put into practice a psychology of interdependence that goes against the grain of modifying the other and asks for mutual change." (P.9) McGee, (1992) described GT as "a prelude to a psychology of interdependence that requires mutual change, starting with the need for caregivers to analyze and increase their value-centred interactions and decrease dominative ones." (P. 869) These more recent accounts of GT have moved even further away from explaining exactly how the approach should be put into practice.
Anthony Cuvo, (1992) has criticised the debate between advocates of GT and applied behaviour analysis as illogical because philosophical arguments have been countered by arguments based on empirical data. He argues that if the hypothetical constructs described in GT literature were operationally defined, they would closely resemble existing, and more compelling behavioural constructs. For example, the constructs of ‘bonding’ and ‘valuing’ have been accounted for using behavioural explanations such as ‘human reward’, ‘stimulus control’, ‘modelling’, ‘positive practice’, and ‘graduated exposure’.

An example of an illogical critique of GT written from an empirical perspective is the paper by Bailey, (1992). He takes GT to task for presenting a treatment outcome (bonding and interdependence) without defining a procedure for achieving it; for presenting existing behavioural concepts in a soft, vaguely defined format; and for over simplifying the function of challenging behaviours by claiming that they always represent attempts to communicate distress and unhappiness. Bailey also argues that the ‘strengths’ of GT are also inherent in behavioural approaches, for example, the need for unconditional positive regard and mutual change. However, Bailey is referring to the adoption of behavioural techniques (such as ignoring inappropriate behaviour, and reinforcing appropriate behaviour), and not to changes in the values held by care givers. Bailey concludes his paper by insisting that “the rules of science must prevail if we are to arrive at an effective technology of behaviour.” (P.882)

Summary.

There are clearly a number of similarities between gentle teaching and applied behaviour analysis at the procedural level, but the two approaches have fundamental differences at the theoretical and philosophical level. These differences are important because they will
lead to differences in the way treatment is delivered at the procedural level.

The use of non-aversive procedures, and the emphasis on unconditionally valuing the client are not features which are unique to gentle teaching. The difference between the two approaches in these areas is one of degree: in GT they are held to be absolute goals, whereas in behavioural approaches, the aversiveness of procedures and the extent to which clients are valued exist along continua. Gentle teaching also places a greater emphasis on interactional processes between carers and clients, and on the basic human need for bonding. Again the extent to which traditional behaviour analysts attend to these factors varies.

The main area in which the two approaches do differ relates to the objectives and goals of treatment. Applied behaviour analysis has developed as a technology of behaviour change, which is generally applied to reduce behavioural disturbances in clients with learning disabilities. The advocates of GT have drawn attention (in a controversial way) to the potential for this technology to be used abusively in order to achieve compliance at the expense of the individual's rights and needs. In contrast, GT has an explicit value base which advocates the rights of clients to dignity and respect. The concept of mutual change implies a fundamentally different basis to treatment than that held by traditional behaviourism. Mutual change implies that the relationship between care giver and client needs to be modified, not the behaviour of the client alone. This relationships should become more equitable, and should strive to be meaningful for both parties.

There are a number of weaknesses in the gentle teaching approach. It has not been operationally defined and therefore is difficult to translate into practice: it may oversimplify the causes of behavioural difficulties in some cases by exclusively focusing on the communicative function of the behaviour: and although its goals are commendable, they are rather
idealistic and it is questionable whether gentle teaching could ever be absolutely achieved. Gentle teaching has not yet been subject to satisfactorily empirical treatment outcome studies, and the evaluative studies which have been carried out have yielded mixed results, including a number of cases in which GT led to detrimental or no change in undesired behaviours. The lack of scientific validation has been the focus of much criticism of the GT approach.

In conclusion, gentle teaching does have an important contribution to make to the treatment of clients with challenging behaviour, but it does not represent a ‘stand alone’ treatment approach. The value of GT may best be observed by combining its value base and treatment objectives with behavioural techniques which have been operationally defined and empirically validated.
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Critically evaluate at least two theoretical models which have attempted to explain the long term impact of child sexual abuse.
Critically evaluate at least two theoretical models which have attempted to explain the long term impact of child sexual abuse.

Introduction.

A history of sexual abuse has been found to be associated with a wide range of negative psychological sequelae and various forms of psychopathology, (Kendall-Tackett, Williams, & Finkelhor, 1993). In a review of research into the impact of childhood sexual abuse, Browne and Finkelhor, (1986) found that “the most frequently noted patterns associated with a history of victimisation included depression, self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self esteem, difficulty in trusting others, a tendency toward revictimisation, substance abuse, and sexual maladjustment.” (Finkelhor, 1990, p.325).

However, the relationship between sexual abuse and subsequent emotional and psychological consequences is not straight forward. It is difficult to disentangle the effects of sexual abuse from other forms of maltreatment and deprivation which may also be present. There is also evidence that different forms of abuse lead to different long term effects. There is not a discrete syndrome of symptoms which result from sexual abuse, but rather victims can present any of a wide range of emotional, cognitive, and behavioural consequences.

A number of models have been proposed to explain the long term consequences of child sexual abuse. In this essay, two models including the Post traumatic stress disorder model (PTSD), and the Trauamagenic dynamics model (Finkelhor and Browne, 1986) will be critically evaluated.
Child sexual abuse defined.

The parameters of child sexual abuse (CSA) have varied across different research studies. For example, some studies have included experiences with older partners only, and others have looked only at abuse perpetrated by family members. In their review of empirical research, Browne and Finkelhor (1986), identified that child sexual abuse "consists of two overlapping but distinguishable types of interaction: (a) forced or coerced sexual behaviour imposed on a child, and (b) sexual activity between a child and a much older person, whether or not obvious coercion is involved". (Browne & Finkelhor, 1986, p. 66).

Sexual abuse can take many forms. Steele defines sexual maltreatment as "the involvement of dependent, developmentally immature children in sexual activity that they do not fully comprehend and without consideration for their stage of psychosocial sexual development. Sexual abuse of children occurs in many varieties and can happen at any age from infancy through adolescence, with various family members, relatives or strangers. It can be a single isolated incident or repeated frequently over many years. It may be homosexual or heterosexual with either boys and girls and involve anything from fondling to full genital intercourse or variations of oral and anal contact. It may be done with some degree of love or gentleness or involve verbal threats and physical violence". (Cited in Levine, 1990, p.21).

Symptoms of CSA as Post traumatic stress disorder.

The key features of Post traumatic stress disorder (PTSD) are that following a recognisable stressor, the victim suffers (a) the re-experiencing of the trauma through flashbacks (in the form of intrusive images, dreams, or sudden feelings), (b) a numbing of responsiveness and affect, and feelings of estrangement from others, and (c) hyper-
vigilance and increased arousal to stimuli related to the traumatic event. Many victims of child sexual abuse present features which are similar to the core features of PTSD such as re-experiencing abuse (e.g. recurrent and intrusive recollections of the abuse), avoidance of abuse related stimuli (e.g. avoidance of certain behaviours and activities), and increased arousal (e.g. sleep disturbance, irritability or hypervigilence).

Although PTSD does account for some important effects of sexual abuse, there are major conceptual weaknesses in its application to abuse victims. The first of these is that PTSD was originally developed to explain symptoms observed in survivors of specific types of traumatic events such as combat, natural disasters, or rape. Child sexual abuse often does not occur under conditions of danger, threat or violence. It tends to occur in situations where a person in a position of influence and authority (usually an older relative) misuses this authority, sometimes with the victim's trust and co-operation. The abuser may use a degree of love and affection to "seduce" his victim. The victim can remain unaware of the meaning of the abuse for a period of years after it ends.

The second major conceptual weakness of the PTSD model is that it does not adequately account for the effects of CSA which have been given a greater emphasis by researchers such as depression, self blame, interpersonal problems, sexual problems, suicidality, substance abuse and revictimization. Furthermore, a large proportion of victims of CSA do not present any symptoms of PTSD, (Greenwald & Leitenberg, 1989). Therefore, although the PTSD model does account for some of the symptoms of some victims, it is not on its own an adequate formulation.

Herman (1992) has proposed that the trauma of child sexual abuse results in a complex form of post traumatic disorder. She suggests that victims of CSA have much in common with concentration camp survivors. In both cases, suffering occurs over a prolonged period, and victims live in a condition of captivity which brings them into continual contact with the
perpetrator of their abuse. Herman has argued that there are different types of traumatic experiences, and that disorders of extreme stress should be conceptualised as a spectrum of post traumatic disorders, as opposed to just one disorder which refers to a specific set of responses to a prescribed type of stress.

There have been a number of efforts to expand the concept of PTSD in order to more adequately account for the consequences of sexual abuse. Gelinas (1983) was the first to propose PTSD as a persisting effect of incest. She used the term "Chronic traumatic neurosis" with the intended connotation of a classical psychoanalytic formulation, i.e. child victims cope with experiences of incest through the use of denial and repression, resulting in repetitive intrusion of certain elements of the trauma, and the emergence of a variety of psychiatric (neurotic) symptoms. The repetitive re-experiencing of specific elements of the trauma is explained within Horowitz's concept of the "completion tendency". Horowitz proposed that memories of difficult life events are stored in a short term buffer or active memory, until they can be integrated into existing beliefs and schemata about self and relationships with important others. The repetition is unconsciously driven, and can be manifested as thoughts (nightmares, hallucinations, ruminations), emotions (panic attacks, weeping episodes), or behavioural re-enactment.

These models of PTSD only partially explain the long term effects of sexual abuse. The original formulation of PTSD describes how conditions of overwhelming fear lead to subsequent symptoms within the affective domain such as re-experiencing, heightened startle response and avoidance of stimuli relating to the trauma. Gelinas's model describes how memories of the abuse are so unacceptable that it is not possible to accommodate them within existing schemata, and hence the victim is forced to resort to denial and repression. Herman (1992) argues that there are three broad areas of disturbance which transcend the diagnosis of simple PTSD. These include the wide variety of psychiatric symptoms
which are frequently observed in victims of CSA; important characterological changes including pathological changes in relationships and self identity; and finally the repetition of harm after prolonged victimisation. A complex post traumatic disorder model is required in order to account for these areas of disturbance.

Studies in which victims of CSA have been administered 'symptom checklists' have consistently found them to present both a wider array of psychiatric symptoms and a greater level of general psychological distress than psychiatric patients who do not have a history of abuse, (e.g. Briere, 1988). Three categories of common symptoms which do not fit in with simple PTSD are somatization, dissociation, and affective sequelae (particularly protracted depression). Dissociation can occur in various forms including voluntary thought suppression and self induced trance states. These techniques have been widely observed in people in captivity, and they serve the function of helping people to endure aversive conditions such as hunger, cold, or pain. The most extreme form of dissociation in which the individual's personality becomes split, (Multiple personality disorder), is associated exclusively with a childhood history of massive and prolonged abuse.

Herman, (1988) has described a process of establishing control over an abuse victim which results in a pathological attachment between victim and perpetrator. In this process, (which is the same as that observed in concentration camp survivors also), terror is instilled in the victim through systematic violence and threats of violence, and an extreme state of helplessness is engendered by the perpetrator who pervasively controls the victim's bodily needs and functions. Hence, the victim comes to depend on their abuser for survival, basic needs and even emotional nurturing. The victim is faced with the impossible task of reconciling the abusive and the nurturing parts of the perpetrator. Abuse victims can do this by blaming themselves which can lead them to develop a sense of self as contaminated, guilty, and evil. In some cases, victims lack a stable
sense of self and this is characteristic of people with the diagnosis of borderline personality disorder.

The repetition of harm following abuse is the third key area of disturbance in victims of CSA which is not accounted for by the PTSD model, and this can take the form of self mutilation, or an increased vulnerability to the risk of rape, sexual harassment, and battering in later life. There are several reasons for this repetition of harm. Firstly, survivors carry the burden of unexpressed anger about their abuse, and this rage may be internalised resulting in malignant self hatred and suicidality. Self blame and guilt is also common among abuse victims, partly because the dependent controlling relationship with their abuser can make them feel as if they colluded in their own abuse. Another way in which harm is perpetuated is by the victim becoming involved in the abuse of other victims. A history of prolonged abuse does seem to be associated with a higher risk of becoming an abuser, particularly in men (Herman, 1988). The process of control may lead the victim to adopt the belief system of the perpetrator, or to identify with the abuser in order to end their own exploitation.

A more complex model of post traumatic disorder is needed to adequately encapsulate the diverse pathological processes inherent in child sexual abuse. The trauma of sexual abuse is more akin to that experienced by victims of concentration camps, rather than the experiences of combatants or survivors of natural disasters. The trauma of sexual abuse is prolonged, and derives in large part from the style of the relationship between the perpetrator and victim. The effects of this trauma include a pervasive long term impact on the individual’s self concept, personality, pattern of interpersonal relationships, and sexuality.

The schools of social and cognitive psychology have provided theoretical models which further help to explain the long term effects of sexual abuse. The attributional style of abuse victims has been found to be more
depressogenic than non abuse victims (i.e. internal, stable, and global attributions for negative events), (Gold, 1986). Wyatt and Newcomb (1990) found that negative effects of sexual abuse were predicted by self blame (internal attributions) for the abuse. Taylor, (1983) proposed that the process of adaptation involves searching for a meaning for the abuse; regaining a sense of mastery over the event and the world in general; and enhancing one’s self esteem through favourable social comparison with others. Janoff-Bulman, (1985) suggests that a trauma shatters assumptions about self and the world (e.g. “The world is just”, “Bad things don’t happen to good people”). Old assumptions are replaced by new malevolent assumptions, which can be understood to contribute to a range of effects of CSA such as anxiety, negative self image, and interpersonal problems.

Despite the limitations of the simple PTSD model for victims of CSA, there are a number of applications of the model in clinical work with adult survivors. Interventions aimed at alleviating post traumatic stress reactions include (i) exposure to stressful features related to the abuse; (ii) training in skills in coping with these stressful features; and (iii) changing the meaning of the abuse. The third intervention involves the use of cognitive therapy (Beck & Emery, 1985) in order to reconstruct maladaptive beliefs such as “I must have permitted sex to happen with my father because I wasn’t forced into it”. Although these techniques have been found to be effective when used with clients with other psychological problems, there is very little evidence of their efficacy with CSA survivors, (Jehu, 1988). A further weakness of these interventions is that they work at the symptom level, (i.e. techniques for reducing anxiety and distress, and cognitive restructuring to modify superficial cognitions), while the complex post traumatic disorder model suggests that victims of CSA require longer term forms of therapy.

The Traumagenic dynamics model.
The traumagenic dynamics model was conceptualised by Browne & Finkelhor, (1985) in an attempt to overcome the shortcomings of the PTSD model. This model which is widely used in clinical practice with adults who have been molested as children, succeeds in encompassing the diverse array of psychiatric symptoms and characterological changes which are known to result from sexual abuse. It formulates that the effects of child sexual abuse are caused by four traumagenic dynamics which operate by distorting a child’s cognitive and emotional orientation to the world. The four dynamics relate to traumatic sexualisation, betrayal, powerlessness, and stigmatisation. It is the combination of these four dynamics which makes the experience of CSA uniquely harmful.

The wide range of psychological and behavioural problems which occur in the long term are caused by the individual’s attempt to cope with the world through the cognitive distortions. PTSD is subsumed within this model, as the mechanism by which affective capacities become distorted by sexual abuse. Cognitive distortions resulting from the traumagenic dynamics include the child’s world view, and self-concept. Finkelhor and Browne’s model acknowledges that children are impressionable and can be taught to adopt incorrect and misleading assumptions. These assumptions may be well integrated in a context where abuse is taking place, but prove to be dysfunctional in coping with a world where abuse is not the norm.

Traumatic sexualisation refers to “a process in which a child’s sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse” (Finkelhor & Browne, 1985, p. 531). Traumatic sexualisation can happen in a variety of ways. For example, sexualised behaviour in children can develop as a result of operant conditioning (i.e. rewards given by an abuser), and can become established as a generalised strategy for getting needs met. Certain parts of a child’s anatomy can become fetishized and given distorted importance and meaning. Confusion about sexual norms, morality and
identity can result from misconceptions propagated by the offender. A child’s sexuality can become traumatised if sexual activity is associated with frightening and unpleasant memories. The extent of these effects can vary considerably across individuals, possibly as a function of the degree to which their own sexual response was evoked by their abuser. This dynamic is thought to account for abuse outcomes such as sexual precocity, compulsive sexuality, sexual aversion or dysfunction, and an adult predisposition to sexualising their own children which may lead to further sexual abuse.

The second dynamic of betrayal, encompasses both the offender and non offending family members who failed to protect the victim. This dynamic is thought to cause feelings of grief at the loss of a trusted figure, heightened dependency in victims who search for a redeeming relationship to protect them, mistrust, and anger, and is linked to clinging, vulnerability to further abuse due to impaired judgement, intimacy problems, and conduct problems.

Powerlessness refers to the process of disempowerment experienced by the child whose will, wishes, and sense of efficacy are repeatedly contravened. There are two sources of powerlessness in sexual abuse: invasion of body space, and life threat. Powerlessness can be heightened in victims who attempt to fight back but are thwarted. This dynamic appears to be connected with three distinct clusters of effects. The first which reflects the experience of having been unable to control a noxious event are the PTSD symptoms (nightmares, hyper-vigilance, dissociation, somatic complaints, numbing of affect). The second cluster includes poor coping skills and low sense of self efficacy. This translates into poor functioning at school and in work, generalised despair, and an increased vulnerability to future abuse. In the final cluster, powerlessness is thought to lead the victim to identify with the abuser, which is manifested in an unusual need to control or dominate (particularly in male victims), and aggressive sexuality.
The final dynamic, stigmatisation refers to the negative connotations that surround the abuse experience - evilness, worthlessness, shame, and guilt. Sources of stigma include messages directly given by an abuser, social responses to victims, and victims themselves, who make self-attributions about why they were chosen. Stigmatisation is thought to lead to lowered self esteem, a sense of differentness and isolation, and is linked with behavioural outcomes including substance misuse, prostitution, self destructive behaviour and suicide attempts.

Hazzard, (1993) has obtained empirical evidence that the four traumagenic dynamics are effective predictors of future psychological problems, and are therefore a useful framework to guide the assessment and treatment of adult survivors of abuse. In her study, she devised a Trauma related beliefs questionnaire (TRBQ) which was designed to assess beliefs which reflected the four dynamics. The four sub scales were found to be internally consistent. The measure was then used to examine the relationship between trauma related beliefs and a range of psychological outcomes such as self esteem, interpersonal sensitivity, depression, anxiety, overall psychological distress, locus of control, sexual avoidance, and sexual problems. A stepwise multiple regression was conducted to examine the relationship between variance on different measures of psychological outcome and variance on the TRBQ.

Stigmatization/self blame was found to be the most powerful predictor of a number of psychological outcomes such as self esteem problems, interpersonal problems, overall psychological distress, and anxiety. Powerlessness was found to be most strongly predictive of depression and an external locus of control, and this is consistent with the literature on learned helplessness (Abrahamson, Seligman, & Teasdale, 1978), and depressogenic attributional styles (Gold, 1986). Sexual problems were strongly predicted by betrayal, and this dynamic was also found to be a significant predictor of interpersonal problems and an external locus of
control. Finally, traumatic sexualisation was found to strongly predict sexual avoidance, and was also a significant predictor of anxiety.

The results of Hazzard's study were inconsistent with some aspects of the traumagenic dynamics model. Firstly, the dynamic of betrayal was not associated with the outcome of depression as Finkelhor has suggested. This contradicts the notion that betrayal causes a grief reaction to the loss of a trusted figure. Secondly, powerlessness was not found to be predictive of anxiety. Finally, a counter intuitive finding of the study was that sexual problems were not predicted by the dynamic of traumatic sexualisation. However, the study did generate evidence to support eight out of eleven hypotheses, thus providing empirical evidence of the overall validity of the model.

The clinical usefulness of the traumagenic dynamics model has not been empirically investigated as yet. However, the TRBQ offers a useful tool for assessing psychological problems, planning treatment goals and measuring the outcome of treatment. The mode of treatment indicated by this model is cognitive-behaviour therapy, and this can include any of the techniques which have been demonstrated to be effective with other psychological problems. For example, the therapeutic relationship will be important in order to address the dynamic of betrayal. This can be used to model a caring and responsible relationship by maintaining appropriate emotional and physical boundaries, and by being dependable and honest. In order to address stigmatisation, the therapeutic goal of improving self esteem is indicated.

One advantage of the traumagenic dynamics model is that it reflects how sexual abuse is often an extended process of traumatisation, rather than a discrete event. This process includes not only the actual abuse, but also the sexualised relationship with (often) a primary carer. The trauma derives from the powerlessness and betrayal inherent in this relationship, and from the stigma of feeling evil and guilty for the abuse. A weakness
of the model however is that it does not account for the impact of circumstances and events surrounding sexual abuse such as the response of family members to the victim's disclosure of abuse, criminal proceedings following disclosure, the intervention of social services, and issues of guilt regarding the break-up of the family.

A second weakness of the model is that it is concerned solely with cognitive coping/mediational factors in the outcome of abuse experiences. Additional important factors which influence the outcome of abuse include the victim's internal emotional resources for coping with distress, and the presence of external sources of emotional support.

Summary.

Two models which purport to explain the long term effects of sexual abuse have been critically evaluated. The first of these is the post traumatic stress disorder model. Sexual abuse is undoubtedly a traumatic experience. The key features of PTSD can be observed in CSA victims: persistent re-experiencing of abuse; persistent avoidance of features related to the abuse; and persistent increased arousal. The PTSD model leads to a number of treatment techniques which have been empirically validated with individuals who have suffered different types of traumas, but there is no empirical evidence of their efficacy with adults who have been molested as children.

There are a number of serious theoretical and conceptual limitations in the application of the simple PTSD model with victims of CSA. The main weaknesses of the PTSD model include: (1) It only accounts for a subset of the many psychiatric symptoms which have been observed in victims of abuse, (2) It does not account for the effects of abuse which have been most emphasised by research, (3) Some victims of CSA don't present any symptoms of PTSD and (4) The trauma of sexual abuse is often a
qualitatively different experience from a trauma as defined within the model of PTSD.

Herman, (1992) has suggested the need for a model of a complex post traumatic disorder to overcome some of the limitations of the simple PTSD formulation. The advantages of the complex PTSD model include the acknowledgement that the trauma of sexual abuse is often prolonged, and derives largely from the relationship between the perpetrator and victim, which is characterised as controlling. This relationship can result in pervasive effects on the victim's personality and pattern of interpersonal relationships which help to perpetuate multiple long term psychological problems. This model needs to incorporate a wide range of psychological concepts and theories including Learned helplessness (Abramson, Seligman, & Teasdale, 1978), attributional theory, (Gold, 1986), learning theories (e.g. Mowrer, 1960), the cognitive model (Beck & Emery, 1985), and the significance of the meaning of the abuse, (Taylor, 1983).

Browne and Finkelhor's traumagenic dynamics model provides a comprehensive and flexible framework for conceptualising the many effects of sexual abuse. This model also provides a good explanation for the many complex pathological processes inherent in sexual abuse. It offers a number of important clinical uses including a framework for guiding assessment, treatment, and evaluation of change through therapy. The four traumagenic dynamics have been empirically validated by one study (Hazzard, 1993), which examined the relationship between the four dynamics and a range of psychological outcomes. However, the efficacy of the model in terms of treatment has not yet been empirically investigated. The weaknesses of this model include its exclusive focus on the individual victim's cognitive coping and mediation, while it is known that other factors such as the individual's internal resources, and external sources of emotional support also influence the psychological outcome of abuse. The model also does not address the influence of circumstances
and events which often follow sexual abuse, in particular the response of family members to the victim's disclosure of abuse.
References


What factors are involved in suicidal behaviour in older adults?
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The incidence of completed suicides in older adults is higher than in any other age group within the population. This phenomenon has consistently been found not only in western cultures (Richardson, Lowenstein, & Weissberg, 1989; Kerkhof, Visser, Diekstra, & Hirschhorn, 1991), but also in countries such as India (Venkoba Rao, 1991), and Japan (Takai & Takai, 1991). Much of the research investigating elderly suicide has been concerned with identifying the relationship between various psycho-social stressors associated with normal ageing, and suicide. The most commonly researched suicide risk factors include loss, physical illness/disability, retirement, depression, social isolation, and alcohol abuse/dependence. Implicit in this research is an assumption that suicide in old age is a rational response to deleterious life circumstances.

In this essay, literature on the suicide risk factors, psychological characteristics of suicide completers, and motivations for older adults to attempt suicide will be reviewed. In order to gain a better understanding of elderly suicide, the evidence from this research will be synthesised within a developmental perspective which takes account of the individual's adjustment to the developmental tasks of later life. It is argued that this is a useful framework for understanding the sources of emotional distress of older adults.

Prevalence and characteristics of suicidal older adults.

Epidemiological data has shown that there is a disproportionately high level of suicide in older adults. For example, in the United States older adults account for 25% of suicides (Blazer, Bachar, & Manton, 1986), while in the Netherlands, 33% of suicides concern elderly people (Kerkhof et al. 1991). Within this age group, the old-old (those over 75) have the
peak suicide rate. Males have higher suicide rates than females in all age
groups, but this difference is particularly marked in older adults where the
male/female suicide ratio is 12:1 (Crisis, 13, 1, 1992).

It has been argued that suicide rates in older adults may be significantly
under reported (Blazer et al. 1986), because they do not take account of
individuals who choose to end their life by non violent means, (such as
non compliance with essential medication, self starvation, and over dose
of prescribed medication). In cases such as these, which are known as
“suicidal erosion” death is often attributed to medical causes.

There are a number of features which distinguish suicide in older adults
from suicides in earlier life. Suicide attempts in older adults are generally
thought to be more serious than those of younger adults because they are
more likely to result in death. 1 in 4 attempted suicides are successful
among older adults, compared with 1 in 12 in the general population, (De
Leo and Ormskerk, 1991). Suicidal older adults tend to choose more
lethal means of suicide, and take care to ensure that no one intervenes,
(Miller, 1979). The elderly are also less likely than younger suicidal adults
to communicate their suicidal intentions to others (Maris, 1969). This
suggests that the function of suicidal behaviour in the elderly is not to
seek help.

Risk factors.

Research studies have investigated the impact of a wide range of factors
on suicidal behaviour in older adults. Much of this research has been
conducted by analysing trends in recorded suicide rates. One problem
associated with this methodology is the potential for suicides to be under
reported particularly among older adults as mentioned above. Two
general trends observed by such studies have been period and cohort
effects.
A period effect is said to have occurred when a flux in the suicide rate can be associated with the occurrence of a unique stressor. For example, Murphy, Lindsey & Grundy (1986), attributed a decline in the suicide rate in England and Wales between 1955 and 1965 to the introduction of non-toxic domestic gas, which removed the previous most popular means of suicide. A phenomenally high level of suicide was observed in Japan shortly after the end of the second world war, when approximately one in every one thousand older adults (over 70) committed suicide, (Tatai & Tatai, 1991). Variations in the suicide rate between different birth cohorts throughout the life cycle have been attributed to socio-economic influences such as periods of high unemployment, (Haas & Hendin, 1983). Clearly, research based on analysing population statistics has limited value, and only in the case of very extreme circumstances is it possible to link underlying social processes with higher or lower frequencies of suicide.

A large number of studies have investigated suicidal behaviour in older adults by examining a wide range of factors associated with and contributing to suicide risk. It is hoped that this form of research will lead to the development of screening tools for assessing suicide risk, and identifying vulnerable individuals. Among the findings generated within this epistemological framework the following factors have been found to be associated with an increased suicide risk: men and women who are divorced, widowed or single (Busse & Pfeiffer, 1969); individuals permanently living on their own (Gubrium, 1974); and low income (Marshall, 1978).

Adults often undergo more losses during late life than at any other time, and in addition, they are handicapped by a diminished ability to cope with stress. The losses which older adults can potentially encounter include loss of work role and income due to retirement, loss of physical health and cognitive abilities, loss of important relationships, and loss of status and
self esteem. The high prevalence of depression in over 60 year olds has been well documented. Between 30 and 65% of this age group have been found to present symptoms of depression, (LaRue, Dessonville & Jarvik, 1985), and depression has been found to be highly correlated with suicide, (Barraclough, Bunch, Nelson & Sainsbury, 1974). In addition to being predisposed to depression by loss and stress, depression in older adults has also been found to result from various biological and chemical changes in the brain and nervous system, (Osgood, 1991).

A further psychological consequence of suffering multiple losses in old age is helplessness. Seligman, (1975) suggested that the elderly are most susceptible to helplessness because they suffer the greatest loss of control. Loss and depression followed by helplessness can lead to a downward spiral in which the individual loses confidence, and develops increasingly negative attitudes towards self. Suicide offers a means of escaping a life which is perceived as being intolerable and hopeless.

Alcohol abuse is a common strategy adopted for coping with the multiple stresses associated with old age. Bienenfield (1987) found that elderly alcoholics are five times more likely to commit suicide than non alcoholic elderly individuals. Alcohol dependence can quickly be established due to the short term relief from distress and an increased sense of control it provides. However in the longer term it has a depressant effect, and can reduce inhibition of self-destructive impulses. It is also known to increase aggression and impulsiveness, both of which are thought to be major factors in suicide. However, Duberstein, Conwell and Caine (1994), in a paper which is discussed below, found that suicidal elderly differ from younger suicidal adults because they are not characterised by impulsiveness or aggression.
Ageism and counter transference reactions to older adults.

Despite the prevalence of suicide in older adults, the issue is not as prominent as suicide in young adults. There seems to be a number of reasons for this. Suicides account for only a small proportion of elderly deaths while in the 15 to 34 age group, suicide is the second most frequent cause of death, (Gunnell, 1994). Preventing suicides in young adults would therefore have a significant impact on the mortality rate of this age group. Secondly, a premature end to a young life seems to be a 'greater loss' because the elderly are chronologically closer to their natural death. Finally, suicide can appear to be a rational course of action in older adults who endure chronic physical illnesses and disability. This view is implicitly ageist because it reflects exclusively negative connotations of late life. In our culture, youth, beauty, efficiency, productivity, activity, and independence are all standards which are widely valued.

The ageing process is something which effects us all. However, rather than acknowledge our commonality with older adults, there is a tendency to project on to them negative attributes, and view them as different. This enables us to avoid contact with the ageing process, and deny the impact of ageing on our own lives and on the lives of those close to us. Katz, (1990) has argued that “Ageism ultimately protects a youth-oriented society from its anxiety about death, illness, and loss of meaning in life.” (Genevay & Katz, 1990, p.20). Butler, an authoritative writer on the subject of ‘Ageism’ has argued that “society must be organised so that people can continue to grow to the very end of life”. (Butler, 1975, p.385).

Ageism influences the issue of suicide in older adults in three ways. Firstly, it detracts from the quality of life of older adults by perpetuating the stigma and devaluing associated with old age. Secondly, ageism may prevent some individuals from adjusting to the effects of their own ageing
process, leaving them ill equipped to cope with the stresses of normal ageing. Thirdly, ageism may influence the responses of others, (including helping professionals, carers, and relatives) to elderly clients, i.e. it may lead others to collude with the patient’s helplessness, and view suicide as an inevitable outcome. People will be less inclined to attempt to treat a condition which they perceive to be inevitable and irreversible. It is in this context that the issue of suicide among older adults has received relatively little attention.

**Motives for Elderly suicide.**

There has been relatively little research into the motives of individual's who attempt suicide in later life. Kerkof et al. (1991) have classified elderly suicides into three types: older patients with incurable diseases who request euthanasia; the chronically suicidal elderly who are characterised by a life history of disturbed social relationships; and the acutely suicidal elderly, who experience a crisis following one or more drastic life event. This classification highlights the range of sources of distress for older adults. Issues which were identified in another study (Kockott, 1988) as having precipitated a suicidal crisis include conflicts with partners and family, social isolation and loneliness, fears about declining physical health, and the threat of dependency particularly if this involves losing one's home and moving into a home for the elderly.

Although these research studies have identified factors which are strongly correlated with suicidal behaviour in the elderly, their designs are not adequate for investigating the complexity of suicide. Clearly it is simplistic to propose a straight forward causal model for suicide since the stressors identified are present in the lives of older adults who do not attempt suicide. In addition, 85 % of suicidal older adults have had no previous suicidal episodes in their life, (Clarke, 1991). It is necessary to investigate the psychological characteristics of individual suicide victims.
in order to explain why some adults are unable to cope with the pressures associated with old age.

**Psychological characteristics of suicidal older adults.**

Very few studies have attempted to investigate the complex circumstances of suicide at an individual level. The methodology of Psychological autopsy has been used by researchers in order to reconstruct an individual's personality and psychological characteristics prior to a successful suicide attempt, (Caine & Conwell, 1990; Clarke 1991; Duberstein, Conwell & Caine, 1994). Psychological autopsy studies involve interviewing close relatives of suicide victims and reviewing records of medical treatment. An advantage of this methodology is that it removes the problem of whether the subject's current mental status confounds efforts to draw conclusions regarding enduring traits or processes.

Duberstein, Conwell & Caine, (1994) conducted a psychological autopsy study of adult suicide completers of different ages in which they used the informant version of the NEO personality Inventory (Costa and McCrea, 1985) to measure personality characteristics. They found that older suicide completers (i.e. those over 50) obtained lower scores on the openness to experiences scale, particularly the openness to action facet, compared with younger suicide completers. Older suicide completers also obtained relatively high scores on the conscientiousness scale. The researchers suggested that older suicides are characterised as relatively organised, persistent and motivated, and that their suicidal actions are not carried out impulsively.

The psychological autopsy studies conducted by Caine & Conwell, (1990) and Clarke, (1991) have generated data which challenges the prevailing theories about the causal role of psycho-social risk factors in suicide. In
particular, a significant proportion of subjects studied were not characterised as being socially isolated, suffering severe stress due to life changes, and were not in worse health than their peers. Clarke proposes that elderly people who die by suicide have a life long 'character fault' which remains invisible until life changes associated with ageing force the issue into the open.

Clarke has made some tentative suggestions about the nature of this 'character fault'. He proposes that adults who become at risk of suicide fail to carry out a number of tasks which are necessary for late life development. These include acknowledging the fact of ageing and grieving for personal losses associated with it (youth, strength and health), and demonstrating the flexibility to modify self identity and find new ways to realise goals. In addition to struggling with the developmental tasks of old age, these individual's also seem to have unresolved conflicts from earlier stages of development identified by Erikson, (1963) including "basic trust versus mistrust", "autonomy versus shame and doubt", and "industry versus inferiority". Thus individuals who find it hard to rely on other people, are proud and independent, and have a self image which is largely defined by their productivity are likely to have greater difficulty adjusting to the life changes of old age.

This model implies that formative experiences occurring during an individual's earlier years will influence the success with which they adjust to and cope with challenges in late life. Clarke has proposed a model of elderly suicide called the 'wedding cake model' which describes a sequence of seven 'tiers' leading to suicide. The first tier is a latent 'fault' which makes the individual intolerant to the normal ageing process. This 'fault' becomes increasingly visible due to successive stressors. At the third stage, a 'narcissistic crisis' erupts as the individual's threshold for tolerating stress is exceeded. This crisis is intensified at the fourth stage if the individual is dependent on alcohol or psychoactive medication, or if the individual suffers a major depressive episode. Further triggering
events add lethal momentum to the crisis which acutely overwhelms the individual. This results in a suicidal crisis (stage 6) which is characterised by a total collapse of defensive denial, traumatic reality testing, and overwhelming states of panic and rage. The final tier represents the suicidal act.

This model is based on limited empirical evidence but it is a conceptually useful framework for understanding the circumstances of elderly suicide. Clearly it is too simplistic to assume that older adults become depressed and suicidal due to the quantity of stressful events in their lives. It is also necessary to understand why they are no longer able to cope with this stress, and how they construe and give meaning to the stressful changes which take place. This latter question introduces a wide range of personality characteristics such as core schemas and patterns of interpersonal relationships which may be pertinent in accounting for variations in ability to adapt to events such as retirement and loss in old age. Further research is needed to investigate the personality characteristics of older adults at risk of suicide, the motivation to commit suicide, older adult's ability to cope with stress, and the factors which cause this coping to break down. The outcome of such research would inform positive approaches to the management of suicide risk in older adults, and would help to counteract ageist attitudes which can lead health care professionals to assume that in some circumstances, suicide is inevitable.

Summary

There are a wide range of factors which contribute to suicide in old age. A general profile for older adults who are at risk of committing suicide has been identified, and this includes older adults who are isolated, suffering from depression, are physically frail, have a recent history of significant losses, and are dependent on alcohol. Later life as a developmental
stage is associated with greater and more fundamental life changes compared with earlier stages of the life cycle. Later life is also a time when individuals have diminished resources for coping with the stress that this engenders. The pace and magnitude of changes associated with normal ageing can result in feelings of intense helplessness and a perception of lack of control in older adults.

The difficulties encountered in later life are compounded by the stigma and devaluing widely associated with old age in our society. Katz, (1990) has argued that ageism can effect the attitudes and emotional reactions of carers and health care professionals towards suicidal older adults. In particular, ageism can lead others to regard suicide as a rational response to difficult life circumstances, rather than seeing it as resulting from transient (and treatable) psychological distress.

One study (Clarke, 1991) which attempted to investigate the psychological characteristics of elderly suicide completers suggests that suicide victims have certain personality features which predispose them to additional difficulties in adjusting to the developmental tasks of later life. Clarke has argued that often these individuals have unresolved conflicts from earlier developmental stages relating to issues of basic trust, autonomy, and usefulness. These issues are intensified in old age by events such as retirement, loss of partner, and increasing dependence due to physical/cognitive decline.

In order to gain a better understanding of the dynamics of elderly suicide it is necessary to go beyond existing research on the known risk factors. There remain several important questions which have not been adequately addressed. For example, what are the psychological characteristics of older adults who are vulnerable to suicide, including personality traits and coping styles? What are the motives for suicide in later life? Answers to these questions are necessary in order to explain why some individuals, who have no previous history of suicidal behaviour,
become vulnerable to suicide in later life, while others facing similar stressors do not.
References


Discuss the contribution that Clinical Neuropsychology can make to the assessment of a neuropsychological illness of your choice.
Discuss the contribution that Clinical Neuropsychology can make to the assessment of a neuropsychological illness of your choice.

Severe Head Injury (SHI).

A traumatic brain injury can result in damage to any structure within the brain and consequently the whole range of cognitive functions can potentially be affected. Less than 10% of all head injuries are classified as severe (Lezak, 1995), but this group present the most difficulties in terms of long term recovery and rehabilitation. Two key diagnostic criteria are used to classify the severity of a head injury. These are the depth and duration of coma, and the length of post traumatic amnesia.

The extent and duration of loss of consciousness is the earliest predictor of long term outcome. The Glasgow coma scale (GCS, Teasdale & Jennette, 1976) is a widely used observational checklist which allows the depth of coma to be measured by grading eye movement, verbal and motor responses. A score of 8 or more on the GCS, or a coma duration of greater than 6 hours are used as indicators of a severe head injury. Coma is not always a sensitive predictor of severity of head injury because there is a high risk of secondary injury occurring during the first few days after injury which can significantly affect prognosis (Gronwall, Wrightson & Waddell, 1991). Length of post traumatic amnesia (PTA) is thought to be a more reliable indicator of long term outcome, (Bond, 1990). PTA is regarded to be present until continuous registration of experiences is observed to have returned. Severe head injury is inferred in cases where PTA lasts for more than 12 hours.

The distinction between open and closed head injuries is an important one. The characteristic pattern of impairment in a closed head injury (which is the pattern most likely to result from a road traffic accident) is
diffuse damage, or reduced efficiency across a wide range of different functions. This differs from the localised and more complete damage to part of the brain which can result from a penetrating head wound, (for example a gun shot wound). A detailed analysis of the precise nature of cognitive impairment is essential because only once this is obtained, is it possible to predict the severity and nature of resulting disability, and accurately plan support needs.

The most common cause of severe head injury among adults are road traffic accidents which account for approximately a half (Kraus, Black, Hessol et al. 1984). Injury results from a blow to the skull which causes a fracture and bruising usually in a localised area of tissue both at the point of impact (coup), and at the area on the opposite side of the brain (contracoup). Rapid acceleration or deceleration can also result in more diffuse damage to axons and clusters of axons, and this is known as diffuse axonal injury. These forms of injury are known as the primary injury. During the days immediately following the primary injury, there is a high risk of further destruction of brain tissue due to a range of physiological processes such as haemorrhage, swelling of tissue (oedema), excess blood supply (hyperaemia), or under supply of oxygen (hypoxia).

A neuropsychological assessment serves a number of important functions including providing a detailed profile of cognitive impairment and emotional status. Detailed information regarding the individual’s specific deficits and residual strengths can inform the planning of rehabilitation, and appropriate work or educational placements. Neuropsychological assessment also provides an objective means of measuring changes in cognitive functioning, and evaluating treatment interventions.

Although a detailed assessment of the nature, extent and impact of cognitive impairment is of great importance, a Clinical Neuropsychologist can also assess other factors which are known to influence long term
outcome. Outcome is usually measured in terms of psychosocial functioning, for example, level of independence and capacity to fulfil socially valued roles relating to work, education, family and leisure. Psychosocial outcomes are not closely correlated with ratings of severity of cognitive and physical impairments. These two areas of impairment and functioning therefore both need to be carefully assessed in turn.

A number of key variables are known to significantly affect psychosocial outcome. Advancing age is associated with greater levels of morbidity and mortality (Stambrook, Moore, Lubrusko et al. 1993). There have not been found to be significant differences between different age groups in levels of cognitive impairment resulting from SHI, (Wilson, Visor & Bryant, 1991), however, younger patients (15 to 21 years) have been found to present significantly more behavioural and emotional problems than older patient (22-44 years old), (Thomsen, 1989). Patients suffering repeated head injury (Gronwall, 1989), or polytrauma where injuries are sustained in other parts of the body as well as the brain (Parker, 1990), are also associated with more severe neurological impairment. A history of alcohol or substance abuse also predicts poorer long term outcome (Dikman, Donovan, & Loberg, 1993). It is difficult to separate out the true reasons for this phenomenon but they are thought to include the educational level of this group of patients, and the effects of alcohol level at the time of the injury occurring.

The long term sequelae of severe head injury can extend to every area of daily functioning. The concepts of impairment, disability and handicap defined by the World Health Organisation, (WHO, 1980), provide a useful framework for understanding the different manifestations of a head injury. Impairment describes the affect of the injury on specific brain structures and functions. Disability refers to the difficulties resulting from impairment, for example difficulty in recalling instructions. Handicap refers to the social disadvantages for the individual and the limitations brought to their valued roles and responsibilities, a common example
being an inability to hold down a job. Clinical neuropsychology contributes to the assessment of all three areas of impairment, disability and handicap, but traditionally to impairment.

Assessment of impairment.

Developments in cognitive neuropsychology have led to a more detailed understanding of a greater range of cognitive processes. This has led to a change in the emphasis of neuropsychological assessment from identifying the location of lesions, to identifying the precise nature of cognitive defects, and relating this understanding to current theories of brain behaviour relationships. Therefore the focus has shifted away from diagnostic issues, to providing knowledge regarding the functional impact of specific combinations of impairments.

Diminished information processing efficiency due to reduced attention span and information processing speed is the most common consequence of SHI (McKinley, Brooks, Bond, Martinage, & Marshall, 1981). Difficulties in attention and concentration, and general slowness are likely to significantly depress an individual’s performance in tests of a range of different cognitive functions. It is difficult to objectively assess skills which we describe under the term ‘attention’, partly because this is not a unitary concept, and also because it has no agreed definition. A range of separate abilities come under the rubric of attention. These include speed of information processing, ability to focus attention and avoid distractions, the ability to divide attention across more than one task or aspect of a task, attention to visual and auditory detail, and ability to sustain attention.

Some tests have been devised specifically in order to assess attentional skills, for example, the Test of Everyday Attention (Robertson Ward, Ridgeway, & Nimmo-Smith, 1994). Attentional capacity can also be
gauged from the manner in which the individual approaches tests throughout the neuropsychological assessment, for example qualitative observation of distractibility and perseverance. Research evidence supporting the existence of attentional deficits is mixed, with some studies finding no difference between patients with SHI and controls in ability to shift, divide or sustain attention in a formal test situation, (Zomeren & Bouwer, 1990). Ponsford and Kinsella, (1992) identified a number of tests of speed of information processing which differentiate SHI patients from controls including the digit symbol sub test of the Wechsler Adult intelligence Scale (WAIS-R). However, they stress the limitations of assessing deficits in attention using formal testing because some attention difficulties are only manifested in more complex situations and over longer periods of time.

Memory deficit is also among the most frequent sequelae of SHI (Levin, 1989). The full range of memory impairments can occur including retrograde amnesia, difficulty in acquiring new information, or in retrieving newly learnt information immediately, or after a delay. New learning is particularly susceptible to damage, and the effects of this damage can be magnified by associated impairments in attention and/or executive functions. A full assessment of memory functions also has important implications for the planning of rehabilitation programmes.

Deficits in executive functioning also commonly occur in patients with SHI. Like the abilities which together determine the efficiency of information processing, executive dysfunction has an overlay effect on a wide range of other cognitive functions. Executive functions “enable a person to engage successfully in independent, purposive, self-serving behaviour.”4 These higher level cortical skills which are located largely in the prefrontal cortex have a number of essential functions including capacity for self awareness, self direction, self control and self regulation. When

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executive functions become compromised significantly, a level of disability and dependency can result which is disproportionate to the severity of the injury, even though many other areas of functioning may remain intact. For example, memory functioning may be spared but a lack of awareness of one’s self and surroundings may result in a patient becoming unable to use his memory unless prompted.

Not only are executive dysfunction’s disabling, but they also limit the potential of the individual to benefit from rehabilitation. For example, lack of self awareness and consequent lack of insight into one’s disabilities undermines motivation to participate in rehabilitation work, as do reduced initiative and apathy which can result from executive deficits. Key executive functions can be assessed both in formal tests of skills such as planning, problem solving, abstract thinking, idea generation and response control, and also through qualitative observation of initiative, self monitoring, error detection, and perseveration. These deficits are particularly marked in novel situations, and assessment needs therefore to include tests and materials which the patient is unfamiliar with.

Although these deficits can present in a subtle way, their effect is pervasive, and result in behavioural and emotional features which are often the hardest for family and carers to understand and deal with. Emotional disturbances can also have an organic basis in the frontal lobes and the underlying structures. There are two common patterns of emotional alteration in patients with SHI. The first involves exaggerated emotional experiences where the individual is excitable, impulsive and labile, and in the second pattern, the individual’s emotional experiences become dulled, leading the person to present as apathetic, flat, disinterested and non-initiating.

Cognitive, emotional and behavioural changes caused by SHI result in a fundamental change in the patient’s ‘personality’, which can be very difficult for those who were familiar with the pre morbid character of the
individual to adjust to. Some behavioural changes can occur which resemble psychiatric conditions, for example, negative symptoms of schizophrenia, disinhibited and florid behaviour similar to 'mania', and paranoia. Emotion control deficits can result in sudden outbursts of anger and aggression. Depression and anxiety tend to become more prominent in the longer term, as the individual becomes more aware of the extent of their disabilities (Prigatano, 1992).

As mentioned above, SHI can result in the full range of severity of damage in every area of cognitive functioning. Walsh (1991) recommends flexibility in selecting a range of tests which are appropriate to each individual patient with SHI, rather than employing a fixed battery of tests. This is because there needs to be more reliance on qualitative features of test performance when assessing a head injured person, because this provides more reliable clues as to the ways in which impairment will be manifested in every day living skills.

Tests of general cognitive skills such as the WAIS-R are often not sufficiently sensitive to pick up cognitive deficits which may be handicapping to the person in every day living. McFie (1975) studied a large number of head injury patients in the post acute stage of their injury, and found that many of them scored patterns on the WAIS which approximate the average. However, a large proportion of these same patients were found on closer examination to have a range of problems such as apathy, memory impairment, slowed thinking processes or mental tracking problems. It is not meaningful to talk about composite scores of IQ, particularly in individuals with greater levels of variability between specific functions. There is a danger that tests of general skills can lead to a misleading over estimation of a patient’s functional capacity, and this can be confusing for the individual, their family and those involved in treating them. Walsh (1991) argues that after following standardised administration of such tests, the experienced neuropsychologist can gain a fuller understanding of the nature of a patient’s difficulties by altering the
form of the test. This emphasises that the profile of test scores do not on their own inform a deep understanding of the cognitive and behavioural sequelae of SHI, but it is also necessary to closely observe qualitative aspects of test performance including the manner in which the patient approaches tasks set.

Assessment of disability

A neuropsychological assessment should also aim to investigate the impact that cognitive impairments have on everyday living. The disabling consequences of defects, particularly in executive functions has already been illustrated above. These cognitive impairments can result in greater levels of disability than physical impairments. Psychometric assessment does not enable the clinician to investigate the extent to which cognitive impairment affects daily living and the maintenance of valued social roles. Studies of recovery from head injury and long term outcome (e.g. Najenson et al. 1978) have found that despite improvements in general intellectual functions, a high proportion of patients with SHI do not return to open employment. A range of factors contribute to this including difficulties on the part of the patient accepting a decrease in work status, and difficulties on the part of colleagues and employers in understanding and tolerating changes in the patient's behaviour and personality.

The World Health Organisation define the concept of disability as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being".\(^5\) There is a wide range of behaviour rating scales and checklists for use both by patients themselves and relatives and carers to assess independence in activities of daily living (ADL). Some scales (such as the Barthel index) focus on aspects of daily functioning which are important for social independence. Rating scales tend to direct assessment towards

instrumental living skills such as shopping or food preparation. However, ADL scales have been criticised (for example by Ponsford, Sloan & Snow, 1995) for not placing sufficient focus on the subtle but pervasive behavioural deficits resulting from executive dysfunction, such as inability to initiate self care, plan spare time, or organise social events. Law (1993) has highlighted the rigidity and lack of client focus of ADL scales to be a further limitation. He argues that assessment should focus on skills identified by the patient to be important. Assessment of living skills also needs to take account of the extent to which the environment supports and facilitates the performance of living skills. For example, a hospital environment has more structure than most living environments. In order for an assessment of functional skills to have ecological validity, tasks which are similar to those faced in everyday living need to be presented in as natural a setting as possible.

Assessment of handicap.

Clinical neuropsychology also has a contribution to make is assessing the nature and extent of handicap which results from disability. Handicap is a socially constructed phenomenon arising from the implicit values placed on certain forms of behaviour by society and by people with disability. WHO define handicap as "a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual". There is no linear relationship between levels of impairment or disability, and level of handicap. Handicap is determined by the roles to which the individual aspired prior to the injury, and the level of support available to them post injury. Ponsford, Sloan and Snow, (1995) point out that there have been no studies which have investigated handicap (as defined by the World Health Organisation) as an outcome of SHI.

There are considerable methodological difficulties in ‘measuring’ handicap since it is a concept which is heavily dependent on a normative view of ‘ideal’ roles, which can be used as a reference to compare the patient’s actual roles against. Several methods for gaining an objective measure of handicap have been suggested. Rose & Johnson (1996) suggest using social adjustment scales such as the Portland Adaptability Inventory (Lezak, 1987), to measure the degree and quality of the individual’s participation in work, social, leisure, marital, wider family, and economic activities. Questionnaires such as the Rivermead Life Goals questionnaire (Davis, Davis, Moss, Marks, McGraph, Hovard, Axon & Wade, 1992) which have been designed to measure handicap from the perspective of the individual can also be used. As with the other areas of assessment however, there needs to be a balance in assessment techniques between structured, standardised measures, and less structured approaches procedures, which yield richer qualitative information about the individual.

Summary.

Clinical neuropsychology has an integral contribution to make to the assessment of the long term cognitive, behavioural and emotional sequelae of severe head injury. The primary role for a neuropsychological assessment is to provide a detailed assessment of the nature and extent of cognitive impairments resulting from brain damage. Psychometric assessment is the foremost method for measuring deficits and strengths in cognitive functioning. Beyond the application of standardised testing procedures, evidence from observation of qualitative aspects of the patient’s manner of test performance provides important clues as to how he/she will cope with challenges in daily living. It is recognised that psychometric tests do not have sufficient sensitivity to pick up the subtle but pervasive effects of impaired attention and
executive functions, which are two of the most common areas of cognitive impairment in head injury patients. A neuropsychological assessment can be crucial in helping to plan appropriate rehabilitation and long term support to the individual, and can be used to measure changes in levels of functioning over time.

In addition to assessing impairments resulting from SHI, the consequences of these impairments in terms of adaptive functioning, and personal and emotional adjustment are also within the domain of expertise of the clinical neuropsychologist. It is clear that the long term outcome of SHI depends not only on the severity of impairments sustained, but on a range of personal factors that are unique to each individual, and also to the level of demands and supports available to them in their environment. Successful rehabilitation involves addressing issues of psychological adjustment, and appropriate environmental support in addition to the remediation of the effects of cognitive impairment.
REFERENCES.


Thomsen, I.V. (1989). Do young patients have worse outcomes after severe blunt head trauma? *Brain Injury, 3*, 157-162.


CLINICAL DOSSIER.
Summary Of Clinical Placements.

1. Adult core placement.


Supervisor: Dr Brian Glaister

Address: Oxted Hospital
Eastlands way
Oxted
Surrey
RH8 0LR

2. PLD core placement.


Supervisor: Tessa Lippold

Address: Community Learning Disability Team
Northfield Hospital
Redan Road
Aldershot
Hants
GU12 4SR


Supervisor: Ann Kimber

Address: John Grenville House
72 Stockbridge Road
Chichester
West Sussex
PO19 2QJ
4. Older adults core placement.

Placement dates: 2nd May 1996 to 4th October 1996.

Supervisor: Lynn Beech

Address: Brecon House
Sutton Hospital
Cotswold Road
Sutton
Surrey
SM2 5NF


Supervisor: Noelle Blake

Address: Brecon House
Sutton Hospital
Cotswold Road
Sutton
Surrey
SM2 5NF

6. Specialist placement - Henderson Hospital therapeutic community.


Supervisors: Danka Gordon and Maggie Hilton

Address: Henderson Hospital
2 Homelands Drive
Sutton
Surrey
SM2 5LT
Abstracts Of Clinical Case Reports.

1. A behavioural assessment and treatment intervention of a woman with long term psychiatric disabilities.

This report describes a behavioural assessment and subsequent treatment plan which was implemented to modify aspects of the client's behaviour which were presenting a challenge both to nursing staff and to fellow residents of her group home. These behaviours (including screaming, shouting and damage to property) occurred predominantly at night causing maximum disturbance to other residents of the home. A functional analysis identified a range of factors contributing to the behaviour including inconsistent management of the problems by the staff team. The behaviour was formulated to primarily serve the function of enabling her to avoid demands made on her by staff. A behavioural programme encouraging reinforcement of appropriate behaviour, and consistency of management within the staff team was implemented for a period of five weeks. The outcome of the programme was evaluated through the recording of target behaviours by nursing staff. Improvement was observed in some targeted behaviours, but not in others. The report considers the reasons for areas of failure, and recommendations for a modified treatment plan are made.

2. Risk assessment and management of a man with learning disability and sexually offending behaviour.

A detailed assessment of factors contributing to a learning disabled man's sexually abusive behaviour is reported in this case study. This assessment included an in depth assessment of the client's sexual knowledge, and of his awareness of the social 'rules' surrounding sexual relationships. A formulation of the development and maintenance of the
his pattern of sexual behaviour is presented which incorporates his learning history, deficits in cognitive abilities, and deficits in his care environment which have prevented him from developing more appropriate ways of expressing his sexuality. The client was also hypothesised to target vulnerable people as sexual partners due to having limited social skills. The outcome of a course on sex education is reported, and recommendations for supervision and group therapy are made in order to address the continued high risk of further incidents of sexual abuse being perpetrated.

3. A cognitive-behavioural intervention of a five year old girl with encopresis.

This report describes the assessment and treatment of a five year old girl with primary encopresis which had proven to be resistant to a previous behavioural approach to management. The assessment includes an analysis of the reasons for the failure of the behavioural programme. The problem was formulated to serve a number of functions for the client. It conveyed onto her a special status within the family, and the behavioural programme itself contributed to secondary gain in the form of increased attention from her parents and siblings. Encopresis and soiling was also hypothesised to represent an important means by which the client expressed anger and frustration at her mother. A summary of treatment is provided which included reducing secondary gain for the problem, engaging the client in the process of treatment through individual sessions, and reinforcement of new activities which were inconsistent with the effort required by the client to control her bowel movements. The outcome of this intervention and a reformulation of the key maintaining factors of the problem are presented.
4. A psychotherapy case study of an elderly man with anxiety and depression.

This case report describes a psychotherapeutic intervention with an elderly man suffering from anxiety and depression. The client had a long standing phobia of heights, which had intensified in recent years due to his failing eyesight. The report describes the outcome of a life review which illustrated the psychological context of the emotional difficulties to include a pattern of abandonment in relationships throughout his life, including his relationship with his mother. This pattern was powerfully recreated during the therapy when the therapist was absent for two weeks due to annual leave, during which time the client’s wife left him unsupported causing him to be admitted to a nursing home on an emergency basis. The report discusses the transferential processes arising through these events between client and therapist, and also the process of establishing basic trust and bringing the therapy to an end.

5. A neuropsychological assessment of a woman with sub cortical dementia.

This case report briefly reviews literature on the nature and core symptoms of sub cortical dementia, and evidence supporting a classification of dementia which is separate from cortical dementia. The assessment of a female client referred by a consultant neurologist due to a combination of difficulties including weight loss, anxiety and memory impairment is described. This assessment included a detailed assessment interview, and a selection of psychometric measures assessing intellectual abilities, memory, language and executive functions. The assessment identified a number of symptoms which are consistent with a diagnosis of sub cortical dementia including a profile of cognitive impairments and spared cognitive functions. The client also
presented physical features such as masked face, muscular rigidity, lethargy and flatness of affect. A recommendation was made for a referral for a psychiatric assessment in order to rule out the possibility of a depressive disorder, and a further neuropsychological assessment was suggested to monitor for deterioration in cognitive abilities and increasing care needs.
Placement Contracts.
Clinical Psychologist in training  Tom Barker
Supervisor  Brian Glaister

Aims of Placement

The aims of the placement are to:

(a) Provide wide exposure to the adult mental health practice of the Trust.
(b) Develop understanding of the roles of clinical psychologists in the Trust.
(c) Develop some competency in formal psychological assessment in adult mental health.
(d) Develop some competency in the provision of psychological therapy in adult mental health.
(e) Develop skills in effective interaction with other members of the Trust. This requires comprehension of the Trust's structure and function.

Experiential Components Arranged by BG

Individual person centred, cognitive or behavioural therapy for a selection of suitable clients referred to Brian Glaister. This is to include an anxiety problem, a depression problem, and an eating disorder. Also if possible, an obsessive-compulsive disorder, a sleep disorder, a survivor of childhood sex abuse, a sex dysfunction, a marital/family problem, a personality disorder, difficulty with suicide thoughts, an adjustment disorder, a functional somatic disorder, and a problem for a person of non-caucasian race. (Aims DE)

Group Therapy as a facilitator/co-facilitator. A problem-solving group for functional elderly patients

Brief direct contact with an acute or continuing care psychotic disorder client

Psychological assessment for (a) psychoneurological referrals (b) vocational guidance referrals (GATB) and others if possible. (Aims CE)

Facilitation of staff group work and/or staff teaching. (Aims BD)

Presentation of a therapy case for the CBT Peer Supervision Group. (Aims D+E)
Exposure Components Arranged by BG

Spend specified time with:-

At least one week with rehabilitation psychologist. At least one day with sex dysfunction and abuse psychologist, mentally disordered offender psychologist, trauma psychologist, child psychologist, teaching psychologist, and two locality psychologists and with psychology technician. (Aims AB)

At least half a day with GP, Psychiatrist, Social Worker, Community Support Worker, Alcohol Worker, Physiotherapist, Occupational Therapist and Manager. (Aim A)

At least half a day with: The Trust's team for the elderly mentally ill including a review meeting, the Trust's team for rehabilitation including a review meeting, the Trust's close supervision unit including a Friday review, the Trust's team for substance misuse, Tandridge Day Unit, and Horley Living Skills Centre. (Aim A)

Educational Components Arranged by BG

Attend at least one meeting of:-

The Trust Mental Health Psychologist's Meeting and subsequent professional development event. (Aim B)

Locality Clinical Team (Aim B)

Locality Operational Policy Meeting (Aim E)

Case conferences as part of shadowing other staff. (Aim A)

Teaching session for ENB A12 (Aim B)

Sex Abuse Supervision Group (Aims BD)

Attend components of the Trust's medical training programme (Aims AE)

Supervision with Brian Glaister for two hours per week

Leave

23.12.94, 28.12.94-30.12.94, 03.01.95 + 5 days in March

Study Day

One day per fortnight
Reading List (for loan from East Surrey Library or from BG)


Burns DD 1989 The Feeling Good Handbook Plume/Penguin


Kaplan HS 1975 An illustrated manual of sex therapy London Souvenir

Lindsay S and Powell G 1987 A handbook of clinical adult psychology Gower Aldershot

Morgan HG and Morgan MH 1989 Aids to Psychiatry Third Edition Churchill/Livingstone Edinburgh

Rogers CR 1951 Clinical centered therapy London Constable


Young J and Klosko J 1993 Reinventing your Life Dutton/Penquin Bergenfield NJ


Listening List (for loan from BG)

Beck AT Cognitive Therapy for a case of depression

Beck AT Cognitive Therapy for an avoidant personality disorder

Beck AT Cognitive Therapy for a case of avoidant personality disorders

Beck AT Cognitive Therapy for a case of anxiety and panic

Beck AT Cognitive Therapy of depression: first interview

Ellis A Rational Emotive Therapy - Help Techniques
Materials

Loan of books and journals from the East Surrey Hospital Library

Loan of tests from the Psychologists' Library. (£30 deposit for initial item)

Loan of apparatus from the Psychologists' Apparatus store. (£30 deposit for initial item)

One copy of each of BG's current therapy forms

One copy of SCL 90 questionnaire plus each adult profile form

Loan of BG's dictation recorder

Loan of tape recorder

Loan of set of BG's relaxation tapes

One copy of BG's standard letters as follows:

Appointment letter
Change of appointment letter
Assessment report Schizophrenic thought disorder

Access to:

Trust Mental Health Psychologists' Handbook
Guide to Client Contact Data
Guide to Termination Form
Primary Aims of the Placement:

1. To develop a range of assessment and clinical skills and knowledge of service systems, whilst working with PLD and their carers. This will include people in community settings, and will cover a wide age range (childhood; adolescence; young adulthood; middle age; older people), as well as gender and ethnicity mix (where possible).

2. To be familiar with and use formal and informal assessment procedures appropriately with this client group, in both individual work and in work with carers and families.

Secondary Aims of the Placement:

1. To understand the different roles of other professional working with PLD, and the "systems" aspects of service delivery and development.

2. To experience and understand the organization of clinical psychologists in PLD work at departmental, Trust and regional levels.

3. To have the opportunity to develop observational techniques, information gathering, interpretation and reporting skills.

4. To become familiar with the network of service facilities available for PLD within hospital and community settings.

University Recommendations for the Placement:

1. Trainee should see in the region of 10 clients (direct work) over the duration of the placement; this would include people seen only for assessments, and where group work was undertaken, this would be taken into account.
2. Trainee should see clients in each level of severity;
   - mild
   - moderate
   - severe
   - profound and multiple handicap.

3. The placement will cover the following areas;
   - sexuality issue (relationships, sex education and social skills, abuse)
   - bereavement and loss (external and internal losses, transition issues)
   - skills teaching (could be joint with OT's or CPN's)
   - interpersonal skills, assertiveness, anger management
   - challenging behaviour (direct work with one client in a community setting; also involvement in a challenging behaviour service, unit or ward in a more observational capacity)
   - applying psychological models and clinical skills across specialities, perhaps with a client with anxiety or depression
   - residential placement of clients.

4. Trainee should have at least two clients where the main focus is through direct 1:1 client work, and at least two clients who have a high level of language.

5. Trainee should have knowledge about a range of therapeutic approaches; work at the Tavistock, RET, Personal Construct Theory, Gentle Teaching, Holding Therapy.

6. Trainee should have knowledge of organisational issues
   - interface with mental health services
   - service to carers
   - interface between social service and education etc.
   - Community Care Act
   - Education Act
   - Statutory Responsibilities
7. Trainee should have knowledge of the key practical and organisational issues related to resettling people with learning disabilities from hospital to community settings.

These Aims/Recommendations will be achieved by:

1. Experience working with the following client groups;
   - adult with mild learning disability
   - adult with severe learning disability
   - adult with profound learning disability
   - adolescent with learning disability
   - child with learning disability (max 2 clients).

2. Participating in a Social Relationships Group for clients with a mild/moderate learning disability (Group at Greenlaws).

3. Experience of formal assessment procedures used to measure;
   - general intelligence e.g. WAIS-R, Leiter
   - skills e.g. HALO, ABS
   - basis for teaching programmes e.g. Bereweeke, Portage
   - sensory loss, physical handicap, language disorder e.g., Leiter, Learning to Learn, Piagetian approaches
   - Needs e.g. IAN, IPP/Life Planning System.

4. Experience of other information gathering, analysis and evaluation;
   - audio tapes of client contact
   - data gathering and analysis related to behavioural approaches.

5. Planning and carrying out behavioural programmes by direct intervention to;
   - increase skills (minimum 1 client)
- decrease problem behaviour (minimum 1 client).

6. Planning and carrying out a behavioural programme through other agencies e.g. parents, staff.

7. Working with Community Nurses (joint working, input to groups).

8. Becoming familiar with one Portage Scheme.

9. Attendance at CDLT Business Meetings (when possible) and Client Meetings and other Client or Service Review/Management/Development Meetings.

10. Visits to residential and day care facilities as follows;
    - Hospital; Northfield
    - Social Services Resource Centre
    - Group Home
    - School/Nursery
    - Community based Day Services
    - Community and/or hospital based OT Department, Sensory Suite, Northfield.

11. Liaison with the following professionals as appropriate;
    - Ward/ Community Based Nurses/Care Staff in Homes
    - Speech Therapist
    - Physiotherapist
    - Doctor (Psychiatrist)
    - Social Worker
    - Day Centre Staff
    - Educational Psychologist
    - Occupational Therapist
Voluntary Agencies e.g. Mencap, Cheshire Homes
- Teachers.

12. Attendance at one meeting of Learning Disability SIG.
13. Attendance (when possible) at weekly Learning Disability Specialty Meetings, participating in taking Minutes.
14. Direct observation of supervisors, and opportunity to be observed by supervisors.
15. Undertaking suggested reading linked to clinical work (0.5 day/week).
16. Research day (1 day/week).
17. Study Leave (preceding submission date of PLD course work - 4 days total).

Supervision:
Formal supervision at least 1½ hours per week, plus informal supervision as required.

Tom Barker
Clinical Psychologist in Training

Tessa Lippold
Supervisor

23 May 1995
Child and adolescent core placement.

Contract for core placement in child and adolescents as per placement guidelines attached.
UNIVERSITY OF SURREY/STRHA(W)
PSYCH D IN CLINICAL PSYCHOLOGY
CORE PLACEMENT IN CHILD AND ADOLESCENTS
PLACEMENT GUIDELINES
SECOND DRAFT - OCTOBER 1994

INTRODUCTION

The Client Group

Children - principally in age range 0-16 with the flexibility to include premature neonates and 16+ as the transition from childhood to adulthood is not a clear one. Some of the legal rights of adults are conferred at age 16, others are reserved until age 18, while young people in special education may continue until the age of 19. The majority of services take the cut off as being leaving full-time education unless there is a specific service for adolescents.

Children and adolescents are developing and changing all the time and what is normal at one age may be a serious problem in an older or younger child. The foundation of working with this client group is a sound knowledge of normal development and behaviour of children in the context of home, school and peer groups. The range of problems which may be experienced is large and difficult to categorise.

The client group should include;

- Children whose development is progressing normally and who come into contact with services only because some aspect of their behaviour presents a management problem for their families, eg sleep problems, or temper tantrums.

- Children whose development is not progressing normally because of physical or intellectual delay/impairment, or chronic adverse social circumstances. These children may have long term contact with a large network of services.

- Children with educational, emotional and conduct problems which range from mild to severe and who may be in contact with a range of services.

- Children who have been diagnosed as having psychiatric illness such as Anorexia Nervosa, Obsessive Compulsive Disorder, Psychotic Disturbance etc. etc. Some of these children may be receiving help in residential services.

- Children who have been victims of physical and sexual abuse or who are beyond parental control and may be living at home, in foster care or in children's homes.

A major feature of work with this client group is the need to develop skills for dealing with the network that surrounds the child. At its simplest this may be the family and school. At its most complex it may include nuclear and extended family, School, Education Office, Social Services, Paediatricians, and Child Development Team etc. Consequently the psychologist needs the skills to interact with people of all ages from baby to grandmother and professionals from a wide range of statutory and voluntary agencies.
Philosophy

Within the whole range of services and agencies that cater for the needs of children and adolescents, there may be different perspectives and models of care and, at times, misunderstandings might arise if these are not recognised and addressed. Generally, however, most people would work the principle that the child's needs come first, and thus dealing with their situation is central to the focus of therapeutic work.

Principles and values held by clinical psychologists would generally include:

- That neither the child or his or her family are to blame for the presenting problem.
- That children’s development cannot be understood independently of the context of the family.
- That families have strengths which can be unlocked to resolve problems.
- That a family's difficulties cannot be understood independently of the context of the child’s development, the family life cycle and the wider network of school and neighbourhood.
- That the child should take an active part in the efforts to overcome his problem and should be included in all aspects of these efforts.
- That psychologists should incorporate equal opportunities in all aspects of their work considering gender, age and cultural/racial issues

Within child and adolescent work some of the models that might be encountered would include:

- Exposure to the Medical Model
- Psychodynamic Model
- Family Therapy Models; Systemic, Strategic, Structural
- Behavioural Model
- Developmental/Cognitive Model

Required experience with the client group

Trainees are required to gain the following experience or expertise to meet the requirements; where a particular placement cannot meet these it is initially the supervisor’s responsibility to seek out the relevant experience from another service; if it still cannot be achieved the Regional Clinical Tutor should be informed so that it can be built in later in the course.

Age

The trainee will see clients across the age span, covering preschoolers, middle childhood, early adolescence and, where possible, late adolescence.

Sex

Across child and adolescent work there is a preponderance of work with males due to a high incidence of problems (approximately a ratio of 4:1). The aim would be that the trainee would take on at least two female cases, bearing in mind the lower incidence of referrals.

Ethnic/cultural issues

The trainee will have some level of clinical contact with at least one client (and preferably substantially more) from a different cultural or subcultural background. Such contact should ideally be assessment or treatment, but if this is not feasible then observation of others’ work, case discussions etc. should be planned.
Settings

The trainee will carry out work in as wide a range of settings as is possible given that the range available will vary in different departments. Some areas that they should aim to work in would be special needs units, nursery settings, inpatient child and adolescent wards, schools, social service run centres and community.

Client work

The trainee will have direct experience with the problem areas described below.

a) **Child Protection** following abuse, high risk families, preventative work (to a limited degree).

b) **Child Development** challenging behaviours, anxieties and phobias, autistic spectrum disorders, family adjustment, separation and parenting issues.

c) **Under 8s** sleep, enuresis, encopresis, conduct disorders, attention deficit and hyperkinetic disorders, eating disorders.

d) **Health related problems** such as asthma, eczema, headache, pain, ME.

e) **School Based Problems** bullying, social anxieties, school refusal, peer relationship.

f) **Post trauma** eg, head injury, rehab, Post Traumatic Stress Disorder, bereavement, problems around divorce of parents.

g) **Adolescent Presentations** eg, anxiety, depression, attempted suicide, eating disorder, obsessive compulsive disorder, family breakdown, reconstituted families, substance misuse, social skills.

h) **Specialist areas** (limited involvement) Paediatrics, Special needs provision, Child Neuropsychology.

Number of clients

The trainee will see a number of clients during observation of the supervisor and will also undertake a number of assessments that may not lead to treatment. The aim should be that the trainee takes on approximately 10 independent treatment cases. In addition it is hoped that the trainee will be involved in a group.

Trainees will be seeing clients over different age ranges, with a range of different problems and different levels of severity. It will be impossible to predict exactly what might be available in terms of covering the whole list of areas; however, the aim should be that they see at least one child from each age range - pre-school, mid-childhood and adolescence.

Placement Guidelines

The following outlines what is seen to be good quality placement experience and skill development for trainees during their course. Experience is either categorised as essential or desirable depending on its level of importance. When a skill is described it is assumed that the skill will be reached by the end of the placement.
Psych D. Court in Clinical Psychology

Placement with Older Adults

Contract agreed between Tom Barker, Trainee, and Lynn Beech, Supervisor, outlining the work to be undertaken, and the experience to be gained in order to acquire a broad understanding of the health and social care needs of older adults with physical health problems, mental health difficulties associated with later life and those with dementia.

1. Direct work with clients
   a) Individual therapeutic work will be undertaken with a number of older people in order to gain a broad understanding of the psychological needs of this client group, the adaptations in therapeutic approaches required, boundary issues, counter transference, process issues, and the social context of the work. It is anticipated that the work will be done in a number of settings (e.g. the client’s own home).
   b) Group work will be undertaken to gain exposure to the issues outlined in (a) in a group context.
   c) Work involving neuropsychological investigation and its sequelae will be undertaken, possibly in conjunction with the neuropsychologist within the service.

2. Indirect work
   a) The provision of advice and support to relatives, informal carers and other health care workers may be undertaken where appropriate in a number of settings.
   b) The placement experience will aim to establish a broad understanding of the organisational issues confronting psychologists working with older adults in the context of a multi-disciplinary team and of a range of health and social care settings.

3. Research
   A small scale research project will be undertaken involving either an evaluation of clinical work undertaken on placement, or an evaluation of an aspect of a service provided by the Elderly Mental Health Team.

4. Teaching and Staff Training
   a) Teaching will be undertaken with non-psychologist staff within the Elderly Mental Health Team, for example on psychological approaches to dementia care.
   b) A training workshop will be carried out with care staff from at least one residential or day care setting. This workshop will focus on the principle of normalisation in dementia care, and will incorporate the use of the “Quality Lifestyles” training pack.

5. Organisational work
   A small scale project will be undertaken which may involve either carrying out a patient satisfaction survey in a dementia care ward, or an audit of the training needs of care staff employed by social services.
6. **Context**

The placement will aim to foster an understanding of the philosophical, social and political issues entailed in the development of a psychological service to older people. It is anticipated that this requires exploring work in the fields of social psychology, sociology, social gerontology and social anthropology in order to establish a sufficiently broad-based perspective.

Lynn Beech  
Consultant Clinical Psychologist

Tom Barker  
Clinical Psychologist in Training

Date ...........................................  

Date ...........................................
CLINICAL PLACEMENT IN NEUROPSYCHOLOGY

PLACEMENT CONTRACT

Psychologist in Clinical Training: Tom Barker
Clinical Supervisor: Noelle Blake, Clinical Neuropsychologist
Placement dates: 22nd October 1996 - 27 March 1997

A. PLACEMENT OBJECTIVES: General

(1) Tom will gain experience in providing a clinical neuropsychology service to adults with a range of neurological or neuropsychological problems on an inpatient and outpatient basis.

(2) Tom will develop competence in the selection, administration and interpretation of neuropsychological assessment techniques, and use these tools in a clinically meaningful way.

(3) Tom will develop competence in the application of clinically appropriate interventions in the management of neuropsychological disorders by means of individual and group based treatments.

(4) Tom will gain experience in working and liaising with other professional colleagues in the neurology specialty (i.e. doctors, physiotherapists, OT's speech therapists, social workers).

(5) Tom will develop insight into the role and functions of a clinical neuropsychologist providing a service within a general hospital.

(6) Tom will attend the regional Special Interest Group in neuropsychology and learn of its role and functions in addition to establishing contacts with other clinical psychologists working in the specialty.

B. SPECIFIC LEARNING OBJECTIVES:

(1) By the end of the placement Tom will have familiarised himself with a range of standardised neuropsychological tests and be aware of their appropriate selection and use in a clinical setting.

(2) Tom will be competent in selecting appropriate tests to assess:

(i) Verbal and non-verbal memory functions.
(ii) Perceptual functions.
(iii) Constructional functions.
(iv) Language functions.
Tests of attention, concentration and tracking.
Executive functions (planning and organizing).
Conceptual functioning.

He will demonstrate an ability to interpret these tests in a clinically meaningful way.

Tom will become familiar (through observation or direct clinical contact) with the major features and psychological implications of a range of common neurological disorders. Specifically, head injury, differential diagnosis of memory disorders, strokes, dementias, epilepsies, and progressive neurological disorders such as multiple sclerosis and Parkinson's disease.

Tom will be competent in his ability to:

(a) Feedback test results (in written and/or oral form) in a clinically meaningful way, to referrers and clients, as required.

(b) Advise clients on the implications of test results for their everyday functioning.

(c) Educate clients in appropriate forms of management or coping skills, depending on the nature of their deficits.

Tom will gain experience in advising and/or counselling relatives on the implications of cognitive dysfunction and on appropriate management strategies.

By the end of his placement, Tom will have formulated a view on the possible roles and functions of a clinical neuropsychologist in a general medical setting.

Noelle Blake
Chartered Clinical Neuropsychologist

Tom Barker
Psychologist in Clinical Training
Placement Contract

Trainee: Tom Barker

Supervisors: Danka Gordon
Maggie Hilton

Location: Henderson Hospital
2 Homeland Drive
Sutton
Surrey
SM2 5LT

Henderson Hospital is a national resource for the treatment of patients with a severe personality disorder. It operates under clear therapeutic community principles, combining psychotherapy and sociotherapy and has a national and international reputation. A year ago the Henderson Outreach Service Team (HOST) was established to extend this work into the community.

Placement aims:

1. To gain experience of assessing and treating people with severe personality disorders.

2. To gain experience and understanding of the therapeutic community model and its application in the wider community.

3. To gain an understanding of the dynamics and pressures associated with this work.

Methods of achieving aims:

1. Tom will participate in a three week induction to the therapeutic community, participating in a wide range of activities as well as regular groups occurring on a daily basis. This will include both verbal psychotherapy as well as work groups both of which will involve staff after groups. Tom will also attend the whole range of staff business meetings during this period.

2. Following this Tom will continue to spend two days per week participating in the therapeutic community, and one day will be spent working in the outreach service.

3. During the community days, Tom will attend staff handover, community meetings, work groups, staff after groups, and staff business meetings.

4. Tom will initially sit in on assessments undertaken by Henderson Outreach Service Team and will carry out assessments observed by the supervisor. Out patients will be seen at clinics in Littlehampton and Reigate.

5. Where possible, Tom will conduct and write up neuropsychological assessments on patients referred to the Outreach Service.
6. As well as providing assessments, where possible Tom will develop a small on-going case load of out-patients for brief focused therapy. As far as possible, Tom will have experience of a wide range of presenting difficulties and their management. These will include suicidal behaviour, eating disorders, substance misuse and other forms of self harm as well as harm to others, including violence and sexual offending. The methods used will be flexible including cognitive behavioural approaches as well as supportive psychotherapy.

7. Tom will attend a weekly staff training group in order to develop an awareness of the literature relating to working with this client group.

8. Tom will also attend a weekly staff supervision group in order to receive practical and personal support in conducting his work in the therapeutic community.

9. Visits to related services will be organised where possible, for example Greenwoods Therapeutic Community in Essex.

Supervision:

Danka and Maggie will both provide one hour of formal supervision per week. Supervision with Danka will be held on Monday mornings and will relate both to work in the therapeutic community and to out patient work carried out with patients in Reigate. Supervision with Maggie will be held on Tuesdays, and will relate to clinical work conducted with out patients in Littlehampton. Consultation and support is also available from other staff members.

Signed (Trainee) ___________________________ Date ________________

Signed (Supervisor) ___________________________ Date ________________

Signed (Supervisor) ___________________________ Date ________________
Research Dossier.
Part 1:

A review of research on the causes, course, and long term outcome of borderline personality disorder.
Abstract.

This review considers the research evidence supporting the existence of Borderline personality disorder, and the sources of controversy over the variations in the use of the diagnosis. The history of Borderline personality disorder is traced, and research examining the clinical characteristics of those who meet the diagnostic criteria, and the developmental history of those with the disorder is presented. A review of treatment outcome studies is also provided. Limitations in existing theory and knowledge regarding this complex disorder are considered.

What is borderline personality disorder?

Severe personality disorders are characterised by the presence of inflexible and maladaptive personality traits which are practised rigidly over a long period of time, and by a chronic tendency to avoid painful memories, associations and memories, (Millon, 1981). These traits lead to significant impairment and subjective distress, particularly in the domains of interpersonal relations, cognitions, affectivity, and impulse control. The essential features of borderline personality disorder (BPD) in the cognitive domain involve a severe instability of self image, a deficit in self control abilities, and a lack of the capacity to maintain a consistent perspective about significant others. Instability in the affective domain is also a typical feature. Dramatic shifts in mood involving depression, anxiety, irritability, anger outbursts, and impulsivity occur rapidly and often. The behavioural manifestations include recurrent suicidal gestures, self-mutilating behaviour, drug abuse, or aggressive outbursts.

The term was originally used within psychiatry to refer to patients who did not fit into either the "neurotic" or "psychotic" psychiatric categories, (Stern, 1938). BPD has since been developed in several different
directions. A number of psychodynamic formulations for BPD have been developed, most notable among which has been Kernberg's model of the personality structure of borderline patients, (Kernberg, 1967). Patients with borderline personality organisation are characterised by a failure to achieve a stable identity, the use of primitive defences, and generally intact reality testing which may fail under unusual stress. Kernberg's model has been criticised because it provides criteria which are broad and can therefore be applied to as much as 10% of the adult population (Stone, 1987). Perry & Cooper, (1986) have also argued that some people meeting diagnostic criteria for BPD do not present all of Kernberg's critical personality features.

Kolb & Gunderson, (1980) developed a model of BPD which describes it to be a distinct clinical syndrome characterised by impulsivity, manipulative suicide attempts, heightened affectivity, mild psychotic experiences, and disturbed close relationships. The improved reliability of this approach in terms of defining a smaller and more homogeneous group has been achieved at the expense of reduced validity, i.e. it emphasises the description of overt behaviour, which does not guide therapeutic thinking. In 1980, the Diagnostic and Statistical Manual of Mental Disorders (DSM III, APA, 1980), established a category of BPD which incorporated Kolb & Gunderson's work in a modified form. This definition of BPD was developed in the subsequent edition of DSM, where it is regarded to be a distinct personality type, (APA, DSM III-R, 1987). The diagnostic criteria for BPD presented in the most recent edition of DSM (APA, 1993) are shown in table 1 below.

Evidence available points against the usefulness of the descriptive diagnosis of BPD. Tyrer, Seivewright & Ferguson, (1990) failed to find any predictive value of categories of personality disorder in terms of response to different treatment interventions. The heterogeneity of symptoms and mental disorders which appear to co-occur with BPD is a key feature of the disorder, and this makes accurate diagnosis
problematic. Clarkin, Widiger, Frances, Hurt & Gilmore, (1983) found that even when the consensus of three raters for the presence of each of the DSM III criteria was required, 60% of their sample met the criteria for other personality disorders as well.

Table 1.

<table>
<thead>
<tr>
<th>Diagnostic criteria for 301.83 Borderline Personality Disorder</th>
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<tr>
<td>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</td>
</tr>
<tr>
<td>(1) Frantic efforts to avoid real or imagined abandonment. <strong>Note:</strong> Do not include suicidal or self-mutilating behaviour covered in Criterion 5.</td>
</tr>
<tr>
<td>(2) A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.</td>
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<tr>
<td>(3) Identity disturbance: markedly and persistently unstable self-image or sense of self.</td>
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<tr>
<td>(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). <strong>Note:</strong> Do not include suicidal or self-mutilating behaviour covered in Criterion 5.</td>
</tr>
<tr>
<td>(5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.</td>
</tr>
<tr>
<td>(6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).</td>
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<tr>
<td>(7) Chronic feelings of emptiness.</td>
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<tr>
<td>(8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).</td>
</tr>
<tr>
<td>(9) Transient, stress-related paranoid ideation or severe dissociative symptoms.</td>
</tr>
</tbody>
</table>
Borderline personality disorder is a controversial concept. Critics of the concept of BPD have argued that it is a meaningless wastebasket category (Abend, Porder, & Willick, 1983), and a pejorative label for patients who are difficult to treat, (Millon, 1981). Others have recognised the limitations of the concept, but support its continued use until more adequate concepts are developed which correspond to a comprehensive psychological model of the disorder, (Fonagy & Higgett, 1992). Fonagy & Higgett argue that it is precisely the ambiguity of the term borderline personality disorder which makes it useful, because this enables flexibility in the way the term is used.

In spite of the ambiguity associated with the concept, Fonagy & Higgett identify three unequivocal features of the group of patients who meet the criteria for the various models of BPD. These include the heterogeneity of symptoms, marked lability in behaviour and coping ability, and impairment of interpersonal relationships. It seems that, although no single model has adequately described or explained the clinical phenomena which represent borderline personality disorder, the category does denote a specific group of patients who are widely identifiable, if only by the negative emotional reaction they typically invoke in clinicians.

**Characteristics of patients diagnosed with borderline personality disorder.**

The majority of those diagnosed with a personality disorder are classified under the category of Borderline Personality Disorder. In the United States, 11% of psychiatric outpatients and 19% of psychiatric inpatients are estimated to meet the criteria for borderline personality disorder, (Widiger & Frances, 1989). Approximately three quarters of those with the diagnosis of BPD are women (Widiger & Frances, 1989), and around 75% of women with BPD have been victims of childhood sexual abuse.
Around 75% of clients with BPD have a history of at least one act of self harm (Clarkin et al. 1983; Cowdry, Pickar, & Davis, 1985). Borderline patients have predominantly been found to be between the ages of 18 and 45 (Akhtar, Byrne, & Doghramji, 1986), and the symptoms of BPD tend to decrease in severity and prevalence into middle age (Paris, Brown, & Nowlis, 1987).

There is a very high risk of completed suicide in BPD patients. Stone, (1989) found that 36% of individuals who met all eight DSM III criteria on admission to hospital committed suicide, (follow-up period 10 to 23 years). The suicide rate for individuals meeting 5 or more DSM III criteria is between 7% and 9%, (Stone, 1989; Paris, Brown & Nowlis, 1987). The risk of suicide is greatest in the early years after first contact with psychiatric services (approximately 5% in the first year), and levels off after that by 0.3% per year (Perry, 1993).

**Developmental history of borderline personality disorder.**

There have been many studies which have shown severe disruption in relations with primary caretakers during early childhood to be an important factor in the development of BPD. Parental neglect is cited by Walsh (1977), Frank & Paris (1981), Gunderson (1984), and Feldman & Guttman (1984) to be a significant causal factor. A number of studies consisting of a retrospective review of case notes have demonstrated a significant proportion of BPD patients experiencing early, prolonged separation from or permanent loss of primary caretakers, (Akiskal, 1981; Soloff & Millward, 1983; Bradley, 1979).
More recent studies have provided evidence of the role of childhood trauma in the development of the disorder. Stone, (1981) found that 75% of a small sample of hospitalised patients (12) had a history of incest. In a review of hospital records Herman, (1986) found that 67% of outpatients with BPD had a history of abuse in childhood or adolescence, compared with 23% of the entire outpatient population. Bryer, Nelson, Miller & krol, (1987) found that 87% of hospitalised BPD patients they interviewed had experienced sexual abuse before the age of 16.

Herman, Perry, & Van der Kolk, (1989) compared 21 subjects diagnosed with BPD with a sample of people with borderline traits and a psychiatric control sample. All subjects underwent a structured interview and completed a number of self report questionnaires. 81% of the BPD sample gave a history of major childhood trauma, compared with 73% of the borderline traits sample and 53% of the psychiatric controls. Histories of trauma during early childhood (0-6 years) were found almost exclusively in BPD subjects. 53% of this group reported such a history.

Herman et al. (1989) found that BPD subjects not only suffered abusive experiences more commonly, but reported more types of trauma, beginning earlier in childhood and repeated over a longer period of time. These authors awarded a childhood trauma score to each subject which was derived from the number of different severe traumas experienced. The mean trauma score for BPD subjects (4.29) was significantly higher than the borderline trait sample (1.73), and the non borderline group (1.63).

Ludolph, Westen, Misle, Jackson, Wixom & Wiss, (1990) in a study of adolescents who met adult criteria for BPD also found a strong association between the diagnosis of BPD and a history of abuse in childhood. 50 inpatients were assigned to one of two groups on the basis of a Diagnostic Interview for BPD (DIB, Gunderson, 1981), carried out by
two interviewers. 27 subjects met the criteria for BPD, and the remaining 23 were assigned to the non borderline control group.

The BPD group were more highly associated with maternal risk factors, (psychiatric illness or disorder, losses, separation, and abuse), and preoedipal risk factors, (separation, losses, and abuse before age 5). They were significantly more likely to have been adopted (23% compared with 0% of the non borderline group), and had significantly more surrogate mothers and fathers, and significantly more foster care placements.

The families of BPD patients were more likely to have been involved with protective services (37% compared with 13%), and 44% had a history of neglect by primary caretakers, (compared with 17% of non BPD patients). 41% of the BPD sample had been forcibly removed from their homes, sometimes with court involvement (compared with 8% of controls), and 44% had experienced “grossly inappropriate parental behaviour” (for example repeated violent, sexual, and sadistic behaviour).

Both groups had high rates of first degree relatives with major psychiatric illnesses. However, the borderline group were more likely to have mothers with BPD, particularly when adoptive mothers were included. Mothers of the borderline patients also tended to have been physically abused and to be physically abusive.

The authors conducted a logistic regression analysis and found that nine variables predicted 89% of the diagnoses of BPD. These variables included neglect, maternal rejection, grossly inappropriate parental behaviour, parental loss, number of surrogate mothers and fathers, number of relocations, physical abuse, and sexual abuse. Their findings did not support the notion that BPD is the result of trauma in any single phase of development. Instead, trauma was cumulative in its effect, and started earlier in life.
The Long Term Outcome Of Borderline Personality Disorder.

Details of the long term outcome of BPD have been provided by a number of follow-up studies. Werble, (1970) and Carpenter & Gunderson, (1977) found that outcomes for BPD patients at 5 to 7 years after discharge were mostly poor or indifferent. Werble, (1970) interviewed 28 discharged patients five years after discharge from inpatient treatment. 46% had been re-hospitalised during this time, and 67% had received outpatient treatment. This group continued to exhibit active symptoms of BPD including impaired relations, and lack of leisure time.

Carpenter & Gunderson, (1977) followed up a small sample of BPD patients 2 and 5 years after discharge from inpatient treatment. They found that there was no change in global ratings of functioning. Symptoms such as impulsiveness and intense affects continued, and this group also continued to exhibit chaotic social relations, lack of stable employment, and frequent re-hospitalisations.

The limitations of these studies include the small sample sizes used, the relatively brief time period covered, and low patient trace rates. Longer interval studies which have been conducted more recently show that BPD patients who survive the first 5 to 10 years post discharge, have considerably better outcomes, (Plakun, Burkhardt, & Muller, 1985; McGlashen, 1986; Paris et al., 1997; Stone, Hurt & Stone, 1987).

Plakun et al., (1985) followed up 63 clients with BPD who had spent an average of one and a half years at an inpatient unit receiving intensive psychoanalytic psychotherapy. The mean follow-up interval was 13.6 years. The dependent measure used was the Global Assessment Scale (GAS), (Endicott, Spitzer & Fliess, 1976), which allows a rater to assign a composite score representing many elements of psychopathology. A
baseline GAS was obtained from a review of medical records. Follow-up GAS was based on responses to a 50 item questionnaire. The outcome of BPD was compared with samples of patients with other disorders including schizotypal personality disorder, schizophrenia, and major affective disorder.

The authors found that GAS scores improved for all clinical groups. Patients with BPD functioned better than schizophrenics at baseline and at follow-up. The mean GAS score for the BPD sample was 34.9 at baseline, and 67.0 at follow-up. This improvement was attributed by the authors to treatment rather than the natural history of BPD irrespective of treatment.

McGlashen, (1986) conducted a follow-up study of 81 patients with BPD, who spent an average of 2 years treatment at a specialist inpatient unit (Chestnut lodge). The outcome for these clients were compared with those of schizophrenics and unipolar depressed patients. The average interval between discharge and follow-up was 14 years. 87% were still alive at average age of 47 years. In comparison with the schizophrenic group, BPD clients had significantly better scores on most outcome indices, but most had made their progress during the second decade after discharge. Global functioning according to the Health-Sickness Rating Scale (HSRS) averaged 64 for BPD patients, compared to 60 for unipolars, and 37 for the schizophrenic group.

The BPD subjects spent an average of 8% of the follow-up period in hospital, (compared with 45% for schizophrenics). They were employed for 68% of the follow-up period in relatively complex jobs, (30% for schizophrenics). 70% of borderlines married and 48% had children. There was a subgroup within the BPD sample who avoided sexual relationships, and eschewed dating altogether. Borderline patients experienced moderate psychiatric symptoms for 50% of the follow-up period. Most BPD patients demonstrated some persisting
psychopathology at follow-up, usually in the form of depressive signs, and action oriented impulsive solutions to problems, including substance misuse. The suicide rate in this study was 3%.

Paris, Brown, & Nowlis, (1987) interviewed 100 patients, an average period of 15 years after discharge from treatment as inpatients at a general hospital. Outcome was measured by the Diagnostic Index for Borderlines (DIB), (Gunderson, Kolb, & Austin, 1981), the HSRS, and the Schedule for follow-up of borderline patients, (Grinkler, 1968).

The authors found that only 25% of the sample still met DIB criteria for BPD. The mean total DIB score fell from 7.94 to 4.54. There were dramatic reductions in mean scores for the impulse-action scale (from 1.44 to 0.33), and affect scale (from 1.99 to 0.76). Social relations were noted to be less intense and chaotic, and in many cases were characterised as being withdrawn and lacking intimate relations at follow-up. The mean HSRS score was 63.2 which is within the "generally functioning well" range.

Stone, Hurt, & Stone, (1987) conducted the largest longitudinal study, of patients discharged from the New York state psychiatric institute. They followed up 181 clients with BPD who had an average stay of 12.5 months, receiving psychoanalytic psychotherapy. A sample of 95 schizophrenics were also followed-up. 80% of the BPD clients were first admissions. A baseline global assessment was carried out from medical records using the GAS, and the follow-up consisted of a telephone interview.

Stone et al. (1987) found the BPD group to be functioning significantly better than schizophrenics at follow-up. Concomitant major affective disorder (MAD), was present in 67.6% of BPD patients, and these clients were functioning better at follow-up than those without MAD. 21% of the BPD group achieved GAS scores of greater than 60, which indicates
much improvement, and 42% achieved scores greater than 70 which meets the criteria for clinical recovery. There was no significant difference in suicide rates between BPD and schizophrenic patients. The overall suicide rate of 9% ranged from 5.4% for BPD females without MAD, to 18.5% among BPD males with MAD. 76.5% of suicides in BPD occurred under age 30 years.

These four studies have found consistent results regarding the long term outcome of BPD. After 10 to 15 years, BPD patients seem to lose their active symptoms including impulsive behaviour, affective symptoms, and chaotic, intense relations. Global assessments of functioning indicate that during their forth decade of life, BPD patients tend to resemble patients with affective disorders, exhibiting some mild residual problems in the areas of employment and social relations. Their level of functioning is significantly better than that of schizophrenics. The rate of suicide ranged from 3% to 9% in these studies, and the period of maximal suicide risk was found to be between the ages of 20 and 30 years.

There are a number of limitations in the methodology used in each of these longitudinal studies. It was necessary to conduct retrospective diagnosis from chart reviews, because the diagnostic category for BPD did not officially exist at the time that the patients were originally being treated. The baseline assessments were also retrospectively carried out in this way. None of the studies used a standardised interview in their assessments. No efforts were made to control for treatment variables in any of these studies, so it is therefore not possible to delineate the role of treatment in assisting the recovery of patients assessed. Furthermore, none of the studies used control samples of BPD patients, so the course of BPD when untreated is not known.

The studies have provided valuable information regarding the long term outcome of BPD, but they do not help to explain the course of the disorder in-between early treatment and long term follow-up. In particular, the
effects of treatment on long term outcome are unclear. Plakun et al. (1985) attribute the positive outcome found in their study to treatment received. Stone et al. (1987) disagree with this, instead arguing that the improvements that they have observed represent the natural history of BPD.

Treatment outcome studies.

There is a conspicuous lack of research to support the efficacy of treatments for BPD, particularly in the short term. In particular, there have been few attempts to carry out controlled outcome studies, (Linehan, 1991; 1993). Controlled outcome studies are particularly difficult to undertake with BPD subjects because of the length of treatment required, the high drop out rate which is characteristic of this client group, and because of the difficulty of obtaining an experimental control sample. Cognitive-behavioural treatment interventions for BPD have been evaluated using the alternative though less empirical methodology of the single case study, (Turkat & Maisto, 1985; Turner, 1989).

Turkat and his colleagues have used a single case experimental design with clients with a range of different personality disorders. Their treatment involved cognitive-behaviour therapy, with an emphasis on individual formulation as opposed to matching interventions to symptoms. Their results indicate that treatment was ineffective with many patients. For example, Turkat & Maisto, (1985) presented 35 cases, of which only 3 had a reported positive outcome. Difficulties which they frequently encountered were an inability to develop a formulation based approach, subjects unwillingness to engage in treatment, and premature termination.

Turner, (1989) conducted a case study evaluation of four BPD patients who underwent an intensive bio-cognitive-behavioural treatment. The study was divided into six periods: A baseline of two weeks, a medication
only phase of two weeks (Alprazolam was prescribed to each patient for six months), an evocative flooding phase of two weeks, a covert rehearsal and cognitive therapy period of four weeks, a four week period of cognitive therapy, and a maintenance therapy period of nine months.

Repeated assessments indicated that the intensive treatment plan, except for the flooding component correlated with reductions in self reported frequency in the most problematic cognitions, behaviours, and mood disturbance for three of the four patients. The alprazolam primarily impacted mood ratings. The cognitive and behavioural components were correlated with reductions in the frequency of the worst symptoms and further mood improvement. All four were still in therapy at 12 months. At two years follow-up, two patients had maintained their improvement, one remained unchanged, and the fourth had lost her gains.

There are a number of methodological limitations to this study which include the case study design, the small number of subjects completing the treatment, the lack of a control group, the use of one outcome assessor who was not blind to treatment condition, and the lack of a control for the order effect in the provision of the treatment components. The favourable outcome of the study does not provide a basis for drawing firm conclusions about the efficacy of this treatment approach.

Psychoanalytic therapists have also used the case study methodology to evaluate treatment outcome. Waldinger & Gunderson, (1984) conducted a survey of therapists to assess the type and outcome of therapy used with BPD patients. Eleven therapists participated, and were required to retrospectively complete a two page questionnaire for patients who successfully completed therapy. Data were collected for 78 patients who collectively were treated over a period of three decades. Level of functioning at the start and end of therapy was assessed using a seven point anchored scale to measure four parameters: ego functioning, behaviour, object relations, and sense of self. No attempt was made to
verify either the reliability of therapist’s ratings, or the validity of the outcome scales used to measure progress.

59% of the patients included in the survey received psychoanalysis while 41% received intensive psychotherapy. Average length of treatment was four and a half years, three times per week. The sample had a considerable amount of previous therapy (mean 2.9 years). 56% terminated treatment gradually, rather than precipitously (44%), and 60% terminated therapy against their therapist’s advice. Patients in psychoanalysis were less likely to end therapy precipitously and had fewer months hospitalisation during the first year of treatment. In all areas, patients improved significantly, but no patients were reported to have recovered completely. At the end of therapy, patients in psychoanalysis were reported to have better object relations and sense of self than those who had been in psychotherapy. There was no difference in the level of improvement in ego functioning or behaviour. The longer patients were in treatment, the more they improved. Furthermore, the more previous therapy received, the greater the treatment outcome.

Stevenson & Meares, (1992) have also conducted an outcome study in which they have successfully demonstrated the effectiveness of psychodynamic therapy for patients with BPD. The treatment model used was based on Kohut’s self psychology approach, (Kohut, 1977) and treatment lasted for one year. 30 patients were included in the study, and all were diagnosed according to DSM III criteria, and on dynamic grounds also. There was no control group in this study. The authors compared level of functioning during the twelve months prior to treatment with the twelve months after treatment. They argued that although not ideal, comparison between different periods of the patient’s lives offers a suitable means of obtaining a control since personality disorder is relatively enduring.
At follow-up there was a significant reduction in the number of DSM criteria fulfilled by the subjects (mean=10.50), compared with pre-treatment, (mean=17.40). The most frequently observed changes were reductions in impulsivity, affect instability, anger, and suicidal behaviour. 70% of subjects fulfilled criteria for BPD at follow-up. There was a marked improvement on a number of objective behavioural measures. The number of episodes of self harm dropped from a mean of 3.77 per year to 0.83 per year, and the mean number of incidents of violent behaviour dropped from 2.70 to 0.80 per year.

There has been only one controlled outcome study which has evaluated a treatment intervention for BPD, (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Heard & Armstrong, 1993). Linehan and her colleagues conducted a randomised clinical trial to evaluate the effectiveness of dialectical behaviour therapy (DBT) compared with a control condition of “treatment as usual” in the community. The DBT model views BPD to be a primary disorder of the emotion regulation system, and argues that it is caused by a combination of biological factors and inadequate social learning experiences. The term ‘dialectical’ is used to convey the multiple tensions which coexist with BPD. This model emphasises the need for therapy to simultaneously address dialectically opposed issues, for example, the need to accept patients as they are within a context of trying to teach them to change.

22 subjects were randomly assigned to each treatment condition. All subjects met diagnostic criteria for BPD and were chronically parasuicidal. Treatment lasted for twelve months. The DBT group received weekly individual therapy which balanced directive, problem-oriented techniques with supportive techniques. Treatment goals were hierarchically ordered by importance as follows: 1) reduction of parasuicide and life threatening behaviours, 2) reduction of behaviours that interfere with the process of therapy, and 3) reduction of behaviours which seriously interfere with the quality of life. The emphasis of therapy was on teaching patients how to
manage emotional trauma rather than reducing or taking them out of crises. Telephone contact with the therapist was permitted in-between sessions. Group therapy met weekly for two and a half hours and followed a psycho-educational format. The “treatment as usual” group received individual psychotherapy during the trial.

All subjects were assessed at pre-treatment, 4, 8, and 12 months by a team of researchers who were blind to the treatment condition. Assessments involved structured interviews to obtain information about frequency and extent of parasuicide episodes, the type and amount of professional mental health and medical treatment and inpatient care received, and self-report measures of suicide ideation, depression, hopelessness, and positive expectancies of living. There were no significant pre-treatment between-group differences on any measures.

The results of this study indicated a significant difference in the frequency and extent of parasuicide between the groups. Control subjects engaged in more parasuicide acts than DBT subjects (median parasuicide acts throughout the year was 9 for controls, and 1.5 for DBT subjects). The DBT group had a significantly lower therapy drop out rate. 83.3% of DBT subjects maintained therapy with the same therapist for the entire year, (compared with 42.0% of controls). Control subjects had significantly more psychiatric days, (38.8 days compared with 8.5 days), and also had a higher number of hospital admissions per person. The self-report questionnaire data suggested that DBT was not effective in improving subject’s depression, hopelessness, suicidal ideation, or reasons for living.

The authors were not able to identify which aspects DBT were responsible for this positive effect, i.e. the individual therapy, group behavioural skills components, or a combination of the two? The fact that a marked behavioural improvement was achieved without a concomitant improvement in mood and cognitions was also difficult to explain.
39 of the subjects were included in a follow-up study (Linehan et al., 1993), which demonstrated that the gains made by patients who received DBT were maintained throughout the follow-up year. The DBT subjects had fewer parasuicidal episodes, although this difference was not statistically significant during the second half of the year. The DBT subjects also reported significantly better employment performance, significantly less anger, and better social adjustment.

**Discussion.**

Borderline personality disorder has been the subject of a considerable amount of research. Despite the volume of these investigative endeavours, the condition has continued to elude attempts both to generate a universally acceptable definition, and to develop a comprehensive psychological model of aetiological mechanisms. The two most significant areas of theoretical development include psychodynamic formulations, most notable of which has been the work of Kernberg, (1967), and personality trait models such as the DSM III category of BPD, (APA, 1980).

Despite the differences in the focus of inquiry of each approach, and the marked heterogeneity among those diagnosed with BPD, the two approaches appear to have described a clinical population which is largely overlapping. There are problems of reliability and validity regarding both Kernberg's attempt to identify the key psychodynamic mechanisms of borderline patients, and Gunderson's phenomenological account of the disorder (Gunderson, 1984). However, both bodies of work can be seen to have contributed to the development of the concept which has been widely used in psychiatry for a long time, and sometimes in a harmful way.
There has been considerable controversy about the use of the term ‘borderline personality disorder’. The main lines of disagreement include the pejorative potential of the concept to label and blame patients who are difficult to treat (Millon, 1981). The concept has also been criticised as meaningless because of its potential to be used to mean different things, the tendency for BPD patients to be classifiable under a range of other diagnoses simultaneously, and because it has a low predictive value in terms of the long term outcome and response to different treatments.

Higgett & Fonagy, (1992) argue that the ambiguity inherent in the concept is actually an important strength. They argue that the complexity and heterogeneity of the features and causes of BPD requires concepts which can be used flexibly. However, in spite of this ambiguity, there is a consensus within clinical and research literature across the theoretical spectrum regarding the core features of BPD. These unequivocal features include the marked heterogeneity of symptoms, variability in behaviour and coping ability, and impairment of interpersonal relationships.

The development of a comprehensive descriptive model of BPD by the Diagnostic and Statistical Manual of Mental Disorders, (APA, 1980) has improved the reliability of accurately identifying individuals with the core features of the disorder, and this has facilitated a large amount of new research. This research has generated new knowledge regarding the prevalence (Widiger & Frances, 1989), clinical characteristics (Clarkin et al. 1983) and developmental history and common childhood experiences of patient with borderline personality disorder, (Stone, 1981; Herman, Perry & Van der Kolk, 1989; Ludolph et al. 1990). A reliable diagnostic system has also enabled empirical research into the prevalence of self injurious behaviour (Widiger & frances, 1987), and completed suicide (Stone, 1989; Paris et al. 1987) among this client group.
There continues to exist a conspicuous lack of comprehensive and empirical research to evaluate the short term effect of psychotherapies on BPD. Most research studies on treatment outcome have adopted a case study design methodology and are therefore of limited value in determining the efficacy of individual treatment approaches. The results of some uncontrolled treatment studies (Turner, 1989; Stevenson & Meares, 1992), have indicated that a relatively brief period of psychotherapy (one year) does have a positive effect on the symptoms of BPD. The results of the only controlled treatment outcome study conducted with BPD patients (Linehan et al. 1991; 1993), demonstrated that a relatively brief period of combined group and individual therapy can have a significant impact on the most problematic aspects of the disorder such as parasuicide and terminating therapy. This study did not demonstrate a significant improvement in the affective features of the disorder, (depression or hopelessness).

Longitudinal studies suggest that the prognosis for BPD is poor over the two to seven year time period, (Werble, 1970; Carpenter and Gunderson, 1977), while over the longer term (ten to fifteen years), people with a diagnosis of BPD seem to lose their active symptoms including impulsive behaviour, affective instability, and chaotic, intense relations, (Plakum et al. 1985; McGlashen, 1986; Paris, Brown, & Nowlis, 1987; Stone, Hurt, & Stone, 1987). Measures of global functioning at long term follow-up indicate that borderlines continue to experience mild problems in the areas of employment and social relations, and that they tend to resemble patients with affective disorders, experiencing some residual emotional difficulties.

These longitudinal studies do not provide evidence which proves that improvement over the long term is due to treatment received, and it is possible that they are illustrating the natural course of BPD irrespective of treatment received. The studies only provide a snapshot of how patients are functioning at two particular points in time, and it is not possible to
conclude from them the course of the disorder in-between early therapy, and long term follow-up. It would be helpful for future research to follow a life span developmental perspective to address this issue.

It is clear that there is a great need for further empirical research to establish the efficacy of different treatment intervention for BPD. In particular, it would be helpful to examine what aspects of successful psychotherapies are responsible for promoting positive change, and also to gain a greater understanding of the process of therapy with this client group.
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Words: 5,300.
Part 2:

Second year research/research on clinical placement.

A pilot study of depression and psychological adjustment in later life.
ABSTRACT.

A pilot study was conducted to investigate depression and psychological adjustment in a small sample of five older adults. Data were collected using a semi-structured interview schedule, and a series of measures were also administered in order to provide quantitative descriptive data on important variables including severity of depression, the presence of cognitive impairment, suicide risk, level of social support, and perceived physical health status. The interviews were recorded and transcribed verbatim, and a thematic content analysis was used as the method of analysis. The study describes life events which were attributed to be etiological factors of depression by the participants, and provides a phenomenological account of the experience of depression. Three issues have arisen from the data which seem to be key to successful adjustment to old age. These are social support; the ability of the person to accept increasing dependence on others, and their ability to undergo role transition. An impoverished social network and an extreme reluctance to depend on others were found to coexist in three of the participants. The same participants also appeared to be struggling to maintain a positive and integrated self identity due to the loss of important roles and relationships. The limitations of this study and its implications for further research are considered.
INTRODUCTION.

The incidence of depression among the elderly is higher than other age groups within the population, although epidemiological studies have produced varied findings. The general trend of such research is that primary depression, which is thought to have an organic basis occurs at a slightly higher rate than among the general population at about 1.7% (Reiger, Myers, & Kramer et al. 1984). However, when secondary depression, (or reactive mood disorder accompanied by problems of adaptation) is included, the incidence is thought to be approximately 13% to 16%, (Blazer & Williams, 1980; Murrel, Himmelfarbs & Wright, 1983). Depression in late life often presents with atypical symptoms, and consequently it can be difficult to identify. This is one reason why the true incidence of depression is not known.

In the past, depression in later life was thought to represent a separate disease entity, characterised by fear symptoms, resignation, and hypochondriacal symptoms. Somatic symptoms, anxiety and cognitive impairment are more prominent features of depression in old age, (Gurland, Dean & Cross, 1980). There is thought to be a closer connection between mental and physical health phenomena in later life, (Berkman & Syme, 1979; Kasl, 1977; Parkes, 1964). Depressed older adults have also been found to have higher frequencies of health concerns (Cohen & Eisdorph, 1985). 15% to 20% of depressed older adults have been found to exhibit signs which are suggestive of a progressive dementing process, including decline in intellectual abilities and concentration, memory difficulties, and apathy, (Caine, 1981).

The literature indicates two main areas which are believed to contribute to the aetiology of depression in older adults: age related biological changes, and psychosocial factors such as loss. There is evidence of biological changes in the endocrine, immunological and central nervous
systems, and also of structural changes to brain tissue in late life, which are thought to be associated with changes in behaviour and affect, (Baldessarini, 1983; De Leo & Diekstra, 1990; Conwell & Caine, 1995). Evidence has also been found which links the level of activity in old age with brain plasticity, (Diamond, Rosenzwieg, Bennett, Lidner, & Lyons, 1972; Cohen, 1988).

Although biological changes are important, the increased incidence of depression in old age is accounted for largely by reactive mood disturbance. Therefore it is necessary to consider the role of psychosocial factors in late life depression such as loss, significant life events and important changes these bring in terms of relationships and roles. These factors are more frequently encountered in old age due to changes that naturally occur at this life stage such as bereavement, retirement, relocation, and decline of physical health. There is a considerable amount of variability in the way in which people adjust to events such as these, which can be predicted by a whole range of factors relating to the internal and external resources which are available to the individual to facilitate better coping. Social support is a well researched determinant of psychological adjustment and well being, (Sarason, Levine, Basham, & Sarason, 1983). Social isolation has been found to be a significant contributor to depression, both because loneliness is a stressor in its own right, and also because lack of social support is a risk cofactor because it worsens the impact of any other event, (De Leo & Diekstra, 1990).

The incidence of suicide also rises as a function of age, and depression has been found to play an extremely important role in this trend. 90% of elderly suicide victims in one study had a diagnosis of depression (Barraclough, 1971). Despite being disproportionately represented in suicide statistics, the problem of suicide in late life has received very little attention or interest. This is because suicide is a relatively minor contributor to mortality among this age group, and also because
senolescent suicide is sometimes misleadingly seen as rational or expectable, particularly among those with poor physical health.

**Aims of the study.**

This study aims to provide an account of the transition into old age from the perspective of a small sample of older adults with depression. The focus of inquiry will be to investigate life events and changes in life style which contribute most significantly to the need for psychological adjustment, and how these changes are perceived by the participants. Maintaining a focus on ‘adjustment’, the study aims to investigate factors which facilitate and impede successful adjustment, such as social support.

The questions which the study sets out to answer can be broadly summarised as follows:

1. What are the main life events and sources of psychological loss in later life?
2. How are these changes/losses perceived and experienced?
3. How does social support assist in the task of adjusting to losses?

**The clinical relevance of the study.**

Depression is an extremely common problem among the very old, yet there has been relatively little psychological research into this area. There has also been a lack of development in forms of therapy which are specifically suited to the needs of older adults. There is a history of pessimism towards conducting psychotherapy with older adults which can...
be traced to Freud’s view that older people (i.e. over 40) have a character structure which is too rigid to permit change.

Evidence from epidemiological studies suggests that the majority of cases of late life depression represent reactive mood disorders, and psychological variables therefore play a key role in their origin. There is therefore a need for research that looks beyond the correlation between psychosocial risk factors (such as retirement and bereavement) and depression, and investigates at a deeper level the impact and process of change that these events cause. Within this it is necessary to understand characteristics specific to the individual which determine their response to changes in later life. Not only will this help to enhance our understanding of the dynamics of late life depression, but it will lead to knowledge which may help clinicians to better formulate the therapeutic needs of older adults.
METHOD.

Participants - Five participants who were receiving outpatient treatment for depression from an Elderly Mental Health Team were included in this study. A brief test of cognitive functioning was used to screen for cognitive impairment, and additional structured measures were used to enable the sample to be described in terms of important clinical characteristics, including severity of depression, suicide risk, level of social support, and perceived physical health status. An interview lasting approximately 45 minutes was conducted using a semi-structured interview schedule. The interviews were recorded on audio cassette, and were transcribed verbatim. A thematic content analysis was carried out on the five interview transcripts.

Data collection - The following assessment measures were used in the study:

1. The Mini Mental Status Exam (MMSE), (Folstein, Folstein and McHugh, 1975) is the most widely used and studied screening measure of cognitive impairment. A score of less than 26 on this was used as a criterion for excluding potential participants from the study. One person was excluded during the recruitment stage due to signs of confusion and memory impairment.

2. The Centre for Epidemiological Studies Depression scale (CES-D), (Radloff, 1977), was selected as a measure of depression both because it is relatively short (20 items), and is regarded to be appropriate for use with older adults, (Osgood, 1992).

3. The Beck Hopelessness Scale (BHS), (Beck, Weissman, Lester and Trexler, 1974), is regarded to be a good indicator of suicidal ideation in younger adults, (Dyer and Kreitman, 1984). The psychometric properties
of the BHS in clinically depressed geriatric population has been investigated by Hill, Gallagher, Thompson, and Ishida, (1988). The scale was found to be internally consistent, and was found to have a factor structure which was similar to the original factor structure identified by Beck, Weissman, Lester and Trexler, (1974). Hill, Gallagher, Thompson, and Ishida, (1988) found that hopelessness, depression and health perception were inter related, and were predictive of suicidal ideation in older adults, but to a lesser extent than in younger adults, (Dyer and Kreitman, 1984).

4. The short form of the Social Support Questionnaire, (SSQ6), (Sarason, Sarason, Shearin, & Pierce, 1987), is a brief measure which is almost as psychometrically robust as the full length SSQ, (Sarason, Levine, Basham, & Sarason, 1987). The SSQ measures two important facets of social support: perceived number of social supports, and satisfaction with social support that is available. There is evidence that personal adjustment and social behaviour are influenced significantly by a person's access to significant others, (Sarason, Levine, Basham, & Sarason, 1987).

5. A verbal rating scale consisting of a bi-polar ordinal scale, was devised in order to obtain a measure of the respondent's perceived physical health status, (see appendix 4). Self ratings of health among the elderly have been found to be a valid measure of objective health, and have been argued to be a more important predictor of various dimensions of well being than actual physical health, (Ferraro, 1980; Madox and Douglas, 1973). Although it is a biological fact that health deteriorates with age, older adults do not report relatively poorer health than younger adults (Ferraro, 1980). Judgements about health are based on comparisons with peers, and in old age, it is thought that good health is synonymous with being free from serious illness or severe disability, (Cockerham, Sharp, & Wilcox, 1983). Health problems tend to be perceived in terms of the extent to which they disrupt a person's life. Myles, (1978) suggests that
disruption is reduced in old age because elderly people are not required to maintain a highly active level of functioning.

The semi-structured interview schedule - The interview schedule was constructed to draw out process issues in addition to descriptive data, (see appendix 3). The interview began with broad, open questioning to enable the issues which were most important for the participant to emerge. Counselling attributes and skills were used by the researcher during the interviews and this was felt to be appropriate due to the potentially sensitive nature of the issues raised. Coyle and Wright, (1996) argue that using the counselling interview to collect research data is useful because "it can foster good rapport, encourage interviewees to elaborate their experiences and help establish potential lines of association and causation in research data", (Coyle and Wright, 1996, p. 431).

Analysis of data - The interview data were transcribed verbatim, and each transcript was read a number of times to allow the researcher to become extremely familiar with the material. The content of the interview data was then analysed by systematically identifying units of information, and classifying them into descriptive categories. These categories represented broad themes that arose inductively from the data, rather than being imposed as an *a priori* analytic framework. A second stage of analysis was then carried out, which involved identifying recurring themes and systems of explanation within each individual transcript. At this stage, there was an emphasis on interpreting the meaning of the data.

Procedures for assessing reliability were carried out to verify both the initial stage of generating categories, and the process of sorting statements from the data into these categories. The first procedure involved asking a colleague to conduct a broad analysis on one of the five transcripts. Only one transcript was included in this procedure due to
constraints of time and resources. The same colleague was also asked to sort a sample of the statements identified from the data into the various themes and sub-themes. A sufficiently high degree of agreement (84%) was achieved in sorting the statements into the categories generated.

**Reasons for adopting qualitative research methods.**

A qualitative research methodology has been adopted because it has a number of characteristics which make it the most appropriate mode of investigation for the purposes of this study. Qualitative research methods have an inductive function, enabling the generation of new knowledge and theory in areas where existing knowledge is inadequate or absent. This mode of research stresses a constructivist epistemology. Within this epistemology, a situation is investigated from the perspective of the informant, by exploring the meaning they give to it and understanding they hold of it. This paradigm emphasises the relative and contextual nature of knowledge, rather than attempting to discover objectively defined facts. There is also an emphasis on obtaining an in depth understanding at the individual level, rather than a more shallow understanding, which can be generally applied across a wider population of people. Within this paradigm, theory generation is regarded to represent a more fluid process, in which new discourses are inserted within old systems of meaning.

The main criticism of qualitative research is that it is highly subjective and indeed it is important to acknowledge the multiple dimensions of subjectivity which exist throughout the process of conducting qualitative research, (Parker, 1992). However, subjectivity and interpretation are a feature of all forms of scientific practice. Henwood & Pidgeon, (1992) have argued that this subjectivity can be addressed by making public the full range of interpretative processes involved in knowledge production.
In this way, the theoretical context within which the theory was generated will be freely open to external audit.
RESULTS.

1. DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF THE SAMPLE.

1.1. Demographic characteristics.

The sample consisted of 5 participants. All of the participants were women, and the mean age of the sample was 82. All of the participants were white. Three were widowed and two were married.

1.2. Clinical characteristics.

None of the participants were found to have significant cognitive impairment, i.e. they all obtained a score of 26 or above on the MMSE, (see Table 1). Three of the participants obtained scores on the CES-D which were above the cut off score for clinical depression (16). Two participants scored well below the cut off indicating that at the time of assessment they were not depressed. Within this small sample, a wide range of scores was obtained on this measure (range = 1 to 43).

Two participants obtained scores on the BHS indicating they hold extremely pessimistic views of their future which is indicative of suicide potential. Two participants obtained very low scores on this scale and a third score was slightly higher. There appears to be a positive association between scores on the depression and hopelessness scales.

Two participants rated their health to be poor (4), while the other three rated their health to be fair (3) or good (2). Poor health rating was positively associated with depression and hopelessness.
Three of the participants had extremely limited access to social support, and expressed corresponding dissatisfaction with this situation. Two participants did have access to social support which they valued and were satisfied with. Both participants were still married. Lack of social support was positively associated with depression and hopelessness.

**Table 1 - Demographic and clinical characteristics of participants.**

<table>
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<tr>
<th>Participant</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Ethnic origin</th>
<th>CES-D</th>
<th>MMSE</th>
<th>BHS</th>
<th>Health</th>
<th>SSQ6 - Number</th>
<th>SSQ6 - Satisfaction</th>
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<tr>
<td>4</td>
<td>76</td>
<td>Female</td>
<td>Married</td>
<td>White</td>
<td>1</td>
<td>29</td>
<td>2</td>
<td>2</td>
<td>2.00</td>
<td>6.00</td>
</tr>
<tr>
<td>5</td>
<td>80</td>
<td>Female</td>
<td>Married</td>
<td>White</td>
<td>2</td>
<td>28</td>
<td>1</td>
<td>3</td>
<td>4.00</td>
<td>6.00</td>
</tr>
</tbody>
</table>

Key to interpreting scores:
- Health ratings: 1=Excellent, 2=Good, 3=Fair, 4=Poor.
- SSQ6 - Number: This number describes the mean number of social supports listed in all six questions.
- SSQ6 - Satisfaction: This number describes the mean average of the satisfaction ratings listed in all six questions.
- The scale used ranged from 1 (Very dissatisfied) to 6 (Very satisfied).
2. SIGNIFICANT LIFE EVENTS.

18 different categories of life events were identified by the participants to have occurred in later life. These are shown in table 2 in order of the frequency with which each event occurred.

Four of the participants had suffered a serious physical illness such as cancer or a stroke.

Three participants described becoming estranged from their families to be a change that occurred in later life.

"all me grandchildren have grown away from me. They used to be all around me at one time and now I don’t see them at all. Only when I go there do I see em."

Three participants had been bereaved of their husbands. One of them had previously been widowed during the war.

Two participants described how their social network has become diminished.

"Well it was very nice at first [living here] because most of them were elderly people like me. But unfortunately within the first three or four years, two or three died, two more moved, and all of a sudden the youngsters came in, and you know, I had a very unhappy time for a while."

One participant described how multiple life changes resulted from a single life event.

"Well the worst thing that happened was when I discovered that my husband had developed Parkinson’s disease which has completely
changed things really because we had quite a good social life, we drove, we had a car, so we didn’t have any problems with regards shopping, or going to visit people.”

**Table 2 - Significant life events.**

<table>
<thead>
<tr>
<th>Life event</th>
<th>Number of participants who experienced it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious physical health problems, e.g. cancer, stroke.</td>
<td>4</td>
</tr>
<tr>
<td>Family estrangement.</td>
<td>3</td>
</tr>
<tr>
<td>Loss of husband.</td>
<td>3</td>
</tr>
<tr>
<td>Diminished social network.</td>
<td>2</td>
</tr>
<tr>
<td>Husband develops organic disorder, e.g. Parkinson’s disease, Alzheimer’s disease.</td>
<td>2</td>
</tr>
<tr>
<td>Loss of mobility.</td>
<td>2</td>
</tr>
<tr>
<td>Cognitive decline.</td>
<td>2</td>
</tr>
<tr>
<td>Relocation.</td>
<td>2</td>
</tr>
<tr>
<td>Retirement.</td>
<td>3</td>
</tr>
<tr>
<td>Loss of family support.</td>
<td>2</td>
</tr>
<tr>
<td>Diminished social life/opportunities for leisure activities.</td>
<td>2</td>
</tr>
<tr>
<td>Son with learning disability is placed in residential care.</td>
<td>1</td>
</tr>
<tr>
<td>Son/daughter develops serious mental health problem.</td>
<td>1</td>
</tr>
<tr>
<td>Son/daughter develops a serious physical health problem.</td>
<td>1</td>
</tr>
<tr>
<td>Loss of son/daughter.</td>
<td>1</td>
</tr>
<tr>
<td>Hearing impairment.</td>
<td>1</td>
</tr>
<tr>
<td>Living on own.</td>
<td>1</td>
</tr>
<tr>
<td>Loss of mother.</td>
<td>1</td>
</tr>
</tbody>
</table>

Three of the participants reported body related changes and/or self related changes.

“And, umm I like to use me brain box if I can. I think its gradually dwiddling. You know, I can tell when I write. It goes to something else. I don’t want it to but it do.”

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Two participants had moved following the loss of their husband. Three had retired from jobs.

"Oh yeah, I had to pack in me work, and I think that made me go down hill a bit. Cause when you have been in work for 15 years, its a long time isn't it, and I was in charge at Boots."

Two participants described losing support from family. In both cases this occurred as a result of another life event such as loss of a close relation.

"Yeah, and I depended on my son such a lot. He used to come round here on Friday and bring me any shopping from Sainsburys, and of course I get nothing like that now."

The remaining life events were slightly more uncommon events which were often very important such as loss of son or daughter. A total of 34 significant life events or life changes were recorded in all five transcripts, (mean = 6.4; range = 4 to 9).
3. THE PHENOMENOLOGY OF DEPRESSION.

The participants provided a rich description of the experience of depression. A wide range of subjective feelings, emotions and somatic reactions were described. These phenomenological accounts included the following:

Several participants described feeling agitated and restless.

"I really was bad, I couldn't sit still. I couldn't stay in the house. When I went out I wanted to come back, I used to go to [the local town] on the bus two or three times a day."

Disturbed sleep pattern was a common complaint.

"I can't sleep at night, I am awake half the night, and I sleep during the day. Its all wrong innit?"

Some participants described suffering anxiety and panic attacks.

"I used to get panic attacks, and I used to ring my husband up, and my daughter, and I would phone my doctor. It was panic stations, and that's how I got all the time."

Feeling lonely was described by several participants.

"I wish I could see more of em [grandchildren]. Its not funny being stuck on your own is it?"

In one participant a feeling of emptiness followed on from loneliness.
"But of course after a while, the loneliness comes on because you have been so busy and occupied, and then all of a sudden you have got nothing. There's a void."

Some participants reported feelings of apathy.

"I can't seem to show no interest in nothing anymore. Whether it's because [...] I don't know."

Three participants described having no pleasure in life.

"I don't get any pleasure out of life at all now. To me life is empty. No I can answer that straight, I don't get any pleasure out of life what so ever."

One participant described a view of the whole world as a malignant place.

"Yeah everything, to me I think the world is a horrible place, I really do. I don't think there is anything that is good about it at present. Everything is going too much the other way."

Helplessness was expressed by some participants.

"They said it [a carpet] would be delivered within three weeks, and now it is going into its sixth week. And I feel hopeless about doing anything about it whereas years ago I would have been down in the shop arguing it out. Now I tend to let things [...]"

Hopelessness about the future was also expressed.

"Yes, two years ago when it sort of got, it overcome me, and then, all I couldn't see any end to it, I just couldn't see what was going to happen to me. And it was just a blank wall."
All of the participants reported having periods of despair.

"I wouldn't go out, and I felt sick, and I felt as if I was trying to get myself out of this hole."

Three participants described having suicidal ideation.

"a few weeks ago I went down very low, and I lay in bed and I got a bottle of Nitrazepam tablets, and I looked at them and I said "no it's ridiculous". I'll be quite honest, I told the psychiatrist I said I might think about it but to put it crudely, I haven't got the guts to do it."
4. SOCIAL SUPPORT.

There was a considerable amount of variability between the participants’ accounts of the quantity and quality of social support which they received. Both the interview data, and the results of assessment questionnaires provided evidence of a negative association between level of social support and the amount of distress experienced.

Two of the participants who feel they have largely overcome their depression described a number of ways in which support from friends or family has helped them. One participant described how she can share the burden of her worries with her daughter.

“Oh my daughter, she is the tops, all the worries of the world on her shoulders but she is the tops. She sticks to her mam like glue.”

The same participant described the role played by her friends in helping her to recover from the depths of her low mood.

“They brought me back down to earth!”

Another participant described the comfort she derived from the knowledge that a safety net of care is available, in her case via the British Legion, should she require it.

“They [The British Legion] will help you in no end of ways, housing, and nursing homes, there is such a lot I can turn to them if I am in need. So I feel a little bit more secure in my future.”

A number of features of helpful support emerged from the interviews, such as support which was responsive, readily available, and not provided in a
rushed manner. The participants identified a need for both practical help, and also emotional support in the form of a confiding relationship.

"my sister in law is very good. We have long chats to get it off my chest."

In contrast to the reports of some participants of positive experiences of receiving support, other participants expressed dissatisfaction with attempts of others to offer support. For example, a lack of empathy from family members was reported.

"my grand daughters phone me, but to me I don't think they can appreciate depression. Their idea is "oh try and buck your ideas up."

One participant reluctantly implied that her family don't provide enough support.

"I don't like saying this. My family is very good to me, I go round there every Sunday for dinner. But My sons will do anything for me. How can I say it without sounding rotten?"

Some of the participants reported having very few sources of support, which left them feeling extremely isolated and lonely. One participant had regular contact with only one set of friends.

"There is nobody really. Only as I say my friend on Thursday, when her husband comes down and picks me up by car and takes me back there and I have me tea with them and he brings me home at night. But other than that I don't see or contact anybody."

A number of processes were described to contribute to the erosion of social support networks in later life. In describing changes in their
relationships with family and friends, the participants provided some insights into their perception of themselves in relation to other people. For example, one participant in reporting that her grandchildren have grown away, made the following comment:

“I seem to have lost contact. They don't bother with you when you are old.”

Here we see the participant is attributing a sense of disconnection from the social environment to her perception of herself as lacking in value.

One participant described her perception of changes in the degree to which families care for their elderly members compared with earlier in her life.

“I've always said, as they used to say “as ye sow, so shall ye reap” and it doesn't work out otherwise I wouldn't be like this”.

This comment implies that the participant feels let down as a result of changes in the younger generation's responsibilities for caring their elders. This disappointment was echoed in a comment made by another participant.

“I never ever visualised myself in this position when I was younger, it never dawned on me that I would be left like this, because I have been married twice, I've got two children and five grandchildren, and I'm still on my own. Having done all of that in my life, and I feel, not cheated, but what have I got out of it?”

Several factors seemed to contribute to the impoverished social networks described by some participants. One participant reported a life long lack of support.
“I have never had anybody to turn to ever. Because when I was widowed first, I had my mother, but I had always supported her because she was a weaker character than me.”

Here we see the potential origin of this participant’s tendency to provide support rather than receive it, in experiences much earlier in her life creating for her an expectation that her needs for support will not be met.

Another participant illustrated attitudes which encourage an interpersonally detached life style.

“I have always kept myself to myself. I was an only child and my mother used to say “you pass the time of day with neighbours, but never invite them in and don’t tell them your private life”, and I’ve always sort of stuck to that, where as round here they are so different, in and out of one another’s flats.”

A range of detrimental consequences of having inadequate support were reported by the participants. Some described having greater difficulty in coping with stressful life events. For example, one woman felt that being alone added to her grief following the bereavement of her husband.

“At that age when you are getting on, you haven’t got anyone at home [ ]. Whereas if he had died younger and the family was still there, you probably would cope with bereavement better.”

The importance of having social support for older adults was illustrated in the interview data. One participant revealed how having little support makes it difficult to be with other older adults who have bigger social networks. It seems that being in such a group was a reminder of her isolation. The resentment towards those with support makes it difficult for the participant to enjoy the company of her peers, which in turn leads to a greater sense of isolation.
"I just have to go to these day centres, I can hear them talking about their families, I'm feeling very envious. Inwardly I'm thinking to myself, oh I do wish you would stop talking about your families, what they do for you and all the rest of it".

Participants who are isolated and who have little to occupy their time reported spending much time engaging in the process of life review described by Erikson (1963), in the final developmental stage of integrity versus despair. In the following comment we see that a focus on predominantly painful reminiscences, combined with a lack of external emotional support increase the participant's vulnerability to experiencing despair.

“Yes, I have grieved more for him [first husband] than I have my second husband. Because, since I have been on my own, that grief has come forward more. I have thought more of those years than I have the recent years.”

Finally, one participant compared her need for social contact to be equivalent to her need for nourishment which is essential for life. She describes how, without love and support, she has lost her will to live.

“I had so much love to give, but I had no return of it, and I always think to myself that a flower that isn't watered wilts and dies doesn’t it? And that’s what I think happened to me.”
5. ADJUSTMENT TO DEPENDENCE.

A key theme which seems to be related to satisfaction with social support is the degree to which the individual has adjusted to dependence on others. Participants varied considerably in their respective success in establishing and accepting dependent relationships. Two participants had negotiated this task relatively well while the other three continue to struggle with it.

Accepting dependence seemed to involve restructuring attitudes towards help seeking. Examples of this included recognising that people don't mind if you ask for help.

"Oh yes, now I have had a bit of help, and I have found that people genuinely don't mind, um I would ask, and I do ask."

For another participant, a pragmatic decision making process seemed to have led to an acceptance of the need to ask for help.

"I suppose you give it some thought, you think as much as you like your independence, there is a time when every body needs somebody else. Um, sensible thinking I suppose."

In contrast to the women who had accepted their dependency needs, some participants continued to be unable to ask for or accept help. These women appeared to be fighting their need to depend on others, and they used various strategies to avoid or minimise their need to seek help. For example, one woman described how she tentatively phrases her help seeking.
"I ask very tentatively. I think about how I am going to phrase it. I don’t say “will you do so and so?”, I say “If you are going to so and so, I wonder if you will?”. That approach.”

Another participant could only bring herself to ask for help from immediate family and would decline offers of help from other people such as neighbours.

“I don’t feel they should have to help me because they are no relation or anything”.

One participant described being reluctant to leave her home due to her fear that she might elicit help from strangers, for example if she should fall in public. This woman was so averse to seeking help that she restricted her activities to things which she could confidently do independently.

“I’m so afraid of being embarrassed if I fall. So rather than do that I stay in. I know it is silly, but I can’t overcome it yet. And I feel all the while, I can keep me house clean, me bed clean, and cook me meals, and cope, I don’t bother anybody then, I don’t have to worry about anybody.”

Another participant also seemed to go to considerable lengths to resist the effects of increasing physical frailty caused by ageing, for example by using stairs even when a lift is available.

“But I keep thinking I must take hold of meself, it’s no good. I mean when I go out, I won’t go up and down in the lift. I make myself go up and down stairs.”

However, it seems that in later life, people become victims of their own ability to feign a high level of coping when help is actually needed. This was illustrated by one woman who said:
"They all think I’m ever so brave at Sainsburys when I go round there with me trolley [laughs]. They say "Oh, you are wonderful". They don't know how I feel inside. Oh I hate it."

The participants described a number of reasons for their reluctance to ask for help. A key motivation for their struggle to maintain autonomy was a fear of being a nuisance/burden.

"People go to offer you help, and you think "oh you know I'm being such a nuisance." Even to my family, I feel that I'm a nuisance. I can't shake it off. It doesn't matter how much they say."

The negative aspects of receiving help were emphasised by some participants. For example, one participant commented on the need to accept other people’s standards rather than your own when you rely on help.

"Yeah I look at the garden now. I can't do the garden and I have to have a gardener around, and he don't do it right."

In describing her reluctance to accept social security benefit one participant illustrated the sense of stigma for those who value highly their self reliance and autonomy. This participant is reluctant to identify herself as someone in high need of help.

"I didn’t feel justified in taking it [benefit] before. I think that is another thing I got from my husband. When he had to retire, he would not accept social security, we lived on our savings. I knew at the time that there's others in more need than me."

Some participants were not used to needing help, being rather more familiar with the role of helping other people.
"Well I do, I feel as though I am imposing on other people, and I hate that feeling because I have always helped other people, and I don't like being helped."

The participants who avoid seeking help described experiencing a range of unpleasant emotions when they are exposed to relying on someone else's intervention. For example one woman commented:

"I've got to a stage where I have got to ask, and it hurts, it hurts really badly."

In the following comment we see again the extent to which the prospect of dependence is viewed as being intolerable by one participant.

"Well, I just feel no, I've got to go on. I've got to cope otherwise they will send me to the funny farm. So that's where I think I must cope, I really must."
6. ROLE TRANSITION IN LATER LIFE.

Changes in roles which results from the transition into old age were also explored with the participants. There were important differences within the group here in terms of adjustment to the loss of previous important roles, and also the participants' ability to adopt new roles.

Two of the participants were able to identify roles which have transcended the ageing process. One woman described experiencing a new lease of life since she has retired:

"Oh I had me darts! I was in me sixties and there wasn't one of them over 21, but they made my life. I have always had company. Now I go out on Mondays and Saturdays to bingo and all my friends are there."

In contrast to this, other participants seemed to have focused heavily on roles which were time limited, such as caring for other people in their family who now were no longer in need of care. For these participants, losing the role of caring for other people was linked with a sense of redundancy, and an absence of purpose in life.

"I don't see my role as anything now. I mean I have that voluntary work at the hospital but that has gradually dwiddled. Now I don't feel I'm any good to anybody. I can't, I used to wash and wipe up round me daughter in laws, I can't do that now. I just sit there and be waited on and I hate it."

The absence of a meaningful role seems to make it very difficult for the women to maintain a sense of self worth.
"I don't like to be still like this [...] useless, cause that's what I feel like: useless. I'm looking at the clock wishing the time away."

For some of the participants, their self worth seemed to be strongly dependent on being useful to other people.

"The thing that I missed was having to look after people, like look after my husband and my family. It was as though I was of some use. Now I feel as though I am of no use what so ever to anybody. my life seems empty, absolutely empty."

A diminished ability to do things for yourself also seemed to contribute to this sense of uselessness in some participants.

"Doing things for me self, I like doing that. But now if you can't do anything, you feel redundant."

One participant seemed unable to identify a new purpose in life once her caring responsibilities had ended. Without this role, she could see no purpose in perpetuating her life any further.

"Because, after I lost my husband, I looked after and helped my daughter with the children while she went out to work. I used to get them from school. But once they grew up and was independent of me, I felt well, that's it. I have done everything as it were. Why am I going on?"

For some people who in the past used busyness as a coping strategy for avoiding painful feelings, the absence of a meaningful role results in the collapse of this defensive avoidance. One participant after describing a series of difficult life events earlier in her life said:
“All the while your life is full, you keep going. But when it is all taken away from you, you are like a ship without an anchor really.”

This participant went on to describe how this avoidance has resulted in later life in re-experiencing all of the painful life events which have accumulated throughout her life.

“I used to shelve it. I used to be a little bit of an ostrich, and hope they would go away sort of thing. They build up without you realising it and all of a sudden when you are on your own and you have got time to go back over things, it hits you and you think, what was it all for? Only to sit here.”

This seems to be another good illustration of the process of life review leading to despair described by Erikson (1963) in his life span model of psychological maturation.
DISCUSSION.

The methodology employed in this pilot study has yielded a large quantity of descriptively rich data from a relatively small sample. Interpretation of this data is necessarily tentative, but interesting patterns have emerged. Before these trends are explored, it is necessary to acknowledge the limitations of the study. The first of these is that only women are represented in the sample, and this precludes any discussion of patterns of adjustment in elderly men. A second weakness of the study is the presence of depression in only three of the five participants, and the sample therefore does not represent a homogenous clinical population. However, the range in severity of depressed mood is also advantageous because it has enabled a comparison between chronically depressed and recently recovered sub groups.

The results of the assessment measures provide useful contextual information for interpreting the interview data. Two of the five participants obtained scores indicating clinically significant levels of depression, a high degree of hopelessness, dissatisfaction with the quality and quantity of social support available to them, and poor perceived physical health status. A third participant showed the same pattern of association between the different measures, but to a more modest degree. The remaining two, were not clinically depressed, obtained low scores on the hopelessness scale, were satisfied with their social support, and perceived their health to be relatively good.

This study has illustrated the wide range of life events and losses encountered by the participants in later life, and has provided a rich phenomenological account of their experience of depression. All of the participants had undergone multiple life events and losses, including loss of important relationships, roles, functions and skills. It is well established that loss is a major psychological contributor to depression. Among the
emotional experiences described were emptiness, apathy, lack of pleasure in life, helplessness, hopelessness, and despair.

The aim of this study was to investigate the individual differences in ways of coping with the transition into old age, and differences in the ways this transition is perceived by the participants. Three issues have arisen from the data which seem to be key to the adjustment to old age. These are social support; the ability of the person to accept increasing dependence on others; and their ability to undergo role transitions.

Having valued social support was identified by two of the participants to be an important factor contributing to their recovery from depression. There is a very great need in later life for both practical and emotional support. The need for increasing support arises due to a range of factors including decline in physical and mental functioning. Consequently older adults are confronted with a loss of their previous capacity to live independently, and with the need to establish relationships which are characterised by greater dependence. We see here an interplay between the two key issues of the need to establish a sufficient network of social support, and the person's ability to accept increased dependence.

Dooley, (1996) identifies two stages to the task of adjusting to dependence. The first is for the person to find some way of maintaining a positive self identity in the face of dependency. The second involves learning how to handle dependency on a day to day basis, for example learning to accept intrusion into private space, to negotiate appropriate care, and to be assertive when carers fail to meet one’s needs.

There were large differences between the five participants in their willingness to accept help and depend on other people. The two participants with low scores of depression and hopelessness had access to a greater number of valued social supports. Both participants were married and this in itself is likely to be a significant protective factor in
coping with stress. In addition to their spouses, these two participants also received support from a wider social network. They were initially reluctant to ask for help, and the process of adjusting to depending on other people involved some changes in attitudes towards help seeking. In contrast, the remaining three participants were not able to adjust to dependence on others. Loss of autonomy for them was an intolerable prospect, and consequently was avoided and resisted.

In this study, greater depression was found to be associated with an inability to ask for or accept help and support from other people. The results of this study describe some reasons that participants were not able to ask for help. The most important of these seemed to be that participants had lacked support throughout their lives. Several participants in this study described how they had supported their parents as children rather than receiving support, and consequently had not received close support from their parents. Another participant described how she had never been shown any love in her life. Therefore, there is evidence in all three participants that autonomy became established due to an absence of love and support from others.

This suggestion is supported by sources of existing theory. Literature on social support (Sarason, Levine, Basham & Sarason, 1983), suggests that the pattern of establishing and using a network of social relationships in adult life reflects the attachment experiences of the person during their childhood. For example, someone who is given love and guidance by parents during childhood will expect and recreate similar relationships subsequently. The childhood origins of obstacles to adjusting to dependence on others in later life has also been identified by Clark (1992). Drawing on Erikson's (1963) model of development, he suggests that a failure to develop basic trust in others in childhood is one contributor to a need for independence in adulthood.
It is suggested here that autonomy is established by some people because self sufficiency enables them to avoid the pain which results from not having their emotional needs met. In addition to being self sufficient, there seemed to be an imbalance of care giving in the most important relationships of some participants. These participants tended to give support, and care for others, but they did not receive support in return. They gave examples which suggest that they had undertaken an extremely high burden of care within their family. It is possible that this was a compensatory strategy, in which they were attempting to meet their own needs by providing care that they required to other people.

Duberstein, (1995) in his research into the personality characteristics of older adults who commit suicide found a tendency among suicide completers to have a rigid, and narrowly defined self concept, and a focus on a narrow range of time limited, proximal roles such as work, or caring for children. He conceptualises these characteristics to represent a low level of openness to experience, and suggests that this places the individual at risk of descending into a state of meaninglessness at times of crisis.

This rigidity and narrowness in roles and self identity can be seen within the three depressed participants in this study. For these participants, holding the role of a carer seems to be extremely important to the maintenance of a positive self concept. This is a further motivating factor for their continued avoidance of relying on others in very old age, even though autonomy is no longer a realistic choice of lifestyle for them.

The loss of this role as carer has brought with it considerable challenges. For some, it has led to a feeling of lack of purpose in life and of uselessness. Another participant described the emptiness and sense of isolation that not being needed brings. Participants reported that they felt they were a nuisance and a burden to their families. All of these experiences have contributed to their tendency to avoid help seeking.
A pattern of being interpersonally detached and autonomous seems to become self perpetuating. It predisposes one to establish relationships with people who conform to an expectation that other people will not meet your needs. Secondly, autonomy creates an appearance that one does not have any needs, which makes it difficult for other people to know what support to offer. In adulthood, this facade of self sufficiency can be a source of self esteem. However in later life, people become victims of their own ability to feign a high level of coping when help is actually required.

Some of the detrimental consequences of autonomy and role rigidity in later life have been illustrated in this study. In the case of these participants, avoiding help seeking has contributed to a very restricted lifestyle, and has led to basic needs not being met. The participants have also lost opportunities to develop new roles to replace key roles lost. The participants seemed to go to great lengths to maintain self sufficiency in their daily functioning, for example one woman withdrew into a narrow range of activities over which she could still exercise mastery, while another woman forced herself to exert unnecessary effort in climbing stairs rather than using a lift, in order to demonstrate efficacy to herself.

This study has shown an association between inability to establish and make use of social support, a reluctance to accept the loss of autonomy, and a self identity which is determined by a narrow range of roles which are no longer available. The constriction in lifestyle which results from these characteristics seems to have significantly contributed to the maintenance, and is possibly a causal factor of depression among the chronically depressed sub group in this study. These three features were all distinguishing characteristic of the depressed participants. As a result, participants were prone to be isolated and lonely, to have 'given up on life', to lack any meaningful roles or purpose in life, and to have disengaged from activities in general.
This pilot study has identified important differences in the pattern of adjusting to the transition into old age within the sample. The data have illustrated a number of processes which can prevent people from establishing and making use of dependent relationships. These relationships become increasingly important in later life.

The value of adopting a qualitative methodology to investigate the psychological processes operating at an individual level has been demonstrated in this study. There is a need for further research into the psychological factors contributing to the experience of emotional distress in later life. The impact of the developmental issues identified in this study on the individual’s identity is an area deserving further investigation. Such a study could investigate how individuals’ perceive themselves to have changed as a result of the losses of autonomy, a meaningful role in life, and their connection with a social network. Future research would benefit from selecting a sample which would enable a comparison of both depressed and non-depressed older adults, and a greater representation of both men and women.
Summary.

Five older adults receiving out patient treatment for depression reported experiencing a wide range of recent significant life events and losses. The quantity and quality of social support available to them appears to be a key variable in their ability to cope with the task of adjusting to these events and losses. Some individuals were unable to establish and make use of social support because this introduced a degree of dependence on other people which was unacceptable to them. There were a number of reasons why participants were not able to depend on others. They were not used to receiving support, and a history of autonomy is suggested to represent a means of coping with a lack of support and love. These participants reported a range of unpleasant subjective experiences such as emptiness, feeling useless, feeling like a nuisance, and despair when exposed to their dependency. Furthermore, fulfilling the role of carer seemed to be fundamental to their self concept.

There was evidence that three of the participants, who reported greater levels of depression and hopelessness, tended to deny their dependency needs and avoided situations in which they would have to ask others for help. This avoidance has many negative consequences. Avoiding asking for help leads to an impoverished network of social support and contributes to isolation. These participants were unable to establish new roles and activities because in later life it is less possible to achieve this independently. Fighting dependence inevitably leads to a constriction in lifestyle, because as the repertoire of skills and abilities diminishes due to physical limitations, the individual is forced to withdraw into an ever narrower range of activities which they can still carry out alone. Consequently they are forced to disengage from activities in general.

This study has illustrated some important dimensions of adaptive and maladaptive adjustment in later life. It has charted individual
characteristics which predispose older adults to respond to the stresses encountered in later life in a maladaptive way. The results of the study suggest that one focus of psychological therapy with some depressed older adults should be to facilitate better adjustment to dependency so that they can become better able to establish and make use of external coping resources, and maintain a sense of self and purpose in later life.
References.


Appendices.
Appendix 1

Transcription notation.

Where quotations have been edited of repetition or unnecessary dialogue, empty parentheses [ ] have been used to indicate where text has been omitted.

A pause in the dialogue is denoted by a full stop in parentheses [.]

Identifying and referential information has been removed, and this is indicated by parentheses containing explanatory text as follows; [explanatory text].
Appendix 2.

Information sheet for Prospective Participants.

**A research project investigating the psychological characteristics of older adults suffering from depression.**

I am a trainee clinical psychologist working for the Elderly Mental Health Team at [Name of] Hospital. I am carrying out research investigating the psychological characteristics of older adults who are suffering from depression. I would like to invite you to take part in this project. The purpose of the project is to improve the way the Elderly Mental Health service assesses and treats individuals who are depressed.

If you agree to take part in the study I will ask to meet with you twice. On the first occasion, I will ask you some questions and I will give you some short and simple questionnaires. This will take less than an hour to complete. On the second occasion, you will be interviewed by me for about an hour. During the interview, I will ask you questions about the difficulties you have experienced in recent years and how you have coped with life stresses, both recently and in the past.

You have been selected as a potential participant in this research from the medical records held by the Elderly Mental Health Team. If you choose to participate in the study, the interview will be tape recorded. Everything that you will say will be entirely confidential, and no name will be attached to the tape. In order to analyse the contents of the interview, your comments will be typed into a computer, and the tape will be destroyed. If you like, I will send the tape back to you. Your name will not be attached to your comments in anything that will be written about this research (reports or publications). Thus no-one will be able to trace your comments back to you. I will comply with the Data Protection Act.

You do not have to take part in this research, and if you do decide to take part, you can change your mind at any time - even in the middle of the interview. Whether or not you take part in the research, your present or future use of this service will in no way be affected.

It is recognised that the interview will cover issues which are potentially distressing. However, every effort will be made to conduct the interview in a sensitive manner. Follow-up counselling will be available if you should feel distressed at the end of the interview.

If you decide you want to take part, please return the attached form in the envelope provided, and I will contact you to arrange a time and date for the interview. The interview can take place either here at [name of] Hospital, or at your home. If you would like to talk about this study before
you make up your mind, you can contact me directly. My Name and contact address is:

Signed by the person in charge of the project: ____________________________
Date: ____________________________
Appendix 3.

Semi-structured interview schedule.

Respondent No:__________________ Date of interview:__________

Preamble.

Firstly, I'd like to thank you for sparing your time to take part in this study. My name is Tom Barker and I'm a Clinical psychologist in training based at [name of] Hospital. I would like to briefly tell you about the aims of this project before we begin the interview. In short, the project aims to look at difficulties people experience in later life, and also to explore the ways in which older adults cope with stress. Sometimes people feel that they can no longer cope with their stress, and I will also be interested to ask why this is. I am interested in finding out about these issues from your perspective.

The interview this morning/afternoon will take about an hour in total - is that OK? If there are any questions which you'd rather not answer, that is fine, and similarly you can terminate the interview at any time. I can reassure you that everything that you say will be entirely confidential.

Does that sound OK to you? Do you have any questions that you would like to ask me? OK - shall we start?

1. General

People tend to experience many important life changes in later life, some of them good and some of them bad. What have been the biggest changes in your life in recent years?

What have been the most significant events to have affected you?

1. 
2. 
3. 
4. 
5.

Checklist of possible events/
changes:
Physical health problems
Loss/bereavement
Cognitive decline
relocation
retirement
financial hardship
hobbies/interests
Now I am going to ask you some questions about each of these changes and events.

2. The Meaning of these changes

Can you tell me about some of the ways that [the change] has effected your life.

Suggested prompts:
⇒ In what ways have things changed since _____ happened?
⇒ How did _____ make you feel?
⇒ What has _____ prevented you from doing?

3. Coping with difficulties

I am interested in finding out about the ways in which you coped with the changes in your life. Can you tell me about some of the things you have done which have helped you to adjust to these changes.

Suggested prompts:
⇒ Have you done anything to help you manage this difficulty?

4. Difficulties in coping in Old Age

Have there been times when you have felt that you were not able to cope with the difficulties in your life?

⇒ What was it about these particular pressures which made you find it difficult to cope?
⇒ What was it about that situation which made you feel you couldn't cope anymore?

5. Social support and the quality of important relationships

Can you tell me about the level of support that you had from other people, and in what ways you found this helpful.

Suggested prompts:
⇒ Did you have anyone who could help you in a practical way?
⇒ Was there anyone who could give you emotional support/advice?
⇒ Can you tell me a bit about the relationships which are important to you now.
⇒ Whom can you really count on to give you help when you need it?
⇒ Is there someone you feel you can confide in?
6. *Past coping*

I was wondering if earlier in your life you have felt as you do now? Has anything like this happened before in your life?

*If yes:*

⇒ How did you cope with it then?
⇒ What did you do at the time to improve the situation?
⇒ What help/support was available then?
⇒ In what ways were things different this time?
⇒ How well do you think you coped with ____ in the past?

7. *Asking for help*

Sometimes people in later life find it very difficult to adjust to having to rely on other people for help with things that they were previously able to deal with on their own. Can you tell me how you feel when you need to ask someone for help?

*Suggested prompts:*

⇒ Do you find it easy to ask for help when you need it?
⇒ How do other people react when you ask them for help? *(Suggest specific people)*
⇒ How does it feel when you have to rely on someone? Depend on someone?

8. *Adaptation to new roles*

People in later life also sometimes become frustrated because they feel that they no longer have an important role or purpose in life. How would you describe your main role (purpose) in life to be now?

⇒ Are you satisfied with this role in life?
⇒ At what stage in your life did you feel most useful?
⇒ Which of your old roles do you miss the most?
⇒ How would you like your current role to be different?

9. *Motivation for living*

Can you tell me about some of the things which give you pleasure now.

⇒ Do you feel fulfilled by doing anything in particular?
⇒ What do you like doing now?
⇒ How would you prefer to spend your time?

10. *The interviewee’s perception of old age.*
What expectations of later life did you hold in the past?

⇒ Did you have any ideas of what it would be like to reach this age?
⇒ In what ways has it been different from your expectations?

11. Religious beliefs

Do you have religious beliefs?

*If yes:*
⇒ Have your religious beliefs been of any use in helping you to cope with difficulties?
⇒ Do you believe in an afterlife?
⇒ Do you receive support from your church?

**At the end of the interview:**

Thank participant for sparing His/her time. 
Reassure Him/her of the confidentiality of the interview. 
Check with the participant how he/she feels, and ask if he/she found the interview in any way distressing. If so discuss follow-up counselling:

⇒ How has the interview left you feeling?
⇒ What can you do to help you deal with those feelings?
⇒ Is there anything that you would like me to do?
Appendix 4.

Physical Health Rating Scale.

Name:____________________

Date:_______________

INSTRUCTIONS:

Please rate your current state of health by circling the word which best describes you.

For example:

Excellent?  Good?  Fair?  Poor?

Overall, I would say my health is:

Excellent?  Good?  Fair?  Poor?

Thank you for completing this questionnaire.
Part 3:

Large scale research project.

A comparative study of the reconstruction of self among depressed and non-depressed older adults.
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1. Abstract.

This study investigated the ways in which older adults perceive their identity to have changed through the transition into old age (>70 years old). The experiences of a sample of participants with depression (n=6) were compared with those of a sample of participants who were not depressed (n=6), matched for age, sex and marital status. Participants were recruited into the study from the caseload of an elderly mental health team, and from luncheon clubs within the same geographical area. Several data collection techniques were used including a repertory grid test and a semi structured interview. Depression was measured using the Schwab-Gilleard Depression Scale. The study aimed to triangulate the two key sources of data in order to investigate the relationship between forms of construing, patterns of adjustment to self related changes, and severity of depression. Repertory grids were analysed quantitatively using a principal components analysis, and qualitatively via an analysis of the content of personal constructs elicited. The interview data were analysed using a qualitative procedure called interpretative phenomenological analysis. Although there was no evidence to suggest there to be a difference between the groups in terms of the structure of participants’ construct systems, participants with depression were found to perceive a greater degree of change in identity, and to overwhelmingly perceive changes in identity to be negative (e.g. depression score correlated +.82 with divergence between self now and ideal self repertory grid elements, P<0.001). The interview data revealed a number of important dimensions of identity transformation which differentiated the two samples of participants. It is suggested that a key factor in maintaining good mental health in old age is the flexibility to adjust values such that intrinsic aspects of old age (e.g. wisdom and experience) are highly valued, and intrinsic values of younger age (such as work roles and youthful appearance) are less highly valued.
2. Introduction.

This study proceeds from a pilot study (Barker, 1996) which investigated adjustment difficulties in a small sample of depressed older adults. The participants in the pilot study were over the age of seventy five, and therefore fell into the classification described as "old-old" by Neugarten (1974). Since "old age" spans a very wide age range, the distinction between young-old (between the ages of 60 and 75), and old-old (aged 75 and above) has considerable utility because these two age groups are characterised by very different issues and experiences. The pilot study identified three specific areas of developmental transition which contributed to the emotional distress of the participants. These areas included a constriction of social support networks, an increase in dependency needs, and a reduction of meaningful roles. The study raised important questions about the effects of these processes on the identities of participants. It seemed that participants had difficulty in maintaining a coherent sense of self in the absence of important identity defining roles and relationships. The participants in the study also seemed to express a negative view of themselves and their position within a wider social network. Expressions of feeling "useless" or a "burden" were common.

The present study is grounded within the theoretical frameworks of social constructionism and constructivism, and aims to investigate participants' perception of their identity, and ways in which participants perceive their identity to have changed over the course of their life, particularly as they have entered later life. In addition to this focus, the study also aims to interrogate what meaning participants give to, and understand of their life. The study is an inductive investigation of the individual ways in which older adults who experience psychological distress construe their present and past. This study is based on the assertion that the subjective processes of construction are an important contributor to the development and maintenance of depression in later life. The clinical relevance of the
study derives from a second assertion that an individual's subjective construction of reality is amenable to modification through psychological therapy.

The influence of the social construction of the ageing process on an individual's mode of construing self in old age also needs to be taken into consideration in attempting to gain an understanding of older adults. It is sometimes difficult for professionals working with the old-old to avoid feeling stuck or thwarted when faced with clients who hold a deep sense of hopelessness (Davis, Elliott, Davis, & Binns, 1987). This raises the need for the development of models of therapy which are different to those used in work with younger adults (Dooley, 1996). The social constructionist framework can help meet this need not only by providing the flexibility for clients to develop alternative constructions of their situation, but also by facilitating a more positive construction of old age both by caring professionals, and by the wider society.

2.1. The social construction of old age.

Some researchers have criticised the tendency of social scientific research to reinforce conventional misunderstanding and demeaning attitudes towards older people (Baltes, 1991; Thompson, 1993). Thompson argues in favour of research which aims to gain an understanding of later life experiences through investigating individuals' life history as a whole. Earlier studies of ageing such as those conducted by Cumming and Henry (1961) have led to ageing being seen as a process rather than a discrete event. This view emphasises the uniqueness of the course of each individual's life and acknowledges that later life experiences and self perception are determined by many formative experiences which accumulate over the course of the preceding life span.
Rapoport and Rapoport (1975) also argue for “the importance of viewing people in the later phase of life in a less stereotyped and more differentiated way”, (p. 312). It can be argued that there is a greater potential for variety of life patterns in later life because life is no longer structured by education or work. Older adults possess the unique necessity to structure their own life style. Although the absence of the structure of work can be viewed as a form of freedom, retirement is more often experienced by people as a serious loss. Thompson (1993) has investigated the difficulties which obstruct older adults in their continued pursuit of an independent purpose and meaning in life. He identifies that a universal constraint to people in old age is “the spoiled personal identity threatened by widespread popular images of old age”, (Thompson 1993; 689).

Psychological research into old age has also tended to focus primarily on deficiency (Baltes, 1991); for example, there has been a particular emphasis on measuring cognitive deficits (Schaie, 1988). Such a focus is consistent with everyday expectations of ageing. Although these expectations are grounded in objective reality, it can be argued that they simplify something which is actually more complex and differentiated. Baltes (1991) argues that ageing has “many faces”, and that deficits may not necessarily impede development, but rather act as the trigger for a search for new forms of mastery and progress. He argues that the essential problem of ageing is in reaching a balance between the dynamics of growth and decline.

Baltes (1991) provides an account of psychological conditions which are necessary for successful ageing. One component which is essential to maintaining a positive sense of self is the principle of many “possible selves” (Markus & Nurius, 1986). This refers to the way in which personal identity comprises a system of selves characterised by different interests, skills, and purposes. The notion of having a wide repertoire of possible selves provides an effective mechanism for adjusting to changing life
circumstances. A second important psychological mechanism is the capacity to change goals and levels of aspiration. This capacity involves being able to be flexible not only in one's level of aspiration but also in the time frame within which one anticipates achieving goals.

A third principle acknowledges the way in which self evaluation is a relative judgement based on the process of social comparison. Baltes, (1991) points out that adverse experiences such as illness can be more successfully accommodated through selecting a new reference group, in order that we can compare ourselves with people who have similar or worse experiences. He argues that these three reconstructive processes contribute to the maintenance of a sense of integrity and productivity in old age, and help enhance individuals' adaptive capacity.

Baltes has proposed a model of the effective management of the process of ageing, called the model of "selective optimisation with compensation" (Baltes & Baltes, 1980, 1990). Selection refers to the selective reduction in one's repertoire of activities. Optimisation refers to developing mastery over the constricted range of activities through affording each task more time. Compensation refers to the strategy of developing new ways of carrying out familiar tasks, when age related losses of physical and mental capacities preclude old ways of coping.

Although this model does provide a framework for understanding the ageing process which maintains a better balance between the positive and negative elements of that process, it does not hold as much explanatory power when applied to the old-old, or those over seventy five, for whom there is a negative balance between personal losses and gains. Baltes (1991) acknowledges that the model is based largely on the study of "young-old" adults. Very few studies of the old-old have been carried out and consequently there is a lack of evidence upon which to base a model of the psychological nature of ageing at this stage of life.
In this study, the two theoretical models of social constructionism and constructivism have been used to interrogate the construction of self among the sample of participants. A brief critique of each model is presented below.

2.2. Social construction theory and constructivism.

Social construction theory is often confused with constructivism, and this confusion is partly due to the areas of overlap between these two theoretical models. These models are based on the proposition that it is not possible to know the real world with objective certainty. This proposition challenges the basic assumption underlying the positivistic research paradigm that a singular truth can be objectively identified and measured.

Constructivism essentially proposes that in each individual, an idiosyncratic system of percepts and constructs evolves as they interact with their environment. Social constructionism differs from this view in the emphasis it places on the mediating role of social interchange and language on the development of ideas, concepts and memories (Hoffman, 1992). Social construction theory asserts that social interaction through ongoing intimate relationships is the primary influence on the development of identity. This model deconstructs the notion of the 'individual', arguing that all of the personal traits which have traditionally been attributed to be characteristics of the individual within social scientific research, are generated within a specific social system.
2.3. The “narrative” mode of thought.

Social construction theory proposes that people communicate their identity through the telling of ‘stories’ of the self (Gergen & Gergen, 1988). The term ‘story’ is a useful concept because it reflects the subjectivity which is inherent in accounting for oneself. The process of relating a story of self involves a series of choices such as deciding which bits of information to include, and what sequence to present the information in. Bruner (1986) has argued that we have a genetic proclivity for communicating through the story form. He distinguishes the narrative mode of thinking from the logico-scientific mode as follows: “A good story and a well-formed argument are different natural kinds. Both can be used as a means for convincing another. Yet what they convince of is fundamentally different: arguments convince one of their truth, stories of their lifelikeness. The one verifies by eventual appeal to procedures for establishing formal and empirical truth. The other establishes not truth but verisimilitude.” (Bruner, 1986: 11).

Gergen and Gergen (1988) argue that self narratives have to be embedded within a context of personal history. The self narrative describes a sequence of self-relevant events across time. In doing so, the individual is seeking not just to describe these events, but to understand how they are systematically related. Bettleheim (1976) argues that this narrative order helps to create a sense of purpose and direction in life.

Gergen and Gergen (1988) describe five essential components of a well formed narrative. Firstly, a narrative must make a ‘point’ which immediately introduces a degree of subjectivity in to the discourse. Once the end point has been identified, it is then possible to explore the way in which events relating to this point have been introduced, the way in which these surrounding events have been placed in an order, and the sequence of causality which has been drawn out by the protagonist.
Finally, a narrative is demarcated by phrases which signal both its beginning and its end. For example "I will tell you why I am so happy", or "and now you know what happened".

A narrative also contains a crucial evaluation regarding the valued end point. This evaluative aspect helps to generate a sense of coherence and directionality in one's life. Gergen and Gergen (1988) have classified three basic forms of narrative based on the narrative's evaluative content. The first is described as a stability narrative in which the protagonist links events in such a way that they remain unchanged with respect to their valued goal. Alternatively, events which either advance or impede the protagonist's position in relation to their valued goals are described as progressive and regressive narratives. This evaluative aspect of narratives underlines the proposition that narrative truth is socially constructed, and as such has an interpretative basis.

Although there is an infinite range of forms of narratives which an individual could use, Gergen and Gergen (1987) argue that culture influences the form of narrative used to a large degree. To demonstrate this, they conducted a study of two populations drawn from specific age groups which included adolescents (aged 19 to 21) and older adults (aged 63 to 93 years). They asked the participants to graphically chart the course of their life along a general evaluative dimension. A life history chart was presented to participants consisting of a two dimensional space (age x evaluation) upon which they were asked to draw a "life line". The researchers found a remarkable level of consistency within each group. Adolescents tended to illustrate a period of struggle during adolescence, and characterised their current stage to be entering a period of upward swing set to continue into their future. Older adults by contrast tended to draw a rainbow shape indicating a "golden" period between the ages of 50 and 60, followed by a progressive decline into old age.
Within the consistency of the narrative forms used, the researchers found considerable variation in the life events upon which the evaluations were made. The researchers argued that the participants in each group appeared to be using a culturally sanctioned narrative form, employing idiosyncratic experiences to illustrate this form. This finding indicates that narratives are used in the construction of a life story, but that they are not directly a product of one's life experiences. This is an important distinction because it introduces the possibility that alternative constructions could be made of the same life events. The authors question the extent to which social science research fosters the view of life as an inverted rainbow, with decline an inevitable part of later life. They argue that such views "furnish the elderly with little sense of hope or optimism. With different views of what is important in ageing - such as those adopted by many Asian cultures - social scientists might furnish constructions of far more positive and enabling potential." (Gergen & Gergen, 1988: 32).

2.4. Personal construct psychology.

Personal construct psychology (PCP) is a constructivist model which is concerned with the subjective meaning which people attach to their experiences. George Kelly, the originator of this branch of psychological theory (Kelly, 1955) argued that people are "scientists" in the sense that we are constantly applying our own personal theories which are based on our past experiences, to new situations. The primary motivation for this activity is to enable us to anticipate future events. These theories and interpretations are called 'constructs' within this model, and are assumed to be bipolar in nature because they are our way of discriminating similarity from difference. The principle of ‘Constructive alternativism’ which underlies this theory acknowledges that there are different ways of seeing, and that alternative constructions are equally valid.
Personal construct psychology has been argued to be useful in working with older adults because it focuses on the way that individuals accommodate changes in their circumstances and experience by modifying their system of constructs (Viney, Benjamin & Preston, 1990). The model regards the reconstruction of experiences to underlie psychological development. Viney et al. (1990) argue that a series of transitions which are ongoing in old age invalidate the elderly person's constructs and disconfirm their prior experiences.

These authors have identified four key categories of transition which challenge the integrity of existing constructs. These include body related changes, self related changes (such as memory lapses), interpersonal losses and changes in social role. Personal construct theory states that when an individual's constructs no longer adequately incorporate their experiences, then they experience unpleasant emotions such as anxiety and hostility. These emotions act as a catalyst for reconstruction. Reconstruction is viewed to be a dynamic process in which people interpret and reinterpret their experiences, continually modifying their system of constructs. Kelly described this process as 'serial reconstruction'.

Viney et al. (1990) make a distinction between constructs which are validating and invalidating. Validating constructs transcend the limitations to body, self and roles which arise in old age. An example of a validating construction of a decrease in physical ability in old age might include "I get a little bit tired, but I enjoy life". Alternatively, invalidating constructs are preoccupied with limitations. An example of an invalidating construction of a decrease in physical ability might include "I can't walk as far as the bus stop anymore". Viney et al. argue that validating constructs are flexible and adaptive, while invalidating constructs are rigid, leading the individual to becoming trapped with ways of making sense of their experiences which no longer enable them to act effectively in their social environment. Invalidating constructs can be overly 'tight' leading the
individual to make predictions which are constraining to self, or they can be overly 'loose' leading to confusion and a lack of a clear sense of self.

A number of studies have investigated the role of constructs in the development and maintenance of depression (Rowe, 1971; Sheehan, 1981). These studies have concluded that individuals who are depressed tend to have construct systems which are rigid and undifferentiated causing the individual to view themselves and the world in terms of a narrow range of strongly held constructs. This contrasts with the more adaptive nature of a construct system in which there is a wider range of core constructs, some of which conflict and therefore lead to a more fluid process of serial reconstruction. There have been no formal studies of the nature and content of construct systems among older adults with depression. Viney et al. (1990) have questioned the appropriateness of using formal psychological tools such as the role construct repertory grid with older adults. They favour instead ways of asking questions similar in form to the repertory grid techniques, but in the context of an unstructured therapeutic interview.
2.5. Review of research into the narrative construction of self.

There has been a renewed interest in the study of the construction of self within academic psychology. This subject is grounded within the life span developmental perspective, and invokes the constructivistic notion of the self as a dynamic, emergent being, which continually undergoes change. Research in this area has followed several strands. There has been a strand which has investigated the role of social cognition in the creation of a personal history. For example, Greenwald (1980) argues that self referential cognitive biases such as selecting self enhancing information, and selective use of autobiographical memory are used in order to enhance self esteem. A second strand of research has investigated the construction of self at a more global level, and this includes the work of Gergen & Gergen (1988) reviewed above.

Empirical studies of reconstruction have identified two differing forces in the process of self reconstruction. The first is a general tendency of people to construct a narrative of self-progress. Lowenthal, Thurner, and Chiriboga (1976) found that people of all ages tended to see the best time of their life as being within five years of the present, and the worst as being distant. Secondly, Cohler (1982) identified a tendency for people undergoing periods of great transition to stress continuities across the transition. Smith (1994) suggests that the impetus for reconstruction is derived from a dynamic tension created by two opposing drives for change and continuity.

Identity transformation as a result of life transitions has become a fruitful area of investigation, in which idiographic research methods have been effectively utilised. Smith’s study of the reconstruction of identity during the transition into motherhood (1990, 1994) is a notable example of this investigative approach. He adopted a case study design to conduct a detailed examination of reconstruction strategies used by four
participants. Using a combination of forms of data collection including repertory grids and semi structured interviews, he identified four forms of narrative reconstruction used by each of the participants which he argued to represent important aspects of the process of identity transformation. He argued that these forms of self narrative were self-enhancing, helping each participant to maintain self esteem as they underwent a period of intensive personal change.

Aspects of the methodology developed by Smith (1990, 1991, 1994) have been adopted in the present study in order to investigate the process of identity transformation occurring in the context of the ageing process. These include the combined use of the repertory grid test and semi structured interviews to collect quantitative and qualitative data. The developmental stage of later life is highly suitable for detailed investigation not just because it is a period of intensive personal changes but also because as has been argued above, the changes associated with this life stage are generally associated with a pejorative social construction.
3. Research Focus and Questions.

3.1. Research focus.

The present study aims to use a social constructionist approach to investigate the effect on identity of undergoing the transition into old age. A comparison of depressed participants with non depressed participants will enable potential differences and similarities in the construction of identity in later life between the two groups to be identified. The study will primarily provide a phenomenological account of the ways in which older adults modify their concept of self in order to accommodate their changing experiences. It is intended that the study will generate some knowledge from which tentative inferences regarding psychological characteristics which inhibit or facilitate successful adaptation in old age can be made.

The study is based on propositions derived from the social constructionist perspective which provides a framework within which negative constructions of ageing can be challenged. These propositions, which were reviewed in the previous section can be summarised as follows: Firstly, social constructionism acknowledges the diversity of the ageing process even in the later stages of life, and challenges the assumption that when people become very old, they acquire a narrow stereotypical identity and lifestyle. A constructionist approach promotes the possibility of alternative constructions of real life, which are subjectively valid, though they do not seek to represent 'objective truth'. This study acknowledges that reconstruction is an integral aspect of psychological development, and that difficulties in adjustment arising from life transitions can be understood in terms of the way that the transition influences the individual's construction of self.

These propositions suggest that the study of individual ways of construing self is a valid area for an inductive investigation, particularly in the context
of individuals undergoing a process of developmental transition. An investigation of old-old age as a developmental stage has particular relevance because of the high potential for life changes at this stage of life to be negatively construed, and because there has been very little in depth psychological research at an individual level of people of this age group. This study therefore aims to explore a gap in existing literature. There is currently no model of effective psychological management of the process of ageing among old-older adults. The development of such a model is beyond the scope of this project, but it does aim to explore the issues that such a model might include.

This study investigates the process of identity transformation in a small number of individuals who have experienced psychological distress as they have undergone the transition into very old age leading them to seek treatment for depression, and a comparison sample of older adults who have not. A range of data collection procedures combining quantitative and qualitative research methods have been adopted in order to generate a data set from which changes in the construction of self can be identified.

3.2. Research questions.

The following questions are addressed by the current study:

1. What are the (within and between) group differences and similarities in terms of the structure and content of personal construct systems? Here, aspects of repertory grid structure and content which have been found to be clinically significant in previous personal construct psychology research into depression will be explored:

   1.1 Do participants in the depressed sample have a higher percentage variance accounted for by the first principal component, indicating that they have a unidimensional, less
differentiated construct system than non depressed control participants?

1.2 Do participants with depression perceive a greater amount of divergence between current self and ideal self elements than non depressed participants, indicating a lower level of self acceptance?

1.3 Do participants with depression have a similar thematic content to core construct dimensions as non depressed participants?

2. How do the participants construe changes in identity arising from the transition into later life?

4.1. Participants.

Twelve participants over the age of seventy were included in this study and were divided into a depression and comparison sample each comprising of six participants. An effort was made to match participants in the two samples for age, sex and marital status. None of the participants suffered from a major physical illness or injury, nor did they suffer from obvious cognitive impairment. No formal assessment of cognitive impairment was conducted by the researcher, but four older adults who were approached as potential participants in the study were not included because they presented mild signs of memory impairment and/or confusion. Pseudonyms have been used in order to maintain the anonymity of the individuals who participated in the study.

Depressed participants were obtained from the current caseload of an elderly mental health team (EMHT), and non depressed participants were sought at two luncheon clubs within the same geographical area served by the EMHT. Participants were assigned to the depression or comparison samples on the basis of a score obtained on a self report depression inventory (The Schwab-Gilleard Depression Scale) (see Appendix 1). An information sheet was given to participants when they were approached to take part in the project explaining the nature of the study and what their participation would entail (see Appendix 2). Written consent to participate in the study was obtained from each person (see Appendix 3).

The number of participants included in this study are too low to yield results which are statistically significant, or which can be said to have a generalisable clinical significance. Some proposed guidelines for doctoral level qualitative research studies have recently been published (Turpin,
Barley, Beail, Scaife, Slade, Smith, & Walsh, 1997) in which it is suggested that such projects should have a minimum of five participants. These authors point out that many published qualitative research projects are based on a sample of between eight and twenty participants.

4.2. Procedure.

Data were collected using a semi structured interview and a standard role repertory grid test. The interview and repertory grid test complemented each other well as both are idiographic data collection procedures. Repertory grids offer a number of advantages over standard interview methods. They can be interpreted subjectively but also provide a means of objective scoring and analysis. Furthermore, grids can access aspects of construing which are at a low level of cognitive awareness, providing information which is unlikely to be revealed in an interview (Winter, 1992). Twelve interviews were carried out face to face in a range of settings which included participants' homes, a day hospital, and two luncheon clubs. The interviews lasted between one hour and two hours in total, and longer ones were conducted over two separate appointments.

4.2.1. The interview.

A semi structured interview was conducted which aimed to encourage individuals to reflect on the process of identity transformation occurring as they have undergone the transition into old age. The interview focused both on exploring participants' current self characterisation and identity as an older adult, and also on key ways in which they implicitly compare current self with identities formerly held, in other words a retrospective comparison of differences in self over time. Current roles and sources of meaning were a third area of investigation. The interview schedule is shown in Appendix 4.
The interviews were tape recorded with the participants' permission, and tapes were transcribed verbatim.

4.2.2. Repertory grid.

The study employed a standard repertory grid technique with elements mostly provided by the researcher, and constructs elicited from the participant. The elements represented 'self' at different life stages in order to investigate areas of perceived identity transformation over time. The elements also included other important people. Ten elements in total were included, nine of which were supplied as follows:

1. Current self 6. Father
2. Ideal self 7. Spouse
3. Self as a child 8. Liked person
5. Mother

The tenth element was elicited through discussion with the participant, and often represented an offspring. Participants were encouraged to specify someone who was currently important to them.

The traditional method of eliciting constructs was used in which the participant was presented with triads of elements and asked to describe a way in which two of the elements are similar and different from the third element (Fransella & Bannister, 1977). Once a construct was elicited by this question, the participant was then asked to supply its contrast by specifying what they viewed the opposite of the construct to be. Participants were then asked to rate each element against each construct dimension using a scale of 1 - 5.
4.3. Analysis.

4.3.1. Qualitative analysis.

The interview data were qualitatively analysed using interpretative phenomenological analysis (IPA) (Smith, 1995; Smith, Flowers & Osborn, 1997) which is concerned with investigating individual participants' perception of an event or experience as far as possible from an insider's perspective. This approach acknowledges the limitations of research grounded within the positivistic paradigm which sets out to produce objective statements about the topic of investigation. A second fundamental facet of this approach is its recognition that research is a dynamic process, in which the researcher cannot experience the personal world of the participant as he or she does exactly. Attempts to do so are inevitably flavoured by an interpretative process through which the researcher uses his/her own conceptions to make sense of the participant's personal world. Interpretative phenomenological analysis can be distinguished from discourse analysis (Potter & Wetherell, 1987) by its concern with cognition. In other words, IPA attempts to say something about the thinking process that underlies the words used by the participant to describe their experiences.

Analysis of each transcript began by recording a code in the right hand margin at the end of each line of transcript which accurately described the content of the script. Interpretative comments were noted in the left margin in an attempt to capture the essential meaning of the data. Emergent themes were noted on a separate sheet of paper and were grouped together reflecting relationships occurring within the source material. Instances from the transcripts of every interview that illustrated each category, theme and super-ordinate concept (concepts which seemed to link other themes) were noted. The interpretation of these themes and sub-themes was conducted by a process of repeatedly
reading transcripts, noting instances within the transcripts which supported tentative hypotheses, and by using diagrammatic representations to explore the possible developments of any overall processes. Interpretations were further supported through consultation with colleagues.

The same procedure was repeated for each of the twelve transcripts. The twelve scripts were treated as one group initially and were analysed in a random order. If the two sets of transcripts had been analysed in two separate batches, the researcher would have approached the second batch of data holding a different set of constructs, which would inevitably have been modified in the process of analysing the first batch. Only after the analysis was completed were the transcripts treated as two separate sub-groups. At this stage of the process of analysis, themes common to and differentiating both groups were sought, and an overall structure of sub-themes, themes and super-ordinate concepts was generated.

The formatting used in presenting quotations is outlined in Appendix 5.
4.3.2. Repertory grid.

Repertory grids were analysed using Factor which is part of the statistical package for social sciences (SPSS) programme. This created a correlation matrix showing the relationship between all constructs, and also performed a principal components analysis. The principal components analysis provides a key source of data for the purposes of this study. The following aspects of the grid data which have maximum relevance to the research questions have been used:

I. The amount of variance associated with the first principal component identified in the principal components analysis has been utilised in this study in order to ascertain the degree of cognitive complexity of each participant's personal construct system. A high percentage variance is indicative of a unidimensional, undifferentiated system of construing.

II. In order to provide data about the ways in which participants perceive changes in their identity, divergence between construct ratings for the current self element and other self elements has been explored. The ratings for the ideal self elements have been compared with ratings for other self elements in order to ascertain how changes in identity have been evaluated. Where there is a large divergence between ratings for self and ideal self elements, this suggests a construct dimension in which self is construed negatively. Winter (1992) suggests that a discrepancy in ratings of more than one point may be regarded as indicating a significant difference in construing of those elements, but that a difference of only one rating point is likely to be accounted for by chance variations in ratings made. For each participant, the number of constructs in which there are discrepancies between the current self, ideal self and happiest self elements have been calculated.

III. The content of constructs correlating with the principal components have been examined in order to compare the thematic content of key
construct dimensions held by depressed and non-depressed participants. This analysis explored ways in which constructs held were facilitating of adaptation to later life, or were more appropriate to earlier life stages. This is consistent with Kelly's (1955) notion that people are continually undergoing a process of serial reconstruction, but that an absence of reconstruing leads to psychological conflict, or invalidation (Viney et al., 1990).

4.4. Evaluation of validity.

The question of finding appropriate means of assessing the validity of qualitative research continues to be a subject of discussion among qualitative researchers. Smith argues that "qualitative research should not be evaluated in terms of the canons of validity that have evolved for assessment of quantitative research since these have different epistemological priorities and commitments." (Smith, 1996: 189). A common approach to assessing the validity of a research report is to submit the report to an independent researcher along with the data in order that a check can be made that the report is credible, and that a logical progression runs through the chain of evidence. This notion of an independent audit has been confused with the notion of interrater reliability, but an independent auditor does not necessarily seek to reach a consensus. Their task is to ensure that the account is credible and based on the data collected, but this does not preclude that other equally credible readings of the data could be produced.

Henwood and Pidgeon (1992) have argued strongly against the routine use of conventional reliability and validity checks which serve the function of creating an impression of the eradication of researcher bias. They argue for a naturalistic paradigm which "challenges the dualistic distinction between knower and known, leading to the realisation that the personal is always present in research." (Henwood & Pidgeon, 1992: 224)
Advocates of IPA (Smith, 1995, 1996) have also acknowledged that the researcher's conceptual framework is inescapably involved in the research product, and that if an independent audit were to be conducted, the auditor would undoubtedly generate a different set of interpretations because they would be interpreting it through a different conceptual framework. If one is attempting to capture the meaning of the phenomenon to the participant, then this necessarily involves interpretative engagement with the respondent's text. Henwood and Pidgeon have argued for canons for evaluating generative research, which do not "seek to eliminate idiosyncrasy and creativity" (1992, p. 105), regarded by them to be essential characteristics of research which aims to produce relevant and good theory.

In this study it was decided that routine evaluative methods such as inter-rater reliability were inappropriate for the reasons outlined above. My aim has been to produce a persuasive analysis, which provides readers with sufficient evidence from raw data to allow them to assess the persuasiveness of interpretations made for themselves. In writing the text, an effort has also been made to adhere to other criteria which have been agreed to be useful for evaluating quality in qualitative research (Smith, 1996). These include ensuring the internal consistency of the script, and coherence of arguments advanced. Secondly, because a number of different forms of data have been collected, the researcher has sought to effectively triangulate the different strands of data in order to strengthen the claims made.

The issue of assessing the validity of repertory grids is also a complex one. Kelly (1955) was prepared to equate validity with 'usefulness'. In the case of the repertory grid, usefulness relates to the extent to which the grid increases understanding, (Fransella & Bannister, 1977). Grids do not have a specific content, but are a framework within which relationships between a person's constructs can be explored. Grids can be argued to have intrinsic validity because they generate a 'population' of responses
on which one can apply a range of statistical techniques which would be applied to a population of participants (for example correlations between constructs, and factor analyses). Grids also have an infinity of forms and therefore cannot be talked about as an entity in the same way that a psychological test is an entity.

A key determinant of the validity of a repertory grid is the extent to which the elements are within the range of convenience of the person's construct system. In other words, whether the participant can use their constructs to make sense of the particular elements. Similarly, if a participant is supplied with verbal labels which are relatively unfamiliar to them, they may arbitrarily attach meanings to these labels and produce a pattern of relationships which are random, resulting in an absence of predictive value in the grid. In this study, constructs have been elicited from the participant rather than supplied to them in order to ensure that they are meaningful to participants. Constructs which are elicited rather than supplied have consistently been found in research studies to have a greater power to differentiate between elements, (Fransella & Bannister, 1977). In this study, participants were encouraged to elaborate the meanings that they attached to constructs during the interview in order to ensure that elements were not sorted in a random manner.

4.5. The epistemological status of the study.

A key issue in the interpretation of the results of this study concerns the status afforded to the data, i.e. what claims can be made of it. Does the data reflect some form of reality, or should it be viewed purely as a social construction? This latter view is consistent with a discursive analytical approach. The approach of discourse analysis regards language “not as simply reflecting psychological and social life but as constructing it” (Coyle, 1995: 244). In discourse analysis the focus of analysis is language and the way language is used to construct personal reality.
This approach rejects the possibility of mapping verbal reports onto underlying cognitions, arguing this to be unacceptable reductionism. However, to take the position that there is nothing but the text disregards material consequences of research.

A central aim of this study was to learn something about the inner psychological world of the participants. This study has adopted an approach of 'critical realism' which is a specific approach within the material discursive perspective. Critical realism argues that "there is a real world, but that our accounts of it are inevitably partial" (Abbott & Wallace, 1990: 221). It acknowledges that there is a social reality which has meaning and consequences for the individual. It also acknowledges that the meaning and value given to these experiences can change because of the mediating influence of reconstruction, bias and interpretation. In this study it has been assumed that the accounts contained in the data reflect social reality, but that the data inevitably represent only a partial account of that reality. Although the data are not isomorphic with the actuality of the events they describe, it has been assumed that there is some relationship between these events and the accounts offered by participants mediated by the researcher's interpretations. No claims about the nature of this relationship can be made with certainty. The value of the research derives from the extent to which appropriate criteria for evaluation (such as the internal coherence and persuasiveness of the report, the provision of raw data to support interpretations made, and the triangulation of data from different sources) are met.

4.6. A note on the statistical procedures used.

Although this study essentially utilises qualitative research methods, the use of repertory grids does enable the use of quantitative methods of
analysis. A number of statistical procedures have been presented in the results section which follows.

The Mann-Whitney U test has been used to assess the independence of the two samples according to three variables: age, depression ratings, and percentage of variance of participants first principal component. The Mann-Whitney U test was selected for the purposes of this study because the data do not meet the requirement for the use of parametric statistics. The data are not normally distributed, and the two samples do not have an equal variance.

The Spearman correlation coefficient has been calculated to measure the relationship between depression ratings and the level of divergence between various self elements. A non parametric alternative to Pearson's product moment correlation has been used because as above, the data do not meet the requirements for the use of parametric statistics. Spearman's correlation coefficient has also been used in this study because it assesses the extent to which a monotonic relationship exists between two variables rather than the extent to which that relationship is linear. In order to assess linearity, it is necessary to have variables with a level of measurement which enables uniform scaling such as interval or ratio levels of measurement (Miller, 1984, p. 139). The variables being considered in this study have an ordinal level of measurement.

The statistical results of these analyses are presented in the results section that follows, and fuller details of statistical procedures are presented in Appendix 7. The repertory grid raw data are presented in Appendix 8 and the principal components analysis of each participant's repertory grid is presented in Appendix 9.
5. Results.

5.1. Demographic information and clinical status of the participants.

5.1.1. Demographic Information.

The two samples were well matched in terms of the gender and marital status of the participants. Four participants in each sample were female and two male. Four participants in each sample were married and living with their spouses, while two participants in each sample were widows living alone. One control sample participant (George) had recently become married having lived alone for most of his adult life. He differed from all other participants in not having any children or grandchildren of his own.

All twelve participants were above the age of 70 years, and the oldest participant was 86. Table 1 shows that participants in the control group had a mean age which was seven years above the mean age of depressed participants. There was also a small difference in the range of ages between the two samples. The mean age for each sample was compared using a Mann-Whitney U test which revealed the difference in age between the two samples to have a low level of statistical significance (U = 7, P= 0.09). An effort has been made to investigate the effect of this small age difference in subsequent analyses which have been conducted.

Table 1 – Median and mean age, and standard deviation for control and depressed samples.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Median</th>
<th>Mean</th>
<th>Range</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control (n=6)</td>
<td>80.5</td>
<td>81</td>
<td>73 – 86</td>
<td>6</td>
</tr>
<tr>
<td>Depressed (n=6)</td>
<td>75</td>
<td>74</td>
<td>70 - 78</td>
<td>3</td>
</tr>
</tbody>
</table>

U = 7 (P=.09, n.s.)
5.1.2. **Formal clinical status.**

There was a clear between groups difference in scores obtained on the Schwab-Gilleard depression scale (see Appendix 6). All of the control participants obtained depression ratings below the cut off score which indicates clinical depression, (14 out of a maximum of 30) (Richardson & Hammond, 1996). Each of the depressed participants obtained a rating score above this cut off level, indicating the presence of clinical depression at the time of interview. The mean depression rating for each sample was compared using a Mann-Whitney U test. There was a significant difference between the two mean scores (U = 0, P < 0.01).

**Table 2 – Mean depression ratings on the Schwab-Gilleard Depression Scale for the control and depressed samples.**

<table>
<thead>
<tr>
<th>Sample</th>
<th>SGDS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Mean 7</td>
</tr>
<tr>
<td></td>
<td>SD 3</td>
</tr>
<tr>
<td>Depressed</td>
<td>Mean 24</td>
</tr>
<tr>
<td></td>
<td>SD 2</td>
</tr>
<tr>
<td></td>
<td>U = 0</td>
</tr>
</tbody>
</table>

Significance level: P < 0.01
5.2. The structure and content of construct systems.

5.2.1. Complexity of construct systems.

A principal components analysis was conducted on each repertory grid yielding for each participant a correlation matrix, a table of principal components, and a factor matrix (see Appendix 9). In order to investigate the difference between the samples in the structure of participants' construct systems, the percentage of variance accounted for by the first principal component was compared. This statistic has been the focus of previous research studies into depression (Sheehan, 1981) because it is thought to be a good indicator of an individual's ability to tolerate and adjust to personal change through appropriate modification of one's system of personal constructs. Sheehan found in his study of adults (aged between 19 and 56 years) that people with depression had a significantly higher percentage variance accounted for by their first principal component than non depressed control participants (Sheehan, 1981). Percentage of variance accounted for by a principal component can also be expressed as an eigenvalue (a measure of the explained variance associated with a factor), and this term will also be used in the following text because of its brevity.

The percentage variance for each of the twelve participants is shown in Appendix 6, and a summary of these data is presented below in Table 3. Table 3 shows that the mean percentage variance for each sample is extremely similar. No between groups difference in the direction predicted by previous research has been found on this occasion. This suggests that there is no difference between the two samples in terms of the complexity of participants' construct systems, as measured by the repertory grids.

The mean percentage variance scores for the two samples were compared using a Mann-Whitney U test, which yielded a non significant
result \((U = 18)\). It is important to note that the statistical procedure used was unlikely to yield a significant result because of the limited power of the test due to both the small size of each sample of participants, and also given that a statistic such as the eigenvalue tends to have a small effect size.

Table 3 – Percentage of variance accounted for by first principal component within the depressed and comparison samples.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Percentage variance of the first principal component.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressed</strong></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>54.28</td>
</tr>
<tr>
<td>SD</td>
<td>8.80</td>
</tr>
<tr>
<td><strong>Comparison</strong></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>54.93</td>
</tr>
<tr>
<td>SD</td>
<td>6.28</td>
</tr>
<tr>
<td>(U = )</td>
<td>18</td>
</tr>
<tr>
<td><strong>P=1.00 (n.s.)</strong></td>
<td></td>
</tr>
</tbody>
</table>

A review of the eigenvalues obtained by participants reveals there to be a high degree of comparability in the spread of eigenvalues within each group, and this is contrary to what one might expect given that there was a significant between group difference in terms of presence of depression. The mean percentage variance for both groups (54.28 and 54.93 for the depressed and comparison samples respectively) were comparable with the mean percentage variance obtained by the depressed sample in Sheehan’s (1981) study (50.58), in which a similar sized repertory grid was used. The mean scores are higher than the percentage variance measured for the comparison sample in Sheehan’s study (38.60). The results suggest that participants in both the depressed and comparison groups in this study have construct systems which can be described as having a narrow and unidimensional structure.
5.2.2. Discrepancy between ratings of self elements.

Discrepancy between the ratings for the current self element and the ideal self element has also been the focus of considerable research and clinical interest in applying personal construct theory to depression. A large discrepancy between self and ideal self elements is thought to indicate the presence of a negative self concept (Sheehan, 1981). Table 4 below shows the number of same and divergent ratings for participants in both groups. This table clearly shows there to be more divergence between ratings for self and ideal self elements among depressed participants compared with control sample participants. This pattern of rating implies that the depressed participants construe current self negatively.

**Table 4 - Convergence and divergence between ratings for self and ideal self elements.**

<table>
<thead>
<tr>
<th>Control Participants</th>
<th>Depressed Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Same</td>
</tr>
<tr>
<td>Ellen</td>
<td>6</td>
</tr>
<tr>
<td>Phyllis</td>
<td>7</td>
</tr>
<tr>
<td>George</td>
<td>8</td>
</tr>
<tr>
<td>Ann</td>
<td>7</td>
</tr>
<tr>
<td>Ken</td>
<td>9</td>
</tr>
<tr>
<td>Nell</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

A scatterplot showing the covariance of divergence in construing these self elements and of depression scores is shown in Figure 1. The scatterplot shows the presence of a positive linear regression suggesting that there is a positive relationship between severity of depression and divergence in construing self and ideal self elements. A Spearman
correlation coefficient has been used to calculate the strength of correlation between the divergence in construing and depression scores, \((r_s = .82, P < .001)\), (see Appendix 7). These results indicate that the depressed participants do construe themselves negatively on a larger number of construct dimensions than the non depressed older adults interviewed in this study.

**Figure 1 - Scatterplot showing the relationship between divergence in ratings for self and ideal self elements, and SGDS ratings.**

A similar analysis was carried out comparing divergence between ratings of current self elements and happiest self elements. The rationale for this analysis was that it reveals something about ways in which participants evaluate transformation in identity. Given that there is a correlation between construing self positively and absence of depression, one would expect participants to have positively construed self during the happiest phase of their lives.

Table 6 shows the number of construct dimensions in which significant divergence in rating of current self and happiest self elements was
observed for both samples of participants. Again, there is a greater amount of divergence among depressed participants compared with control participants.

Table 6 - Convergence and divergence between ratings for self and happiest self elements.

<table>
<thead>
<tr>
<th>Control Participants</th>
<th>Depressed Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellen</td>
<td>Same: 6 Divergent: 2-ve/1+ve</td>
</tr>
<tr>
<td>Phyllis</td>
<td>Same: 8 Divergent: 2</td>
</tr>
<tr>
<td>George</td>
<td>Same: 8 Divergent: 0</td>
</tr>
<tr>
<td>Ann</td>
<td>Same: 7 Divergent: 3</td>
</tr>
<tr>
<td>Ken</td>
<td>Same: 9 Divergent: 1+ve</td>
</tr>
<tr>
<td>Nell</td>
<td>Same: 10 Divergent: 0</td>
</tr>
<tr>
<td>Total</td>
<td>Same: 48 Divergent: 7/2</td>
</tr>
<tr>
<td>Jacqui</td>
<td>Same: 2 Divergent: 6</td>
</tr>
<tr>
<td>Edith</td>
<td>Same: 3 Divergent: 6</td>
</tr>
<tr>
<td>Jean</td>
<td>Same: 1 Divergent: 8</td>
</tr>
<tr>
<td>Stephen</td>
<td>Same: 3 Divergent: 6</td>
</tr>
<tr>
<td>Paul</td>
<td>Same: 5 Divergent: 4</td>
</tr>
<tr>
<td>Rene</td>
<td>Same: 7 Divergent: 3</td>
</tr>
</tbody>
</table>

It was found that participants tended largely to apply a similar rating to ideal self and happiest self elements which adds further support to the proposition that depression is associated with negative evaluation of self on a greater number of construct dimensions. The data which are summarised in Table 6 shows that the depressed participants perceive a greater amount of divergence between current self and happiest self elements, and therefore perceive a greater amount of change in identity as they have entered old age. Furthermore, depressed participants construe these changes in self in an overwhelmingly negative way.

The relationship between the amount of divergence between ratings of self and happiest self elements, and depression scores is shown in the scatterplot illustrated in Figure 2. A Spearman correlation coefficient was used to measure the association between these two variables, (see Appendix 7). As with divergence between ratings for current self and
ideal self elements there is a significant correlation coefficient between divergence in ratings of current self and happiest self elements, and depression scores, \( r_s = .81, P < .001 \).

It was found that among the non depressed participants, some of the construct dimensions in which there was divergence between self and happiest self elements represented a positive change in construing of self in favour of current self. This was inferred because in two cases, the current self was construed to be closer to the ideal self element than the happiest self element was. Although this did not arise in the data very often, it did indicate that there was more of a balance in how perceived transformations in self are evaluated among the non depressed participants compared with depressed participants.

**Figure 2 - Scatterplot showing the relationship between divergence in ratings for self and happiest self elements, and SGDS Ratings.**

These results indicate that the depressed participants do construe current self differently from self in the past along more construct dimensions than participants in the control sample. Therefore they perceive a greater amount of identity transformation, and this transformation is evaluated in
an exclusively negative way. The non depressed participants perceived transformation in some construct dimensions to represent a positive identity change, suggesting that some adaptive modifications in construct systems had taken place, which was not in evidence among depressed participants’ construct systems.

Spearman correlation coefficients were calculated to examine the correlation between the variables of age and divergence in ratings of self elements. These analyses revealed that there was not a monotonic relationship between age the degree of divergence in construing self elements, (age and divergence between ideal self and current self elements, $r_s = .55$, $P = .032$; age and divergence between happiest self and current self elements, $r_s = .61$, $P = .017$), (see Appendix 7). This is further evidence of the significance of the correlation between severity of depression and the degree of perceived change in identity illustrated in the previous section.
5.3. The thematic content of core constructs.

In order to explore further the differences in construing self used by the depressed and non depressed participants, the thematic contents of core constructs were analysed, (construct dimensions are presented for each participant in Appendix 8). The relative importance of each construct dimension within the individual’s overall construct system can be gauged from the factor matrix (see Appendix 9) which shows the correlation between each construct dimension and each principal component. Constructs which correlate highly with the first and second principal component therefore represent core ways of construing (superordinate constructs). Furthermore, the correlation matrix (also shown in Appendix 9) reveals the ways in which clusters of constructs exist within an individual’s construct system. These constellations of constructs indicate ways in which an individual links units of meaning together, and enable a more complex understanding of an individual’s system of construing to be gained.

The previous section revealed that the depressed participants perceive more areas of change in their identity than participants who were not depressed, and that these changes were predominantly viewed in a negative way. The non depressed participants not only perceived less change in identity, but also held a slightly more balanced view of changes that had occurred in which changes were viewed both positively and negatively. Analysis of the content of participants’ constructs has revealed a number of qualitative differences in the content and nature of constructs held.
5.3.1. Constructs featuring roles which are linked with specific life stages.

A frequently occurring difference between depressed and non depressed participants was the presence of constructs which featured roles linked to a specific life stage, and were no longer appropriate to the individual. Three depressed participants (Stephen, Paul and Rene) held constructs relating to the role of being a 'worker' while none of the constructs generated by comparison participants related to specific roles such as 'work'. In addition to holding the construct of 'worker', these three participants were found to have generated a very pejorative contrast pole such as 'lazy' or 'loafer'. Here we see how negatively each of them construes people who are without a work role, and because these participants have not modified their construct systems as their circumstances have changed, they are compelled to view self negatively.

The importance of holding a caring/supporting role was evident among two of the depressed participants' construct systems (Rene and Jean). Again it was found that constructs relating to this role were given a contrasting pole which lead the individuals to construe themselves negatively in old age. Jean produced two constructs relating to the role of a carer. At the extremes of one dimension were 'doing things for others' contrasted with 'useless', while the other dimension contrasted being 'dependable' with being 'unreliable'. Rene held a similar construct dimension contrasting 'dependable' with 'unreliable'. In addition, she generated a construct discriminating between people who 'support' or are 'supported' (see Appendix 8).

These appear to be examples of the way in which a mismatch between an individual's construct system and their circumstances can create psychological distress and impair the individual's ability to act effectively within their world.
5.3.2. **Constructs promoting a level of activity which is not viable in old age.**

The depressed participants were also found to generate constructs which promote an unrealistically high level of activity, and consequently a lot of divergence was observed between current and past self elements in these construct dimensions. What emerged here seemed to illustrate the failure of adaptation described by Baltes (1991) to be important for successful ageing, i.e. the need to reduce goals and select more appropriate reference groups for self comparison. Constructs held by some depressed participants related to lifestyles which were no longer viable for them. Stephen was the clearest example of this and he construes there to have been negative changes in his identity on a high proportion of the construct dimensions he generated. Six constructs correlated highly with the first principal component, which represented a very significant factor within the construct system. Four of these six construct dimensions emphasised having a highly active lifestyle ('lively', 'occupied', 'workaholic', and 'happy go lucky') and were highly correlated with constructs relating to happiness and success, illustrating the way that Stephen has linked being highly active with these desired outcomes.

The construct dimension of 'busy' versus 'bored' was generated by two other depressed participants (Jean and Paul). This seemed to indicate dissatisfaction with an absence of purposeful activity in old age. These participants had not managed to replace lost roles and sources of activity with new ones appropriate to their current stage of life.

In contrast to these constructs promoting a high level of activity, some non depressed participants generated constructs which were conducive to a more sedentary lifestyle. Among the constructs correlating highly with Ken's first principal component were constructs relating to being 'easy going' and 'patient'. His repertory grid illustrates that he views having become 'easy going' rather than having 'high standards' to be a positive
change in his identity. This seems to be illustrative of adaptive reconstruction through which he has placed more value on a sedentary lifestyle in old age, thereby helping him to relinquish the part of himself which previously gained esteem from leading a high pressured life style.

5.3.3. Constructs which were congruent with depressed mood.

Unsurprisingly, a high number of constructs generated by depressed participants were congruent with their mood, and one would expect an individual with depression to have a negative style of construing. Jean generated a number of constructs to describe her current self which appear to be mood congruent, for example, 'miserable', 'dull', and 'guilty'. Several participants generated constructs which directly reflected having developed a low mood such as 'unhappy' and 'sad' (Stephen, Edith, and Jacqui). A number of depressed participants also generated constructs directly reflecting the development of worrying as a characteristic, which possibly could be attributed to be a manifestation of their depression (Edith, Paul, and Jacqui).

Constructs featuring mood were generated by three of the control participants (Ellen, Ann and Nell), but none of these individuals construed themselves to currently be unhappy.

5.3.4. Constructs relating to qualities which transcend ageing.

In contrast to the participants with depression, comparison participants generated construct dimensions which featured qualities which were not specific to any particular stage of life, or role/activity. This characteristic of construing among non depressed participants helps to account for the disparity between the two samples in the amount of perceived change in self due to ageing. The constructs generated by non depressed participants tended to have the capacity to endure changes resulting from ageing, enabling the individuals to continue to construe self in a similar
way at different life stages, thereby reducing the amount of perceived change in identity.

Examples of constructs which transcended ageing included the construct of being 'educated' which was held by two participants (George and Phyllis). Both participants valued their educational attainment as a positive defining aspect of their identity, and through valuing this aspect of self, they created a way in which they could continue to exercise mastery over their world. Other participants generated constructs relating to positive qualities such as 'honesty' (Ellen, Nell, and Ann), 'strong character' (Ellen), 'selfless' (Nell), 'fun loving' (Ann), and 'moral' (George). Each of these constructs relate to positively valued qualities which the participants regarded to be long term aspects of their character.

5.3.5. Constructs which facilitate adjustment to ageing.

Prominent among construct systems of non depressed participants were construct dimensions which appear to positively facilitate adjustment to old age. George's construct system contained a constellation of constructs which seemed to promote a high capacity to be flexible to personal change. In particular, he generated two constructs which correlated highly to the first principal component which were 'having a sense of the ridiculous', and being 'unconventional'. These qualities encourage him to find a novel way of being in relation to others. A goal such as being unconventional is likely to present an equally fulfilling challenge in old age as it is in earlier adulthood. Furthermore, the high value he placed on having a sense of humour about life presents a way of coping with adverse life situations which is likely to facilitate coping in general.

Nell generated a construct which also seemed to be facilitative of coping with adversity. Her construct system contained the construct 'never
grumble' which was contrasted with 'depressive type', indicating her to be someone who strives to look on the positive side of situations.

5.3.6. Deficits as a constant aspect of self rather than having arisen in later life.

While depressed participants were found to construe negative aspects of self to represent an area of personal change (decline), the non depressed participants tended to view negative aspects of self as enduring characteristics not resulting from old age. Phyllis's construct system illustrates this tendency. She construed a high level of divergence between current self and ideal self on three construct dimensions ('easy life versus striving hard', 'strong character versus passive' and 'boring versus colourful and exciting'). However, she construed herself to have always diverged from her ideal in these three dimensions. Although this suggests that Phyllis has held areas with a low level of self acceptance over the long term, her construct system does not create the same sense of decline in self generated by participants with depression.
5.4. Identity related themes emerging from the qualitative interview data.

An interpretative phenomenological analysis was carried out on the interview data to explore identity related themes. This analysis will be presented under four main headings: sources of meaning in later life; the meaning attached to the close proximity of death; forms of temporal self comparison; and coping strategies which appear to facilitate or impede adaptation to old age.

5.4.1. Meaning in later life.

There was a clear difference between participants' transcripts regarding the ways in which individuals from each group spoke about current sources of meaning in their lives. Of the six participants with depression, none of them were able to identify any aspects of their lives which currently provides them with a source of meaning or purpose. Here the data may reveal a difference between the groups which can be accounted for by the presence of depression in itself, or to an important psychological process underlying depression. Several participants spoke of a lack of motivation or energy preventing them from engaging in interests. Stephen's account contained an example of this:

[I] did like gardening, but it's not the weather for the garden and, [.] it's not having the patience. It's more of a job getting going to do these things.

Ellen describes having a number of sources of continued meaning and purpose in her life. These current sources of meaning seem to be connected with events and circumstances earlier in her life. For example, in her childhood, Ellen was not able to go to Grammar school because this was beyond her family's means, and she regards these economic circumstances to have prevented her from achieving her full potential.
The following statement shows how past frustrations can help to direct current interests:

I always regretted that I couldn't further my education and that is why I am so interested in my grandchildren because they have got the opportunity that I never had. I have seen what they have learnt and are capable of [...]. That interests me, and I only hope I live long enough to see how they come out at the other end. Specially my grandson because he and I are ever so close.

By adopting an interest in her grandchildren's development, she has been able to compensate both for the absence of goals for herself, and also for unfulfilled aspirations from her past. Her role as a grandmother provides her with a vested interest in the wider world. The following quotation illustrates the sense in which she regards herself to still have a vested interest in life even though she wants nothing for herself now:

I consider that my grandchildren are my challenge now. I am interested in what they are doing and where they are going in life. And also the outside world, how is it going to affect them. It isn't a worry but it is a concern. [...] And that is part of my life still. I have still got an interest in life.

Nell and Ann also spoke about the importance for them of holding vicarious goals and ambitions through their children and grandchildren.

The absence of key roles such as work roles in itself can be construed in a positive manner, and this was illustrated by one participant who highlighted how no longer being engaged in activities to the extent that he previously was when he was employed enabled him to hold the role of observing events from the outside. From this detached vantage point, George construes the loss of his work role to have protected him from aversive circumstances.
I am a sufficiently reflective person to realise that now that the pressure is off, I am retired, I realise that I am not having to endure some of the things that your generation is having to go through right now. I mean uncertainty and unemployment, there was none of that, there never has been in my life. I just went from one job to another. Frankly, I don't want a place in the modern world. I am very apprehensive about the experiences of young people at the moment.

A number of participants also highlighted the reduction in pressured roles including work, or a high burden of caring for others to be a positive change resulting from entering later life. Ken's account reveals how he construes the loss of his work role in a positive light because it led to an increase in leisure time.

The opportunity arose for me to leave my job when I was 60 and that suited me admirably. I had been working for the same company for fifteen years which involved a lot of travelling, and it reached the point that we rarely had time to relax, to attend to our house and garden as we would have wished.

Several non depressed participants described engaging in roles which were similar to work roles such as voluntary work, but which are less demanding of time and effort. George's account of self in the most recent five years of his life indicates that he has succeeded in finding new sources of meaning in his life, and has reconstructed his circumstances in a positive way. The creation of new meaning has involved new roles, for example he has joined a league of friends organisation at a local hospital and he and his wife jointly run a residents' association, and consequently he has been able to retain the 'worker' aspect of his identity. He expressed a very positive view of his current work roles.

It could be said that I work harder now than I did when I was at work, when I was gainfully employed. But in fact it is much more pleasant to
do it the way I do now than when I had to attend an office from nine to five.

5.4.2. The meaning attached to the close proximity of death.

One of the most important issues which emerged from the interview transcripts was the meaning which participants attached to reaching the end of life. Death and mortality are core existential concerns which underpin much anxiety. These concerns are generally managed by viewing death to be something which will occur somewhere in the future, i.e. by distancing and minimising the perceived threat. This form of coping becomes difficult to maintain in old old age, when the close proximity of death is a reality which requires to be processed in a new way. Differences in the ways closeness of death was processed by individuals emerged, which differentiated the two groups of participants. These differences are consistent with the developmental positions of integrity versus despair described in Erikson's model of personality development (Erikson, 1963).

Among participants who conveyed 'integrity' there was an expressed acceptance of death as an inevitable and natural event. The following comment reveals how Nell's faith enables her to feel assured that the end of her life is in the hands of God:

I live from day to day, but don't plan. Well I am old now, and who knows, I can't say Christmas or anything else. I just wait until it comes. That's the plan, that's life innit? God speaks first. I'm not afraid to die, but I am thinking of them [her children]. Are they going to be upset? Although I think they will say "oh well, she had a good innings!" [laughs]. But I mustn't grumble, and they can't grumble.

This comment also illustrates her patient acceptance of being at the end of her life. There is no suggestion in her account that she wishes her
death would come quickly, but she does seem to view herself to be in a 'limbo' state in which she is psychologically prepared to die, but making the most of life while she can on a day to day basis. Living from day to day rather than making future plans seems to be an adaptive way of coping with the uncertainty around the timing of her death.

George's account illustrated that he also has psychologically resolved the distress arising from the closeness of his own death by grounding this knowledge in a perspective of looking back through his life with a sense of satisfaction.

I do not worry about reaching the end. When it comes it comes, but I do think more about the passing, you know, how it will happen. But I have had a very full life. I have earned a reasonable amount, I have achieved a good amount, and worked very hard.

Reaching the end of life was portrayed to be a liberating circumstance by several non depressed participants whose accounts focused on the way that reaching the final stage of life reduces the need to worry about one's life. Ellen's account reveals how she has been able to live a less pressured life due to the proximity of death:

I mean it doesn't matter to me now, I am not concerned because I have reached the end of me life, and I haven't got that struggle, I haven't got to achieve anything as it were. I don't have to prove me self.

In contrast to the acceptance of death expressed by some non depressed participants, the accounts of depressed participants revealed that some were preoccupied with worries and distressing thoughts about death and dying. In the following comment, Jacqui describes how aspects of her environment frequently remind her of her own ageing and mortality, causing her to feel upset:
I think I have changed because of the atmosphere here too. People are forever dying of cancer, or this and the other. Or they find them dead sitting in their arm chair, and it's bound to depress. And you know that you are getting old and you have got to die of something, and you wonder what you are going to die of. And it's at times like that that I feel that I have had enough. Just disappear.

The tendency to avoid awareness of being at the end of one's life by not thinking about the future was illustrated within Rene's interview transcript. This avoidance of looking into the future suggests that she experiences despair when thinking about her own death, and that her inability to accept death has created an impasse in which she feels that her life has now stopped.

When I look forward, I want to feel better, but I can't do that because I just fear what might happen. So now I don't think about the future. You know, my life has stopped.

5.4.3. Temporal self comparison.

The way in which participants described changes in their identity also provided an important means of distinguishing between depressed and non depressed participants. Two general processes emerged from the transcripts. In the first, participants tended to portray self changes in a positive light, and simultaneously reconstrued previously valued aspects of self in a less favourable way. By contrast, in the second process participants perceived changes to self as loss or decline, therefore leading to an unfavourable self comparison. Previous aspects of self which had been lost due to ageing were described in idealised terms. This aspect of the qualitative data accords with the repertory grid results previously presented, and suggest that negative temporal self comparison may result from an absence of adequate reconstruction of one's personal
construct system resulting in a construct system which is not supported by one’s current circumstances.

There were a number of examples of valued changes in identity arising in old age within the accounts of non depressed participants. Several participants noted wisdom as a quality specific to older adults. Ann described how “the wisdom of age” has enabled her to understand people better, and be better able to offer comfort to those in distress. This wisdom derives from the greater amount of life experiences that older adults have compared with younger generations. Linked with the quality of wisdom was the unique role older adults have as witnesses of the past. Ellen described the importance of being a witness to difficult life experiences she has undergone as follows:

Well by living longer, I have experienced things that they [grandchildren] only read about in books, and um, although they talk about the war, they never lived through it. But I did. People tend to forget and I don’t think that they should really. Still, until we eradicate greed, nothing will change.

Linked with the sense of wisdom distilled from a life of experience, several participants also described having a greater ‘strength of character’ as a result of having coped with difficulties in earlier life. Previous suffering was described to contribute to one’s wisdom, enabling the individuals’ to speak as one who has personal knowledge of something. A perception of having coped well with difficult circumstances also seemed to create a sense of increased self efficacy, enabling the individual to perceive self as better able to cope with new difficulties than they previously were. The following statement, also from Ellen’s interview illustrates this:

Well having come through what I have lived through, I am a stronger character now than I have ever been, because events in life either destroy you or make you. When I look back at what I have lived through,
if any one had told me I had got to do that I would have said I couldn't do it. But when you meet these things you either battle at the other end or fail.

Several non depressed participants described having a more 'laid back' attitude to difficulties in old age compared with earlier life. This change was attributed to different factors by different participants. Ken described becoming more patient and tolerant as an adaptation which is essential to maintaining good health in old age:

I think that mentally you can probably cope better with situations [in old age] but you find that from a physical aspect that life is becoming tougher. I learned, obviously people mellow as they age. I think I learned to be more tolerant. My wife is patient and I learned a few things in that direction. You have to slow down if you are to remain healthy.

For Ann and Ellen, their laid back approach to difficulties seemed to be facilitated by having increased self efficacy. Their previous experiences of coping had enabled them to learn that worrying about situations is unnecessary because in the past they had got through. The following comment from Ann illustrates this:

In lots of ways I have had tragedies and at times I didn't think I would get through. I used to worry a lot more about things than I do now. Now when something happens I just think 'well you have had worse than this before and got through, you'll come through this as well'. There's no point worrying now.

Loss and decline featured strongly among the accounts of changes in self provided by the depressed participants. A range of losses emerged from the transcripts including core losses such as the loss of key roles and sources of meaning in life. Jacqui was among several participants who described feeling without a role:
I mean nobody asks my advice, and I wouldn't give it either. Um, I think I have got on with the family very well indeed because I don't force my opinions. But I haven't got a role now. Not since my husband died have I had a role.

Several depressed participants had difficulty adjusting to decline in physical health and losses associated with this. In the following comment, Edith illustrates how physical decline has created so much change that her lifestyle has become unrecognisable:

I think it's frustration that you can't do what you did before. You know one thing, I can't get out of the bath, and I can't get up the stairs properly. You feel everything has stopped and you have to start again, do you understand what I mean? It is like starting a new life really.

The issue of physical decline and the reduction in one's physical capacity to carry out tasks due to becoming tired more easily seemed to interact with the experience of depression, leading to a sense of being unable to pull oneself out of the situation. Stephen's account illustrated two ways in which this tiredness militates against recovery from depression. Firstly, the reduced level of activity one is capable of in old age can be difficult to accept for people who enjoy being very active, and secondly, the tiredness means one has less energy to fight the depression.

This has lasted for nine months now [being depressed]. Mind you I think that it is because I am getting older. I think I have nothing left to fight it. I don't have the energy or the will power. This breakdown is due to me age to tell you the truth. I was always lively, I would get up and do something. I don't do anything now.

Linked to these themes of loss of roles and reduction in one's level of activity in old age, Edith spoke of her regret at the way her life has become a limited routine lacking meaning and diversity.
Well really you know what is going to happen every day now don’t you? Get up in the morning, do some house work, watch the telly, do some knitting, and that's the day. The same thing day in day out.

Some of the depressed participants expressed a reluctance to adopt an identity of being an 'old person' because they perceived it to hold very negative connotations. Edith’s account illustrates well the conflict which arises for older adults who deny their own ageing, and then have difficulty accepting when other people begin to respond to the as an elder:

They [her grandchildren] tell me all about their football. As I said, I used to play football with them and [...] they are just more careful with me now. I suppose my son has said something to them. They treat me like a grandmother now which they didn’t do before and I don’t think I like that very much [laughs]. They treat me like an old woman!

Some depressed participants stated that they do not regard themselves to be old, and spoke about ‘old people’ as if a group to which they did not belong. For example, one participant (Paul) spoke about the loneliness of old people as something he does not identify with himself, but which he seeks to relieve when he has an opportunity to:

I don’t class myself as old. I know a lot of elderly people and they are lonely, and when I see them I always talk to them.

5.4.4. Coping strategies which appear to facilitate or impede adaptation to old age.

The analysis of qualitative data revealed a number of differences between the depressed and non depressed participants regarding ways of coping with the changes resulting from the ageing process at this stage of life. In this final section of results, these coping strategies will be briefly explored. One dimension which did emerge from the analysis strongly indicating it to
be a key predictor of ability to successfully adapt to old age was the extent to which individuals held onto roles and aspirations rigidly versus having a capacity to be flexible in one's expectations, interests and values.

The participants who had a tendency to hold onto roles and aspirations which they had held in earlier life had encountered difficulties in later life as these roles and aspirations had either gradually or suddenly become unsustainable. Rene's account illustrates how she values things which are not sustainable in old age. She has always been interested in fashion and ageing has created an important loss in terms of the decline in her physical appearance and beauty. The following comments illustrate how continuing to aspire to youthful beauty results in difficulty accepting herself, and her ageing:

   If I look in the mirror it frightens me, it really does. I always try and look smart whereas some people of my age don't bother. I am beginning to feel my age though, which I am not happy about.

Another important area of personal decline which emerges from the interview transcript is her physical health. She has a series of physical health problems such as a hernia, arthritis and a bowel complaint. The meaning attached by Rene to her declining health is that she is no longer physically able to continue to work as a market trader. By continuing to use her capacity to undertake physically demanding work as the criterion for evaluating her health status, Rene maximises the significance of any limitations in her physical capabilities:

   When you get to my age, it's only natural, your body wears out, which is true isn't it? I can't do a lot now. I have lost interest and that's the truth. But then I am too old to do any responsible work.

In contrast to rigidly holding onto past roles, there were many examples of non depressed participants deriving new sources of meaning which
enabled intrinsic aspects of old age to be valued (see section 5.4.1.
above). This required that participants be flexible in their own
expectations of self. Ken identified the need in old age to allow an
expectation that obstacles and problems will arise, to moderate one's
aspirations and goals. This attitude is less likely to generate criteria for
self evaluation which will lead to a negative appraisal of self:

You cannot set off [in retirement] intending to be highly ambitious
because inevitably I am sure that problems would arise that would knock
your hopes for six. So you have to be mildly optimistic about the future.

Some of the depressed participants who have not managed to develop
new goals and sources of meaning appropriate to later life described
experiencing a lot of fear and anxiety. Several participants coped with the
loss of ability to fulfil roles from earlier life by withdrawing from all
activities. It seemed that the absence of identity change had created a
crisis for these individuals, who having been stripped of effective ways of
acting in the world had become 'paralysed' by fear. Edith's account
illustrates this experience:

We have got two allotments and I can't help on them no more because I
can't bend down, and um, I used to belong to the ramblers club, and I
don't belong to that now. [...] And I have got this terrible fear that if my
leg gives way again, I will just be stuck there, and the obvious thing to do
is to stay in the house as much as you can. I know I am hiding away, but
there is no other way out. I never even knew what fear was before I
don't think.

Some participants described how they had simply not anticipated that
ageing would lead to the need to adjust and live life in a different way.
For example, Edith commented:

I could never imagine myself changing. That's why it has been such a
shock that I have changed you know.
There were some examples of forms of adjustment which participants seemed to have a personal intolerance to. For example, Jacqui described herself always to have found being alone difficult:

As a child I was terribly apprehensive. If my parents were out, I used to get terribly worried, so that I have had that worry all my life if you like. I find it hard living on my own. I was not meant to live on my own. I am very family minded.

The life long anxiety of being alone has made it particularly difficult for Jacqui to adjust to the loss of her husband. Old age has consequently been a struggle, because it has introduced a level of isolation which she has until now not experienced. In the following comment, she illustrates how her sense of self is defined in terms of her relationship with others, and her tendency in life to adopt a supporting role rather than a directing one:

I have always had a secondary role if you like, except when I had to manage my husband [due to his illness]. I don't want to direct my life. I am quite happy to be told what to do.

Some participants described the potential for difficulties from earlier life to re-emerge in old age. The following comment from Ken illustrates how past events can intrude into current consciousness when one is less occupied:

When you have retired, your thoughts intrude much more into your life, and you begin to realise how things from the past influence what is happening now.

Jean described being preoccupied with feelings of guilt which have recently arisen over events which have happened much earlier in her life.
These seem to be central to the depression she has suffered in later life. In contrast to Jean, Ken described how he has taken action to resolve a similar source of distress in his life:

Even though I was divorced over forty years ago, you never forget about it. I regretted I was never able to really explain what went wrong in the marriage [to his in laws], and in the late eighties, I had a chance to make contact with them again after thirty years, and that has helped me enormously to be able to say to them what I had harboured in my mind for thirty years.

In terms of coping strategies which significantly facilitated adjustment to later life, the ability to select an appropriate reference group for self comparison emerged as an important aid to adjusting to forms of personal decline. George’s account revealed how he is able to evaluate himself favourably by selecting peers suffering from major physical health problems as a reference group:

I am physically fit. I have always found that a proper balance between physical and spiritual is an essential thing. But some people of my age are quite plainly physically disabled. I mean, they have worries about getting out of bed. I don’t have worries like that. I mean if you are teetering around at eighty and you can’t get out of bed, that’s a considerable worry.

Nell described a similar view of her situation. For her, being mindful of other people in worse situations that her own enables her to be thankful for abilities which some of the depressed participants (such as Edith and Rene) do not place any value on.

Well I think I am lucky, you know I enjoy life. I can always think of people worse off than me, and I think I am lucky. I can walk about and um mix with people. See, I wouldn’t think I was lucky if I was in a wheel chair.
6. Discussion.

6.1. Limitations of the study.

This study has set out to combine research methods in order to investigate how older adults perceive changes in their identity resulting from the ageing process. It has been argued that the use of a qualitative research methodology augmented with quantitative forms of data collection and analysis, is an appropriate paradigm for psychological research, and particularly suitable for researchers within clinical psychology (Turpin et al., 1997). Although this approach brings with it the advantage that different sources of evidence can be combined to provide a more compelling argument to support the findings of the research, it also introduces a number of tensions into the research process due to the influence of competing epistemological approaches.

The first and most important tension relates to important differences between the idiographic and nomothetic philosophies underpinning qualitative and quantitative methods respectively. The idiographic research approach yields extremely detailed information and enables a deeper understanding of the psychological processes of individual participants to be gained than is possible in a nomothetic study. Nomothetic studies use larger samples, statistical methods of analysis, and a hypothesis testing approach in order to establish findings which can be applied to a specific population of people. Therefore, nomothetic studies enable the researcher to infer that the research findings are true of a wider group of people than those who were actually included within the sample.

A tension between treating the participants of this study as an individual focus of investigation, or as a member of a sub group has frequently arisen in the course of conducting this study. The main data collection
methods adopted (semi-structured interview and repertory grid) are both idiographic methods in that both provide the researcher with an access to the idiosyncratic reality of a particular individual. However, in order to have a sufficiently large sample size, and due to the volume of data generated by this methodology, it has not been possible to use a case study research design. This has led to aspects of a nomothetic research approach being incorporated into the design of the study. In practice, this has led to the data being analysed and presented as group data, with evidence derived from particular individuals being presented throughout.

A second key tension which has had to be managed throughout the process of conducting this research has been the need to remain clear about the epistemological status of the data. The aim of this study has not been to discover objective evidence of psychological processes which underlie depression in later life, but rather it has been to capture something of the personal experiences from the individual's perspective, and of the meanings attached to these experiences by each individual participant. The status of the data has been explained earlier in this report (see section 4.5). Although the data have been presented as group data, no claims can be made regarding the extent to which the findings are 'true' of other members of the same group. The study essentially provides a phenomenological account of some aspects of the experience of ageing for twelve individuals, half of whom can be described to have been depressed at the time of interviewing. From these phenomenological accounts, interpretative inferences about the relationship between experiences and the outcome of depression have been made.

It has been necessary to have relatively small samples owing to the nature and aims of this study. The results of this study represent the experiences of only twelve individuals and therefore generalisations of the findings must be made very tentatively. It is important to acknowledge that with a sample of twelve people, there is a high risk that the sample is
significantly biased due to the possibility of including one or more individuals who deviate markedly in their experiences and responses from any potential norms which are representative of more common experiences. In this study, it has been necessary to introduce a sampling bias of including older adults who are sufficiently psychologically minded to be able to provide responses to the complex data collection procedures used. The repertory grid was particularly demanding because it requires a good capacity for abstraction, which is a complex cognitive task.

Despite this potential for a sampling bias, there are strong arguments underpinning the sampling approach adopted in idiographic research. This mode of research advocates an inductive approach to the development of knowledge in which general laws are developed from intensive studies of individuals. Smith, Harre and Langenhove (1995) argue that the research process should begin by examining the experiences of individuals rather than samples of individuals because “we can recognise an attribute only if we possess the appropriate concept, and in principal every concept is capable of general application, that is, more than one individual might fall under it”. (Smith, Harre and Langenhove, 1995, p. 60).

Some non parametric statistical procedures have been carried out in this study on quantitative variables which lent themselves to this form of analysis. It is important to acknowledge that these tests have had a low level of statistical power because they have been carried out on a relatively small data set. Despite this, the tests did indicate significant group differences on several variables (depression ratings and divergence between repertory grid ratings of self elements), because there was a very large difference between the samples on these variables. In these cases the statistical analyses were useful, but ambiguous results would have occurred had there been a significant but smaller difference between the groups.
The fact that it has not been possible to conduct repertory grids at different time points is a further limitation of the study. Adopting a longitudinal design would have enabled questions about the way that a participant's construct system changes at different stages of the developmental process. In this study, the data reflect a participant's construct system at the time of interviewing, and it is not possible to ascertain to what extent the system has changed or remained stable over time. The use of past self elements has enabled a retrospective investigation of changes in identity, but only as perceived in terms of the current system of constructs. In short, the study lacks a contemporaneous account of perceived changes in identity.


Despite the tensions between focusing on data at an individual level and a broader group level, the different levels of analysis have concurrently helped to illustrate a number of important dimensions of identity transformation undertaken by a diverse sample of older adults. There was great variation in the ways in which participants construed the changes in self which resulted from the ageing process, and in general the data underlined the importance of forms of construction as a mediator in the process of psychological adjustment.

The data presented in this study suggest that the forms of narrative construction described by Gergen and Gergen (1987) are pertinent to the forms of construction which mediate psychological adjustment in later life. Two contrasting forms of construction were identified within this study. In the first form, the individual constructs a narrative of self which can be described as 'progressive' i.e. the individual continues to predominantly value aspects of their identity, and holds a sense of continued growth and development. In the second form, the individual constructs a narrative of self which can be described as 'regressive' because the individual
overwhelmingly holds a negative view of their identity. Rather than having a sense of continued development, there is a focus on losses and areas of decline.

It is suggested that in order to develop a progressive narrative construction, it is necessary to carry out important psychological changes including modifications to one's construct system in order to be able to adopt different goals, aspirations and values which can transcend the ageing process. Thus the ability to be flexible in one's aspirations and values emerged as a key differentiating characteristic between depressed and non depressed participants.

This study has demonstrated through detailed analysis of individual cases the possibility of maintaining a positive construction of self despite the presence of aversive circumstances, and in the face of suffering personal losses and invalidation of previously valued roles. The study did not find that the participants who were depressed had suffered more, or different types of losses in recent years. What emerged from the data was the importance of the meanings which were given to those losses by each individual, and the individual's openness to undergo subsequent change. For example, participants in both samples had suffered some degree of physical decline resulting in limitations of physical capacities and indeed this is an experience which is common among the participants' peers. Some participants with depression (such as Rene and Edith) were relatively intolerant of these changes in them compared with participants who were not depressed, (such as Nell, and Ken). A number of psychological processes seemed to underlie the individual's ability to tolerate losses such as this.

The first of these was the ability to value intrinsic aspects of old age rather than the desire to hold onto old characteristics of self, which often were contingent on being 'young'. Examples of intrinsic aspects of old age identified by participants in this study included qualities such as wisdom,
having a greater breadth of experience, and the ability to observe events in a detached way because they have less direct consequences to those in later life. In contrast, some participants were found to have held onto aspirations and qualities which were valued during earlier life, such as a highly active lifestyle, the beauty enjoyed in youth, or the status derived from holding an important job or from having responsibility for caring for other people. Holding onto goals which one is no longer able to attain inevitably detracts from one's ability to evaluate self in a positive way. The qualitative results presented in this study have illustrated the invalidating effect of this tendency on participants who have suffered depression.

The second important psychological factor which emerged from the data was the way that participants construed the losses which they faced. Participants who were not depressed were found to generally have the ability to develop a positive construction of losses, such as the loss of work roles which was construed by several participants to be a liberation from the struggle and toil which accompanies them. However, participants with depression generally appeared to see losses as signalling 'the end', seemingly seeing no possibility of replacing aspects of self lost with something new. Roles tended to be seen not as something that one does at a particular time, but as a fundamental aspect of self, and of one's reason for being. It is here that the importance of Marcus and Nurius's (1986) notion of the 'many possible selves' is illustrated, because it emphasises the importance of holding a multifaceted 'identity', in order to promote options for identity change and transition.
6.3. The interplay between underlying psychological characteristics and forms of narrative reconstruction.

The triangulation of the different forms of data gathered in this study suggest that there is an association between some aspects of personal construct systems, and the process of adapting to personal changes. The data have illustrated possible ways in which the participants' construct systems have facilitated adaptation, or have thwarted the process of development. The model of validating and invalidating personal constructs (Viney, Benjamin & Preston, 1990) has received support in this study.

The repertory grid data for each of the twelve participants revealed that there was no difference between the groups in terms of the structure of construct systems as measured by the value of the first principal component (the first eigenvalue). The eigenvalues obtained in this study indicated each of the participants' systems of constructs to be unidimensional in that they appeared to be dominated by one core means of construing. It is possible that this phenomenon reflects an age effect on construing, for example, older adults may characteristically have a relatively narrow range of construct dimensions, possibly as a result of a process of distilling a life's experiences within constructs which have an ever greater range of convenience. Alternatively, these results may reflect a reduced capacity in later life to carry out the complex cognitive tasks involved in generating construct dimensions, including abstracting important characteristics through differentiating between elements.

According to personal construct psychology theory, individual's construct systems are proposed to become 'narrow' in response to changes in circumstances. Kelly (1955) proposed that tightening and loosening of construct systems occurs in cycles as part of the continuing process of serial reconstruction. A narrowing in the range of core constructs is
regarded to facilitate unvarying predictions, which can be advantageous when the individual needs to be able to make sense of an unfamiliar social environment. However, a balance needs to be reached because a construct system which is too narrow can result in experiences being beyond the range within which a construct system has predictive value.

A number of important differences between the groups were found to emerge from the data regarding qualitative characteristics of participants’ construct systems. There was a striking difference between the groups in terms of the amount of discrepancy between ratings of the different self elements, indicating both that the depressed participants perceived a greater amount of change in their identity than non-depressed participants, and also that these changes were exclusively perceived as negative changes in self by depressed participants, whereas there was more of a balance between perceiving some changes in self to represent positive forms of change among the non-depressed participants.

These findings appear to hold much significance for the process of adaptation under investigation in this study. The level of divergence in construing different self elements indicates that the depressed participants hold construct dimensions which emphasise the changes in self which do result from the ageing process. Examining the content of constructs held by some of the depressed participants has illustrated the way in which core constructs can lead to invalidation. For example, some participants were found to generate construct dimensions in which a pejorative pole was contrasted with the construct pole, so that changes in identity automatically led them to construe self in terms of the negative extreme of the dimension. Participants with depression also tended to generate constructs which featured roles which were no longer available to them. Invalidation was found to be the inevitable consequence of these two characteristics of construing; as the roles promoted by the construct system become eroded in old age, the individual experiences a
diminished sense of purpose and meaning, and is compelled to evaluate self unfavourably.

Analysis of the content of constructs held by non depressed participants indicated that these individuals perceived a greater sense of continuity of their identity rather than the overwhelming sense of having become almost unrecognisable, which emerged from participants who were depressed. It seemed that non depressed participants either held or had developed new constructs which did not feature roles or qualities which are specific to any particular life stage (such as work roles), but which were transcendent of age such as constructs which value the ability to maintain a wider perspective, to be unconventional and to uphold a strong moral standard. These constructs appeared to facilitate adaptation rather than leading to invalidation, because non depressed participants continued to be able to evaluate self highly in these areas, thus maintaining a high level of self acceptance. The fact that constructs held by non depressed participants seemed to be more congruent with the lifestyle of older adults is evidence that some adaptive modification of their construct system has been carried out which has enabled these individuals to view identity transformation in a positive way.

6.4. Towards a model of effective psychological adjustment in old-old age.

This study has found evidence to suggest that Baltes' (1980, 1990) model of effective psychological adjustment among young-older adults does have some explanatory power for old-older adults also. The strategies of selectively reducing one's repertoire of activities in order to facilitate a continuing sense of mastery over a smaller range of activities is a key aspect of successfully adapting to the personal limitations resulting from the ageing process. The strategy of compensation which refers to developing new ways of carrying out familiar tasks when personal
limitations preclude old ways of coping is also inevitably an important aspect of adjustment.

However, these forms of adjustment do not provide a sufficient armoury for adults facing the transition into very old age, because the developmental issues faced by individuals at this life stage are qualitatively different from those faced by young-old adults. There is a need for the development of roles, relationships, aspirations and sources of meaning which will be supported by the real life circumstances faced by adults at this latter stage of life. There is also a need for old-older adults to relinquish roles, aspirations and aspects of their identity which are no longer compatible with these real life circumstances. The accounts of participants with depression have illustrated the way that continuing to hold on to old roles and sources of meaning and purpose can lead to negative self evaluation, low self acceptance, and a heightened sense of loss and despair.

The task faced by old-older adults to find new sources of meaning is an extremely difficult one because there is an absence of socially valued roles for older adults, at least within this society. Young adults can adopt a wide range of roles which are highly valued by others such as worker, provider, supporter, mother, or father. In later life, many of these roles are no longer appropriate, and consequently older adults are faced with finding new ways of creating a sense of productivity, purpose and of personal agency. This absence of an alternative set of roles and purposes which are more appropriate to older adults may complicate the process of adjustment by preventing older adults from relinquishing their previous set of roles.

It is here that the social construction of ageing can be seen to limit options for change. There is a need for roles for older adults which acknowledge their intrinsic value, as in some Asian cultures (Gergen & Gergen, 1988). This intrinsic value could derive from the positive aspects of old age such
as the wisdom that results from a long life of experiences, the capacity to view events and difficult situations in the role of a detached observer, bringing the benefit of experience of dealing with similar difficulties in the past. This intrinsic value could also acknowledge the contribution made by older adults to the well being of the young.

The roles which have successfully been adopted by the participants of this study were characterised to be rather passive, involving the observation of events from the outside rather than actively participating in events. Establishing the status of being a valuable resource due to one’s age and wealth of experience seems to provide a justification to comment on events from a different perspective. The study has also illustrated that older adults face a need to undergo a transformation in the manner in which goals and aspirations are fulfilled. As adults undergo increasing losses in their active roles, a need arises to fulfil their sense of purpose through monitoring the progression of other people. In other words, a shift from holding goals for one's own future to holding goals for the future of younger generations. The accounts of several participants demonstrated their sense of vicariously achieving self development through monitoring closely the development of their grandchildren.

The importance of “connectedness” in old age, as in earlier stages of life has strongly emerged from the results of this study. It is very difficult to establish roles, purpose and meaning in life independently of relationships, and this is particularly so in old age. The importance of “connectedness” for self-development and self-definition has been highlighted by Gergen (1987), and feminist writers such as Gilligan (1987) have criticised the emphasis on autonomy and individualism in western psychology as a masculine construct which marginalises the importance of “connectedness”. The need for connection seems to increase in old age because all of the new sources of role and meaning described above are contingent upon being connected within a network of relationships.
This does not hold true to the same extent for adults at earlier stages of life, who can derive meaning through independent work roles.

The triangulation of data from the repertory grid and from the qualitative analysis of interview transcripts has illustrated the potential for older adults to develop a rigid construct system which invalidates the individual's personhood. This pattern emerged from the data sets of each of the participants with depression, although to different degrees. In personal construct terms, the range of experiences within which these participants' constructs held predictive value did not coincide with the experiences which they have faced in later life. This underlines the value of construct systems which are characterised to be more fluid and flexible, with a wider range of core construct dimensions. Where an individual becomes the victim of a rigid construct system which is not compatible with their real world circumstances, there is a need for psychological assistance to help them to modify aspects of this system.

6.5. The implications of the study for future clinical practice and research.

This study has inductively explored the forms of narrative construction of self in old age, and investigated the ways in which underlying psychological factors influence the forms of reconstruction used. Information which could inform a model of effective psychological adjustment in old-old age has been generated through analysis of the data gathered. There are a number of implications of this study for clinical practice. Firstly, the study has demonstrated the potential relevance of using a constructionist model for working therapeutically with older adults experiencing difficulties in adjusting to developmental transition into old age. Variability between the twelve participants' accounts has demonstrated the possibility of developing alternative constructions of self
which facilitate continued fulfilment and sense of purpose into very old age.

The study has demonstrated the applicability of repertory grid tests with older adults through the degree to which this method has generated an understanding of the inner psychological world of participants. Minor modifications in applying the method were required in using it with the participants of this study. For example it was necessary to adopt a more conversational style in eliciting constructs, and it was also necessary to explain the nature of the tool in terms which minimised the abstract nature of this method.

This research has raised a series of questions for future research. The results of this study do suggest there to be significant differences between the two samples of participants in psychological structures (i.e. constructs) which influence and drive construction processes. This raises the question of whether the differences are a manifestation of depressed mood, or whether they represent a psychological mechanism underlying and causing depression? This is an area which could be further explored in the clinical domain through applying a personal construct therapeutic approach with older adults with depression. A clinical study adopting a case study design, in which repertory grids were repeated at different intervals would provide one potential way of investigating psychological change and concomitant changes in adjustment.

The current study has examined how participants have perceived identity transformation retrospectively, as viewed through their current system of constructs, rather than exploring the way in which self related changes resulting from the ageing process are experienced as they happen. A longitudinal study in which data are collected at different time points would enable a contemporaneous analysis of the process of transformation in identity. This would enable the question of how individuals actually make modifications to their construct system to be explored. Such a study
would potentially generate additional evidence to support the hypothesis tentatively advanced in this project, that changes in construing can influence an individual's ability to adapt to important changes in identity, and may help to identify individual factors which impede the process of serial reconstruction.
7. Conclusions.

This study has generated detailed accounts of perceived changes in identity occurring in the context of the developmental transition into old-old age. The diversity of patterns of adjustment, and indeed of patterns of life has strongly emerged from the data set. Some of the participants of this study have experienced psychological distress, and it is suggested that this has resulted from difficulties in adjusting to personal changes resulting from the ageing process. Comparison between the two samples of participants has illustrated forms of reconstruction which appear to either enable or inhibit successful adaptation to old age.

It is suggested that the findings of this study could form the basis of a model of effective psychological adjustment to old-old age. One of the key psychological determinants of emotional well being in old age was found to be the flexibility to adjust values and goals such that intrinsic aspects of old age are highly valued, and intrinsic aspects of younger age are less highly valued. This flexibility is necessary in order to enable older adults to embrace changes in their identity, rather than remain preoccupied with the loss of past aspects of self.

This study has focused on ways in which personal construct systems facilitate or thwart adaptation to changes resulting from the ageing process. Participants who were depressed were found to construe a significantly greater degree of divergence between self elements within their repertory grid than non depressed participants. Therefore depressed participants were found to perceive a greater degree of identity transformation, and to exclusively perceive identity changes in a negative way. Participants with depression were found to hold constructs which valued characteristics of younger age, and which simultaneously devalued characteristics of old age, resulting in an erosion of their sense of purpose and meaning, and in negative self evaluation. In contrast, participants
who were not depressed tended to hold constructs which valued qualities
which transcended age (such as wisdom and patience), and this enabled
them to have a greater sense of stability of identity, and to continue to
hold a positive view of self.

The findings of this study suggest that a key developmental task in old-old
age is to find new ways of creating a sense of productivity, purpose and
agency. In order to do this, it is necessary to adopt roles and aspirations
which are supported by the real life circumstances of the individual. The
research has illustrated that it is possible to develop new roles and
sources of meaning in later life, but that the roles which were successfully
adopted by participants tended to be rather passive, such that a shift had
taken place from holding goals for one's own future, to holding goals for
the future of younger generations. The findings provide evidence of the
importance of modifying personal constructs in order that the individual
has sufficient flexibility to relinquish previous roles and aspirations, and
establish new sources of purpose and meaning which are sustainable in
later life.

The results of this study have illustrated the importance of construction as
a mediator in the process of psychological adjustment to change. The
possibility of constructing a progressive narrative of self in old age despite
experiencing a series of personal losses due to the ageing process was
revealed. This finding is suggested to have important implications for
clinical practice with older adults who are depressed because it indicates
the value of assisting an individual in the psychological process of
reconstruction in order to facilitate adjustment to old age.
References.


Appendix 1.

Schwab-Gilleard Depression Scale.

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Date: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tick the column which best describes how often you felt or behaved this way <strong>during the past week</strong>.</td>
<td>Most of the time</td>
</tr>
</tbody>
</table>

1. Do you feel tired in the mornings? 

2. How often do you feel alone and helpless? 

3. Do you feel in good spirits? 

4. How often do you have crying spells or feel like crying? 

5. How often do you have trouble getting to sleep? 

6. Have you ever had periods when you couldn’t take care of things because you just could not get going? 

7. Do you suffer from loss of appetite? 

8. Do you feel sad and without interest when you wake in the morning? 

9. Do you sometimes wonder if anything is worthwhile anymore? 

10. How often do you feel you don’t enjoy doing things anymore?
Appendix 2.

Information sheet for research participants.

A research project investigating self identity in later life.

I am a trainee clinical psychologist currently working in the psychology department at [Name of] Hospital. I am carrying out a small research project investigating the way in which older adults view themselves and the ways in which they perceive themselves to have changed in recent years. I am particularly interested in researching participants who have experienced distress, which may have brought them into contact with the Elderly mental health team at [Name of] hospital. The purpose of this research is to enable the team to better understand the causes of emotional distress in old age.

If you agree to take part in this study I will ask to meet with you to carry out an interview which will explore the ways in which you perceive yourself to have changed as you have entered later life.

If you agree to participate in this project, the interviews will be tape recorded so that I can accurately report the information when I come to write about the study. Everything that you say will be entirely confidential, and no name will attached to the tape. In order to analyse the contents of the second interview, your comments will be typed into a computer, and the tape will be destroyed. If you like, I will send the tape back to you. Your name will not be attached to anything that is written about the research (reports or publications).

You do not have to take part in this research, and if you do decide to take part, you can change your mind at any time - even in the middle of the interview. Whether you take part in the research, your present or future use of the Elderly Mental Health Team will in no way be affected.

It is hoped that the participants of this study will find the interviews of some interest to themselves. Every effort will be made to conduct the interviews in a sensitive manner. Follow-up counselling will be available if you do feel distressed at the end of the interview.

If you agree to take part, I will contact you to arrange a time and a date for the interview. The interviews can take place either at [name of] Hospital, or I can visit you at home if this is more convenient. If you would like to discuss the study more before you make up your mind, you can contact me directly. My name and contact address is:

Mr Tom Barker
Psychology Department
Appendix 3.

Consent form.

[Name of] HEALTH AUTHORITY

CONSENT FORM

TITLE OF PROJECT

A research project investigating self identity and depression in later life.

(The patient should complete the whole of this sheet himself/herself) Please cross out as necessary

Have you read the Patient Information Sheet? YES/NO

Have you had an opportunity to ask questions and discuss this study? YES/NO

Have you received satisfactory answers to all of your questions? YES/NO

Have you received enough information about the study? YES/NO

Who have you spoken to? Dr/Mr/Ms. .............................................................

Do you understand that you are free to withdraw from the study:
• at anytime,
• without having to give a reason for withdrawing
• and without affecting your future medical care? YES/NO

Do you agree to take part in this study YES/NO

Signed ............................................................................. Date ..........................

(NAME IN BLOCK LETTERS) .............................................................................
Appendix 4.

Interview schedule:

The aim of this part of the interview is to investigate ways in which you feel that you and your lifestyle have changed as you have undergone the transition into later life. I will be asking you some questions for which there are no right or wrong answers. What I am interested in is the way that you view things.

1. Self characterisation:

How would you describe yourself now, how would you describe your character, who you are? Tell me a little bit about the sort of person that you are.

Prompts:

⇒ Can you tell me a little bit more about that

What do you regard to be your positive/negative qualities?

Do you have a strong sense of the person that you are?

How would you describe your ‘life story’ over the past n years?

What have been the most important events and experiences you have undergone?

Prompts:

⇒ How has that impacted your life?

⇒ What has the effect of that been?

2. Temporal self comparison:

I am interested in looking at how people compare themselves with how they were at earlier stages of life. How do you think that you have changed as a person over the past n years?

What have been the main/most important changes?

Prompts:

Can you tell me a bit more about that change?

How has that affected your life?

3. Roles/Sources of meaning and purpose:

Often people’s roles are important to their sense of who they are. What are the most important roles that you currently have?
Have you developed new roles in recent years?
  ⇒ Can you tell me a little about these.

Have you noticed that you have lost some roles in recent years?
  ⇒ What are the most important roles that you have lost?

What are the most important things in your life now?

Do you have a sense of purpose now?
  ⇒ What is it about? What gives you that purpose?
Appendix 5.

Transcription notation.

Where quotation have been edited of repetition of unnecessary dialogue, empty parentheses [ ] have been used to indicate omitted text.

A pause in the dialogue is denoted by a full stop in parentheses [ . ]

Identifying and referential information has been removed to preserve confidentiality, and this is indicated by parentheses containing explanatory text as follows; [explanatory text].
Appendix 6.

Summary of demographic data, SGDS depression scores, and percentage variance of first principal component for all participants.

<table>
<thead>
<tr>
<th>Name</th>
<th>Group</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>SGDS Score</th>
<th>Percentage Variance of 1st component</th>
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<tr>
<td>Nell</td>
<td>Control</td>
<td>83</td>
<td>Female</td>
<td>Widow</td>
<td>3</td>
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<tr>
<td>Ken</td>
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Appendix 7.

Summary of descriptive statistics.

<table>
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Mann-Whitney U - Wilcoxon Rank Sum W Tests:

1. AGE by SAMPLE

Mean Rank  Cases
8.33       6   SAMPLE = 0 Control
4.67       6   SAMPLE = 1 depressed
--
12 Total

<table>
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<th>U</th>
<th>W</th>
<th>Exact 2-Tailed P</th>
<th>Corrected for ties Z 2-Tailed P</th>
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<td>-1.7707 .0766</td>
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2. SGDS Depression rating by SAMPLE

Mean Rank  Cases

3.50  6  SAMPLE = 0  Control
9.50  6  SAMPLE = 1  depressed
--
12  Total

Exact  Corrected for ties
U  W  2-Tailed P  Z  2-Tailed P
.0  21.0  .0022  -2.8975  .0038

3. Percentage variance of 1st principal component by SAMPLE

Mean Rank  Cases

6.50  6  SAMPLE = 0  Control
6.50  6  SAMPLE = 1  depressed
--
12  Total

Exact  Corrected for ties
U  W  2-Tailed P  Z  2-Tailed P
18.0  39.0  1.0000  .0000  1.0000

Spearman correlation coefficients:

1. SGDS depression rating by Ideal self/self divergence.

SGDS  .8188
N( 12)
Sig .001

IDEALDIV

(Coefficient / (Cases) / 1-tailed Significance)
2. SGDS rating by happiest self/self divergence.

SGDS  .8104
N( 12)
Sig .001

HAPPYDIV

(Coefficient / (Cases) / 1-tailed Significance)

3. Age by ideal self/self divergence.

Age  -.5506
N( 12)
Sig .032

IDEALDIV

(Coefficient / (Cases) / 1-tailed Significance)

4. Age by happiest self/self divergence.

Age  -.6136
N( 12)
Sig .017

HAPPYDIV

(Coefficient / (Cases) / 1-tailed Significance)
Appendix 8.

Repertory grid raw data.
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Very like this

1 2 3 4 5

Very like this

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Very like this: 5

Very like this: 1
Name: Phyllis. Date: 

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Very like this: 1 2 3 4 5

Very like this: 1 2 3 4 5
### Repertory Grid

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<td></td>
<td>4. Spontaneous</td>
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<td></td>
<td>5. Content at home</td>
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<td>6. Happy</td>
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<td>7. Strong</td>
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<td>8. Generous spirit</td>
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**Contrast**

- Fast
- Quiet
- Serious
- Planned
- Outgoing
- Sad
- Weak
- Superior
- Cold
- Honestly spoken

### Very like this

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Name: Ann. Date: ____________________

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295
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**Very like this**

1 2 3 4 5

296
Name: Ellen. Date: ________________

### Repertory Grid

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#### Contrast.

- Disagrees with my views
- Exaggerates problems
- Miserable
- Concerned with me
- Unreliable
- Humorous
- Dishonest
- Close to me
- Forward looking
- Weak in character

**Very like this**

1 2 3 4 5

Very like this

297
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Very like this

| 1 | 2 | 3 | 4 | 5 |

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Very like this

1  2  3  4  5

Very like this
## Repertory Grid

**Elements:**
- 1. Current self
- 2. Self as a child
- 3. Happest Self
- 4. Ideal Self
- 5. Mother
- 6. Father
- 7. Spouse
- 8. Liked person
- 9. Disliked person
- 10. Son

**Constructs:**
- 1. Worrier
- 2. Help anyone
- 3. Workers
- 4. Bored
- 5. Feared the worst
- 6. Enjoys life
- 7. Cool
- 8. Respects others
- 9. Giving
- 10. Very like this

### Matrix

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**Contrast:**
- Not a worrier
- Unhelpful
- Lazy
- Busy
- No fears
- Can't enjoy life
- Friendly
- Disrespectful
- Mean

**Date:** Paul

**Name:** Paul
### Repertory Grid

**Name:** Jacqui  
**Date:**

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**Very like this:** 1 2 3 4 5
Repertory Grid.

Name: Rene.  Date: ____________________________

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Very like this

1  2  3  4  5

Very like this

303
Appendix 9 – Analysis of repertory grid data.
Correlation Matrix showing significant correlations (P < .05).

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## Principal Components Analysis

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PC extracted 2 factors.

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Correlation Matrix showing significant correlations (P < .05).

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307
Principal Components Analysis.

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PC extracted 3 factors.

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Principal Components Analysis.

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PC extracted 3 factors.

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Principal Components Analysis.

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315
Principal Components Analysis.

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PC extracted 3 factors.

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Correlation Matrix showing significant correlations ($P < .05$).

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Principal Components Analysis.

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PC extracted 3 factors.

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Correlation Matrix showing significant correlations (P < .05).

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326
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Principal Components Analysis.

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PC extracted 3 factors.

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Appendix 10 – Sample interview transcript.
Interview 7 - Ken.

I: The aim of this interview is to talk to you about how you feel your lifestyle has changed in recent years, particularly as you have undergone the transition into later life, and also to look at how as a person you think you might have changed. I will ask some general questions for which there are no right or wrong answers. I am interested in your view of things. Can I ask you to begin by briefly describing yourself to me, your character, the sort of person that you are.

S: Um, I am not a student of astrology but I think there is more than an element of truth in the character as portrayed in astrology, and I am a typical Virgo in that sense, and my wife is a Taurian, and in that sense we blend very well. I have been married twice, the first one didn't succeed. I am methodical. I can be painstaking in things which need to get done. I like to think that I am tidy and organised, and indeed the work that I did before I retired required me to be tidy and organised because of controlling other staff and their activities. I tend therefore not to be outgoing, not to be extrovert. The pleasures that I have that we have developed over the years tend to be non exciting. Um the type of holidays that we have had [...] um touring around in this country, my wife took an interest in cricket which is very fortunate for me as I have been a fanatic ever since I was a boy. Visiting stately homes, walking in the countryside, members of the RSPB, visiting bird reserves. Unfortunately we can’t do that now because my wife suffers from Parkinson’s disease, and it has got to the stage in the last 2 years where, she can move around in doors, but her mobility is poor. This wholesale change in her lifestyle has made my wife depressed. We are home loving people, and therefore we only go out for our own pleasure.
I: What would you say had been the changes do you think in your character over the past fifteen years or so?

S: Undoubtedly I have changed since I retired, and with the change in circumstances, the opportunity arose for me to leave my job when I was 60, and that suited admirably. I has been working under considerable pressure, and I had been working for the same company for fifteen years which involved a lot of travelling, and it reached the point that apart from holidays we rarely seemed to have time to relax, to attend to our house and garden, as we would have wished.

I: So it was a good change for you, that as you retired you had more time for your house and leisure things and to relax?

S: Yes, uh I think I learned, obviously people mellow as they age. I think I learned to be more tolerant. My wife is patient and understanding, and I think I learned a few things in that direction. You have to learn to slow down if you are to remain healthy. I was ill several months ago. And also to cope with my wife's need now, she was diagnosed seven years ago, but it has only been in the last few years that the illness has taken hold of her, and it requires a great deal of patience to be able to cope with her which I think I do fairly successfully. And nobody can really tell you the reason, but I had a heart attack in April. The doctors say it was a combination of things, but I think the pressure of my wife's condition is very warring, and at my age you haven't got the physical resources that you have when you are younger, and therefore you have to adapt to a different life style. I have been trying to do that for several years. My wife has felt guilty for my misfortune which I don't think is completely fair, but it does point to the fact that if you hope to succeed in retirement, have more of a relaxed time. I don't mean vegetate, that was never on the agenda, I wanted to spend more time in the garden. Now she can't garden at all and I am limited in the sense that I have been told by the doctors to do an hours work I the garden and then rest for an hour. Um I have got
somebody helping at the present moment to tidy up in the garden, and for DIY in the house. So whilst there is an improvement in trying to fit into a slower life style, than was possible years ago, when you encounter problems that you no longer feel you can cope with adequately, then that aggravates the feelings that she has "what has happened to me?" that she can no longer be active like she used to.

I: Is that something that you have found to? That you find that you can no longer do things like you used to?

S: Yes that's what I am saying. When you come to the physical side, I think that mentally you can probably cope better with situations, but if you find that from a physical aspect that life is becoming tougher, then whilst you can look at your life from a distance and say, yeah I can cope with that of course, I can adjust, but when you are faced directly onto it, and it is close up, when the will to do things is there but there may not be the energy. We used to think that when we retired there would be so much time on our hands we wouldn't know what to do with it. It has never worked out that way. We have quite a lot of long standing neighbours, and I have heard it from everybody, you do not suddenly find that there is oceans of time available.

I: So you have found that you have had to do a couple of things in adjusting to retirement. One has been mellowing, and the other has been slowing down and reducing perhaps what you would expect to do in terms of activities.

S: Yes, I would agree. You cannot set off intending to be highly ambitious because almost inevitably I am sure that problems would arise that would knock your hopes for six, so you have to be mildly optimistic about the future, um [...] and everybody has their high points, low points. I was rather unfortunate; I was brought up by an aunt more than by my parents, and that aunt was very dear to me, and she started to decline in
health in her late seventies. And at the time that I retired she was living in north London, and contact was by telephone. We didn’t know what the problem was and eventually it became recognisable as Alzheimer’s. One night she just walked out of her house and for the next four years we had to visit her, she eventually ended up at a mental hospital. And we had to visit her regularly there which placed a great strain on us. That was a highly stressful period which lasted for four and a half years. Then my wife began to suffer after this time.

I: So you have had quite a few serious stresses to deal with in your post retirement years, but it sounds also that you have dealt with them well.

S: Well I think you obviously have to strive to deal with the problems and seek help when you can. I underwent some rather difficult things when I was younger. I was married before, and we had a son who died very tragically of meningitis. This was what led to the end of my first marriage. When I retired, I went through a very difficult period and my present wife was invaluable for helping me to overcome it. Even though I was divorced over forty years ago, you never forget about it. One of the greatest things I regretted about getting divorced was losing touch with my in-laws, who were the best in-laws one could wish to have. I regretted I was never able to really explain what went wrong in the marriage, and in the late eighties, I had the chance to make contact with them again after thirty years and that has helped me enormously to be able to say to them what I had harboured in my mind for thirty years.

I: Why do you think that it has been in your later life that this has had a greater impact on you?

S: Well during your working life, I suppose you can say that I concentrated so much on the work that you must essentially concentrate on what you need to do so that you benefit from the lifestyle that you
would like to have. When you are in employment, you build up an image of what you are striving to achieve and you must concentrate 100% on your role, and the company you are working for. And I don't think you have much time to look over and say well something went wrong in the past. When you have retired your thoughts intrude much more into your life, and you begin to realise how things from the past influence what is happening now.

I: Was it difficult when you did retire? You must have lost quite a few roles both through the job itself and through all of the aspirations and goals that you were striving towards. Was it difficult to adjust to losing those when you retired?

S: No. I believed I would. I thought that I would find the daily involvement difficult to lose. When the chance came up to retire, I grabbed it. I kept in contact with my colleagues for a brief time, but I no longer felt I belonged so those relationships have dropped away during the last eleven years. It has never presented any difficulty. I could feel that I had released my self from those shackles of being involved day in and day out.

I: So you saw retirement as being released from something so you could go onto something more positive or more enjoyable.

S: Oh yes because you then set out to achieve your own personal goals.

I: So what have been the key roles and goals that you have adopted in recent years since you have retired?

S: Well to make the most of that leisure time. We have found it possible to for example have more holidays, mostly in short breaks. We have been able to go off when we have pleased. At home we did more
gardening, and house maintenance. Um, going to music concerts became
easier for us to organise. You can organise things to suit yourself in a
relaxed manner.

I: Lots of positives about retirement.

S: Absolutely, I realise that it depends on individual circumstances
and individual interests really.

I: I guess you have had quite an important role as a carer in recent
years of your wife, which you may not have expected. How have you
found that?

S: It is something you cannot foresee in advance. When you find that
you need to cope with a problem then you just have to knuckle down and
see what you need to contribute. I have had to learn how to cope being a
carer which has perhaps taxed my patience at times, but you just have to
subdue that feeling of irritation. Most time during the working day I have
to make provisions for what she may need.

I: It sounds like you have learnt well to accommodate her needs. []
Thank you very much for answering all of my questions so fully.