Constructing (dis)order: A discourse analysis of constructions of ‘personality disorder’ in British clinical psychology literature

Volume I (Volume 2 does not exist)

by

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INTRODUCING THE PORTFOLIO
This portfolio contains a selection of work completed during the PsychD Clinical Psychology training course. The portfolio consists of two volumes. This volume comprises Volume I and contains three dossiers. The first dossier comprises the academic dossier and includes two essays, three problem-based learning reflective accounts and the summaries of two case discussion group process accounts. The second dossier comprises the clinical dossier and includes the summaries of five case reports and brief overviews of the clinical placements completed over the three years of training. The third dossier comprises the research dossier and includes the service related research project, qualitative research project abstract, major research project and research log checklist.

It is important to note that the work contained within this volume has been arranged into dossiers in an attempt to aid readability. The separation of the work into academic, clinical and research areas should not be read as implying that the areas are necessarily separate and distinct from one another.
INTRODUCING THE ACADEMIC DOSSIER
This section of the portfolio comprises the academic dossier. The academic dossier includes two essays, three problem-based learning reflective accounts and the summaries of two case discussion group process accounts.
“Service user and carer involvement in the training of clinical psychologists”

ADULT MENTAL HEALTH ESSAY

January 2005

Year 1
Introduction
This paper is concerned with exploring ways of involving service users and carers in the Clinical Psychology Training Programme at the University of Surrey. The paper is organised into five sections. The first section attempts to contextualise service user and carer involvement by providing a brief overview of the political and social climate that facilitated its development. The second section considers the discourse adopted and highlights the importance of clearly defined constructs. The subsequent section suggests specific ways of involving service users and carers in the programme and is divided into eight sub-sections each pertaining to a different aspect of the programme’s organisation. The final section introduces particular theoretical dilemmas and practical issues that need to be considered before service users and carers can be effectively and meaningfully involved in the programme.

The central reason for deciding to write on this subject was my anticipation that an engagement with the issue would readily permit a combination of traditional academic work with a measure of creative and reflective thought. Accordingly, the assertions and suggestions contained within this paper will be substantiated academically, through research evidence, and supported in a more obviously anecdotal way, through reflections on my own experiences of involving service users and carers in health services research.

The opportunity to include a creative and reflective element in my academic writing was not something I had encountered previously, in either my undergraduate or postgraduate studies. I welcomed the opportunity, albeit with some trepidation.

Contextualising service user and carer involvement
The involvement of service users and carers in the planning and delivery of healthcare is becoming increasingly familiar rhetoric among healthcare professionals working within Britain’s National Health Service (NHS). The current emphasis on service user and carer involvement has been facilitated by the contemporary political and social climate.
Subsequent to the Labour Government’s success in the general election of May 1997, successive national policy documents have emphasised the government’s commitment to a patient-centred NHS (Department of Health, 2000, 2001a). Service user and carer involvement is fundamental to this approach. Indeed, in the area of mental health policy, the involvement of service users and carers comprises one of the ten guiding values and principles outlined in the National Service Framework for Mental Health (Department of Health, 1999).

Within the wider community, the last three decades has seen the proliferation of voluntary and charitable service user and carer organisations (Felton & Stickley, 2004). While the objectives of these organisations are as diverse as the organisations themselves, informing policy makers and the public is a role shared by many. The significance of this social movement has been endorsed nationally by the establishment of INVOLVE and the Commission of Patient and Public Involvement in Health. These government-funded organisations are responsible for ensuring the promotion of service user and carer involvement both academically and clinically within the NHS.

Despite this apparently complementary political and social climate, my experience of conducting and promoting health services research suggests that service user and carer involvement remains a somewhat extracurricular activity. Consistent with this observation, Barnes and Wistow (1992) argue that service user and carer involvement is more strongly observed in rhetoric than in practice. The lack of research literature evaluating the impact of service user and carer involvement can be interpreted as supporting this claim. A recent systematic review of service user and carer involvement in the delivery and evaluation of mental health services, for example, identified only 12 comparative studies (Simpson & House, 2002).

Commentators have offered numerous reasons for the disparity between policy and practice. One prominent argument explores the ideas and knowledge held by healthcare professionals themselves. Rush (2004), in an historical analysis of service user
involvement in mental health services, argues that the assumptions held by healthcare professionals about service users’ rationality influence the degree to which involvement can be realised. Similarly, Hansen et al. (2004) argue that effective involvement is reliant upon the employment of healthcare professionals who acknowledge the value of service user and carer knowledge.

These arguments highlight the centrality of education in developing a culture of acceptance among healthcare professionals. This is acknowledged by the National Service Framework for Mental Health which states that ‘service users and carers should be involved in planning, providing and evaluating education and training’ (Department of Health, 1999). With specific reference to the training of clinical psychologists, the British Psychological Society do not presently have a policy on service user and carer involvement (L. Dexter, personal communication, 21 October 2004). The involvement of service users and carers in the training of clinical psychologists is, however, implied in the learning outcomes specified by the Society (British Psychological Society, 2002).

Conceptualising service user and carer involvement

Prior to any discussion of how service users and carers can contribute to the programme, it is necessary to consider the definitions adopted for the terms service user and carer and involvement. The conceptualisation of these terms is fundamental in determining who is considered eligible for involvement and the extent and diversity of their involvement. Moreover, any robust evaluation of the programme’s process or outcome would require that these terms be operationalised.

Service user and carer

In determining the definition for the term service user and carer, a number of questions can be asked. For example, who defines who is invited or enabled to participate? Does the definition include ex-service users and carers, or is it restricted to those who are presently using services? If ex-service users and carers are deemed eligible, are there limits on the amount of time elapsed between their experience of services and their
involvement with the programme? Is it a requirement that service users and carers experience local services, or is it sufficient that they be able to reflect on services generally? Are certain types of service experience more sought after than others? Does the term incorporate all mental health difficulties, including those that are severe and enduring? Are specific demographic factors considered when determining eligibility for involvement? Who is excluded by the definition adopted?

It is acknowledged that these questions do not comprise an exhaustive list and that the concerns and issues of service users and of carers are not necessarily congruent. The intension here is to highlight the ambiguity of the term service user and carer. Indeed, even the appropriateness of the term itself has been questioned (Barnes & Bowl, 2001; Livingston & Cooper, 2004).

Defining the term service user and carer not only makes clear the individuals for selection but also suggests where and how these individuals may be recruited. For example, will service users and carers be recruited from primary, secondary or tertiary care? Will recruitment be based around existing relationships with service users and carers or will new relationships be sought? Will service users and carers be contacted directly, or will recruitment be directed through patient advocates, voluntary organisations or national bodies?

To enable a thorough exploration of ways of involving service users and carers in the programme, a broad, all-inclusive definition of service user and carer is assumed throughout this paper.

Involvement
In determining the definition for the term involvement, both the extent and diversity of involvement must be considered. The extent of involvement is often represented as a continuum of participation (Forrest et al., 2000). Conceived in this way, involvement can range from low levels of participation characteristic of traditional professionally-led
services, to high levels of participation typical of contemporary joint partnership approaches. The position adopted on this continuum also suggests the diversity of involvement. For example, the adoption of high levels of participation typically enables a more extensive range of opportunities for involvement. Conversely, the adoption of low levels of participation limits the range of involvement opportunities.

My experience of involving service users and carers in health services research was confined to the lower levels of participation. Service user and carer consultation was invited only after the research protocol had been established and consequently left little opportunity for influence. This approach reflected the ad hoc nature by which service user and carer involvement was considered within the institution in which I was working. In reflecting on the outcome of these consultations, it is not surprising that both parties were left feeling frustrated by the futility of this level of involvement.

To facilitate a comprehensive exploration of the ways of involving service users and carers in the programme, this paper adopts a position on the continuum that promotes high levels of participation. The adoption of this position is compatible with the reflective and collaborative philosophy presently governing the programme.

**Realising service user and carer involvement**

Having established an appreciation for the context and conceptualisation of service user and carer involvement, this section will present ways of involving service users and carers in the programme. For the purpose of an ordered discussion only, this section is divided into eight sub-sections. This division does not suggest an order of implementation, nor does it imply that involvement in one aspect of the programme be independent of involvement in other aspects.

**Selection**

The process of selecting candidates for training could provide opportunities for involvement. Service users and carers could be invited to contribute to the process of
short-listing candidates for interview. This could include involvement in generating short-listing criteria and screening of application forms. This could provide one means of ensuring that the short-listing process acts as a corrective to possible structural biases.

Service users and carers could also be involved in the interview process. Harper et al. (2003) suggest that service users and carers are in a unique position to evaluate the personal qualities of candidates and may be able to evoke certain responses from candidates during interview. Candidates invited for interview could be encouraged to meet informally with service users and carers throughout the interview day. More formal involvement could see service users and carers invited to sit on interview panels.

Service users and carers could also be involved in the development of promotional material relating to the programme’s organisation and entry requirements. This could include contributions to the information contained in the Clearing House entry handbook and on the university website. Specifically, service users and carers could contribute to developing promotional material that is supportive of potential candidates with personal experience of mental health difficulties.

**Evaluation**

Service users and carers could be involved in deciding what aspects of the trainee’s activity should be evaluated and how this could best be achieved. Service users and carers may be able to suggest innovative approaches to evaluation not previously considered by the programme team.

Consistent with the programme’s existing evaluation methods, service users and carers could be involved in developing assignment questions and establishing marking criteria. Service users and carers could be members of the pool of markers established as part of the recently introduced moderated marking scheme.

Currently the programme invites trainees to incorporate evidence of reflective thinking in
their written work. The suggestion that written work contain a service user and carer perspective could also be stipulated. In written reports of clinical experience this could include a discussion of process and relationship issues.

Service users and carers could also assume a more visible role in trainee evaluation. This could include assessment of the trainee’s presentation skills, evaluation of the trainee’s contribution to group work or direct observation of the trainee’s ability to build a therapeutic relationship. Anonymous and confidential follow-up questionnaires could be sent to service users and carers upon completion of clinical work with a trainee. These questionnaires could assess satisfaction with both the outcome of the work and the process.

In addition to contributing to trainee evaluation, service users and carers could be involved in the evaluation of teaching staff and placement supervisors. This evaluation could focus specifically on the level of consideration given to service user and carer perspectives in teaching and supervision sessions respectively.

**Support**

The programme currently offers a variety of sources of support to facilitate the personal and professional development of trainees. Service users and carers could provide trainees with an additional source of support. Trainees could access this support through the establishment of meaningful relationships with service users and carers.

Consistent with the existing method of allocating support, trainees could be assigned a service user or carer for the duration of the programme. This approach could operate independently of the programme’s organisation with ownership of the relationship being the responsibility of the individuals involved. In addition to providing a foundation for support, the process of relationship building could help to foster an appreciation of different perspectives and encourage the development of a shared understanding.
Supportive relationships could also be established between groups of trainees and service users and carers. This could be facilitated through service user and carer participation in trainee case discussion groups. Service users and carers could either be permanent members of the case discussion group or invited to attend specific sessions. The successful implementation of a similar reflective and supportive initiative involving mental health nursing students and service users is reported by McAndrew and Samociuk (2003).

In reflecting on the relationships that I established with service users and carers during my employment in health services research, the majority were temporary and perfunctory. I would welcome the opportunity to establish more enduring and meaningful relationships with service users and carers.

Research
National and local implementation of the Research Governance Framework for Health and Social Care (Department of Health, 2001b) has facilitated service user and carer involvement in research. The recently revised application for research ethics committee approval, for example, asks applicants how the results of the research will be disseminated to participants and the communities from which they are drawn. The research governance procedures adopted by many NES Trusts also address the issue of service user and carer involvement in the research process (H. Laver, personal communication, 17 December 2004). My experience of involving service users and carers in health services research, however, suggests that such procedures are interpreted by many researchers as merely suggestive and are in no way considered to be mandatory requirements for research.

One way in which the programme could promote more meaningful involvement in research is through the establishment of a service user and carer research advisory committee. This committee could comprise service users and carers and members of the programme team. The committee could be responsible for ensuring that service user and
carer involvement is considered at all stages of the research process. For example, involvement could begin with service user and carer consultation in formulating the research question and could conclude with the dissemination of results to a service user and carer audience.

The committee could encourage the use of research methodologies and outcome measures that are respectful of service user and carer perspectives. For example, trainees could be encouraged to consider adopting qualitative research methodologies including community-based and participatory action research designs.

The research advisory committee could liaise with national and local organisations already engaged in research involving service users and carers. Establishing relationships with such organisations could enable the open exchange of research information and suggest opportunities for collaborative research projects.

Placement
An understanding of service user and carer perspectives could be specified as a placement objective and included in the contract agreed between the trainee and placement supervisor. How this objective could be achieved would necessarily vary depending on the nature of the placement. Placement in a community setting, for example, could provide opportunities for informal engagement with day hospital attendees and involvement with service user and carer groups. Experience of patient advocacy and workability services operating within the community could also help to foster a broader understanding of service user and carer perspectives.

Elective placements could be offered that incorporate a strong service user and carer element. Trainees with a specific interest in service user and carer involvement could therefore be provided with an opportunity to develop their interest further in the final year of training.
Trainees could be required to provide a reflective account of their initial experiences on placement. This account could invite trainees to consider the setting and organisation of the placement from a service user and carer perspective. Placements offer trainees a unique and curious position as they are at once both part of the service and separate from it.

Clinical work invariably requires that trainees work as part of a multidisciplinary team. The process of working effectively within a multi-disciplinary environment demands the development of skills that enable the appreciation of others’ perspectives. The link between the development of these skills and developing an understanding of service user and carer perspectives could be made more explicit.

**Teaching**

Service users and carers could be involved in recommending what trainees should be taught and what teaching methods should be adopted. Service users and carers could provide guidance to instructors on how to incorporate service user and carer perspectives in their teaching sessions. This could include, for example, encouraging instructors to reflect on their own experiences of mental distress and use of mental health services.

The majority of teaching on the programme is currently delivered by clinically qualified psychologists. Opportunities could be created for service users and carers to contribute to the delivery of teaching sessions. Service users and carers could collaborate with existing instructors to deliver combined teaching sessions. The contributions of service users and carers to a combined teaching session could include the presentation of first-hand accounts of mental distress or critiques of prominent psychological theories (Harper et al., 2003). In either circumstance, this approach to teaching could provide trainees with an appreciation of the diversity of perspectives and encourage the development of critical appraisal skills. Moreover, the ability of instructors to work collaboratively with service users and carers outside of a clinical setting would be a valuable process for trainees to observe.
Service users and carers could also be invited to present specific teaching sessions independent of other instructors. The topics for presentation could include those that reflect the particular interests of service users and carers and those in which they are able to offer a unique perspective. Themes identified in the research literature include communication, roles and relationships, and labelling and stigma (McAndrew & Samociuk, 2003). Service users and carers could also be invited to present the results of research on the experiences of individuals in receipt of mental health services (Harper et al., 2003).

Service user and carer involvement need not be limited to teaching by individuals but could also include teaching by service user and carer groups. A number of service user and carer groups have established their own independent training courses and conference programmes. Trainees could be invited to attend these events and experience service user and carer involvement beyond the confines of the university setting.

The teaching of reflective practice among trainees could also promote an appreciation of service user and carer perspectives. Goodbody (2003) suggests that trainees should be encouraged to consider their own experiences of difficulty, inequality, self-advocacy and help-seeking. Reflecting on such experiences could help to remind trainees that service users and carers are not categorically different from themselves.

To supplement teaching sessions, academic resources that include service user and carer perspectives could be recommended. Trainees could also be encouraged to seek resources outside of those endorsed academically. Fictional (e.g., Haddon, 2003) and non-fictional accounts (e.g., Redfield Jamison, 1997) of mental health difficulties could offer trainees unique insight into service user and carer perspectives.

Management
Irrespective of the extent and diversity of service user and carer involvement, involvement needs to be managed. Service users and carers could contribute to the
management process. A steering committee comprising service users and carers and university staff could be established. The committee could be responsible for ensuring that effective and meaningful service user and carer involvement is realised and maintained. This could comprise the continual evaluation of the process and outcome of involvement across all areas of implementation.

As trainees
The discussion thus far has focused on service user and carer involvement in the practice of training. It is important to recognise that service users and carers could also be involved as trainees. Indeed, the trainee selection procedures outlined by the British Psychological Society (2002) state that candidates must not be discriminated against on the grounds of disability. These procedures also encourage training programmes to actively promote diversity within trainee cohorts.

The programme currently maintains a number of practices that encourage service users and carers to apply for training. These include the separation of health screening from the selection and interview process and the inclusion of supporting statements in the Clearing House entry handbook. More active promotion could include inviting candidates to reflect on their own experiences of mental distress and use of mental health services. This could form part of the candidate’s written application or be elicited during interview.

To ensure that trainees with experience of mental health difficulties are adequately supported once on the programme, support services operating independently of the programme’s organisation could be offered. Participation in confidential counselling could, for example, be made mandatory for all trainees.

Dilemmas and issues
This section introduces particular theoretical dilemmas and practical issues that need to be considered prior to service user and carer involvement in the programme. As with the previous section, each theoretical dilemma and practical issue is considered under a
separate sub-section to enable an ordered discussion.

Representation
The issue of representation is commonly cited in the debate surrounding service user and carer involvement (Barnes & Bowl, 2001; Felton & Stickley, 2004). Indeed, the assertion that involvement is valid only if those involved are representative of service users and carers as a whole is a view that I frequently encountered during my employment in health services research. In reflecting on these encounters, I would maintain that absolute representation is unattainable and would, therefore, argue that the issue of representation is more often raised as justification for no involvement. Moreover, I would argue that the issue of representation is borne out of a largely positivist approach to health services research and is incompatible with the government advocated patient-centred approach.

Motivations
A related issue, and one that I often encountered during my work in health services research, concerns the belief that those service users and carers that do get involved do so to promote their own agenda. In my experience, the healthcare professionals that tended to adopt this view did so more out of a fear that their research ideas would not be compatible with those held by the service users and carers involved. I would argue, therefore, that their concerns regarding motivations were more likely an attempt to excuse any involvement. McAndrew and Samociuk (2003), in an exploration of service user involvement in mental health nursing, argue that questions of motivations are somewhat naïve as individuals will bring their own agendas whether they are at a conscious or unconscious level. Indeed, contemporary theories in psychology maintain that the adoption of a position of neutrality is impossible (Burr, 2003). Individuals should, however, be understood not only as sources of interests or motivations but also as sources of arguments - with the latter being analytically, at least, distinct from the former.

Empowerment
A consideration of service user and carer involvement invariably raises the issue of
empowerment. Broadly speaking, the level of power afforded to service users and carers corresponds to the extent and diversity of involvement. For example, the adoption of high levels of involvement affords service users and carers more power than the adoption of low levels of participation which invariably limits their power. It is important to recognise that the way in which involvement is defined both influences, and is influenced by, the power assigned to service users and carers.

Felton and Stickley (2004) suggest that many of the reasons provided by healthcare professionals for not involving service users and carers in training protect against a potential loss of professional power. This view assumes a model of power that is absolute. Under an absolute model of power, empowering previously powerless individuals or groups necessarily disempowers those who already hold power. An alternative, more helpful conceptualisation, therefore, would see power as being amenable to increase (Barnes & Bowl, 2001). Conceived of in this way, professionals need not relinquish their power to afford power to service users and carers. By conceptualising power as a relationship, and not as a zero sum game or a thing, both parties have the potential to be enabled.

Assumed roles
Service user and carer involvement questions the roles the medical and scientist-practitioner models ascribe to healthcare professionals and service users and carers. Involvement challenges the role of the service user and carer as a passive recipient of care. Accordingly, service user and carer involvement is perceived by many healthcare professionals as threatening to their assumed role as expert (Felton & Stickley, 2004; Soffe, 2003). Repper and Perkins (as cited in Rush, 2004) argue that professionals need not perceive themselves as lacking in expertise but rather appreciate that they do not have a monopoly on knowledge. This is consistent with the programme’s current approach to training which emphasises that service users have expert knowledge of their own lives.
Paradoxical policies
Government policies simultaneously exist both to enable and disable service user and carer involvement. On the one hand, the National Service Framework for Mental Health (Department of Health, 1999) includes service user and carer involvement as one of the key guiding values and principles. Yet, on the other hand, the Mental Health Act (1983) and its proposed amendments denote service users as synonymous with danger and unpredictability.

The policies and procedures issued by the British Psychological Society are similarly paradoxical. The programme accreditation criteria, for example, state that the majority of teaching should be provided by clinically qualified psychologists and yet demand that training programmes be responsive to new developments and areas of concern within the profession (British Psychological Society, 2002).

Remuneration
Service users and carers should be remunerated for their involvement. Remuneration should extend beyond the tokenistic reimbursement of travel expenses and include preparation time. A payment scale could be developed collaboratively by the programme team and service users and carers. This could help to ensure that arrangements for payment are equitable and made clear from the outset.

The financial implications of involvement, however, must be considered both in terms of affordability on the part of the employing institution and the service user and carer in receipt of payment. For service users and carers in receipt of benefit, payments may need to be arranged individually. McAndrew and Samociuk (2003) suggest that in such circumstances payments be made to a group of service users or carers as a whole or to a representative organisation.

Roles and responsibilities
In addition to the provision of a clear payment structure, service users and carers must be
clear about what is expected of them, how long they are required to serve and what resources are available for their use. The development of individualised job descriptions could make the roles and responsibilities of each service user and carer explicit. Moreover, the formal provision of job descriptions could provide a means of monitoring and reviewing the activities of each service user and carer as necessary.

Support
Structures should be in place to ensure that the service users and carers involved are well supported both personally and practically. Personal support could be offered through the provision of a confidential counselling service. A member of the programme team could also be nominated to ensure that service users and carers are sufficiently debriefed following their involvement and that they are given an opportunity to provide feedback on their experience of involvement.

Practical support should include both the provision of generic and specific information and training. An induction package could be provided for each service user and carer irrespective of their level or type of involvement. This package could include information on the university and training programme and details on institutional policies and procedures. More specific, bespoke training sessions could also be offered as required. Topics could include how to cope with difficult situations and how to plan teaching sessions.

It is important to acknowledge that the provision of support should not be limited to service users and carers. The programme team and trainees should also be offered personal and practical support to enable them to respond to the changes and demands resulting from service user and carer involvement.

Administration
The relationships between the programme team and service users and carers take place within an organisational context and are thus subject to administrative routines and...
conventions as well as professional priorities and service user and carer concerns. The programme team will need to relate to and accommodate the employing organisation and its administrative processes.

**Ethical considerations**
Service users and carers should be required to abide by the same rules of confidentiality that guide the practice of trainees and the programme team. Service users and carers should be given the right to withdraw their involvement in the programme subject to the relevant contractual obligations.

**Accessibility**
Involvement should be made as accessible to service users and carers as is possible. This should include a consideration of the language used by the programme team and the suitability of times and locations.

**Conclusion**
Despite representing the largest stakeholder in the training of clinical psychologists, service users and carers remain the least represented. This paper has suggested a means of addressing this imbalance through an exploration of ways of involving service users and carers in the Clinical Psychology Training Programme at the University of Surrey.

The paper began by reviewing the contextual and conceptual background of service user and carer involvement and concluded with a presentation of some of the dilemmas and issues inherent in service user and carer involvement. While problems of organisational and occupational inertia and resource allocation inevitably exist, it is here argued, through the combination of an advocacy role and a systematic consideration of the issues, that service users and carers can be effectively and meaningfully involved in the Clinical Psychology Training Programme at the University of Surrey.
Acknowledgements

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References


Clinical Psychology, 21, 15-18.
"To consult or not to consult... What is the role of consultation in clinical psychology practice?"

PROFESSIONAL ISSUES ESSAY

December 2006
Year 2
Introduction

This paper is concerned with exploring the role of consultation in clinical psychology practice. The paper is comprised of two main sections. The first section identifies consultation as being one of the least recognised of the activities of the clinical psychologist. This section acknowledges the diversity and the specificity of the term consultation and attempts to define consultation in a way that is most compatible with the purpose of this paper.

Having identified a compatible definition, the second section addresses the various roles of consultation as it applies to clinical psychology practice. This section is divided into three sub-sections, each pertaining to a distinct role. The roles identified are considered to be of relevance to all of the consultation initiatives reviewed and are not, therefore, deemed to be unique to any one initiative. The significance of each identified role is substantiated academically, through research evidence, and supported in a more obviously anecdotal way, through reflections on my own experiences and observations while on placement.

I initially declined the invitation to write on the role of consultation in clinical psychology practice. I was aware of my theoretical unfamiliarity with the subject. The role of consultation in clinical psychology practice was something that I had not formally encountered in either my undergraduate or postgraduate training, nor had I previously been encouraged, or indeed compelled, to read around the issue. Moreover, the ambiguity of the term consultation suggested to me that there was no predetermined right way to approach the subject. I felt somewhat overwhelmed by the myriad of possibilities that this presented. I feared that an engagement with the issue would uncomfortably extend me beyond my academic abilities. Furthermore, I suspected that consultation was an activity that only well established clinical psychologists participated in. Given my status as a second year trainee, I thus queried the professional and personal value of my engaging with the issue.
It was not until I began to reflect on these perceived barriers to engagement that I was able to reconsider my position in relation to the issue. Specifically, I decided to view these barriers, not as convenient excuses for dismissing the issue, but rather as motivators for engaging with it. Furthermore, I anticipated that an engagement with the issue would readily permit a combination of traditional academic work with a measure of creative and reflective thought on the clinical experiences I had accrued thus far. It was the process of re-evaluating my position on the issue that ultimately lead me to decide to accept the invitation to write on the role of consultation in clinical psychology practice. Although I was pleased to have reached this decision, I nevertheless approached the task with some residual trepidation.

**Recognition and definition of consultation**

The traditional conception of the role of the clinical psychologist is that of a trained professional who offers direct, one-on-one therapeutic intervention to individuals experiencing mental health difficulties (Marzillier & Hall, 2003). Although this traditional conception is not necessarily inaccurate, it does fail to incorporate the diversity of activities undertaken by the clinical psychologist working within the National Health Service (NHS) in the twenty-first century.

Educational, training, supervision, service evaluation and research, for example, are now widely recognised as legitimate activities for the clinical psychologist. There exists an abundance of literature that attests to the relevance and value of these activities in clinical psychology practice (Marzillier & Hall, 2003). The very fact that these activities are included in the clinical psychology training curriculum, and routinely specified in the job descriptions of clinical psychologists, is further testament to their significance in current practice.

Of the myriad of activities that the clinical psychologist is involved in, Brunning and Huffington (1990) argued that consultation is the least recognised. Broome (1994) identified consultation as being the most contentious and problematic area for clinical
psychology. Certainly, my immediate experience of researching this paper suggested that consultation is both a less documented, and a less formally demonstrated, activity. I was surprised by the lack of research literature on the subject and by the paucity of authors contributing to the debate and evidence base. The lack of available literature, however, did not appear to reflect the realities of clinical psychology practice, as suggested by my observations while on placement. Direct observation of the daily activities of the clinical psychologists on placement suggested that they all regularly engaged in some form of consultation activity. For the most part, this consultation activity appeared to occur informally and internally, within the multidisciplinary team. It is perhaps not surprising, therefore, that neither the team members, nor the management, formally recognised the activity as consultation. Indeed, in some instances, consultation activity was not recognised by the clinical psychologists themselves. On the occasions when the clinical psychologist did recognise the activity as consultation, the terms service development or support and advice were the descriptions the clinical psychologists preferred to employ. Despite these observations having been made in 2005, they appeared to affirm the assertions made some fifteen years earlier in relation to consultation being an unrecognised (Bruning & Huffington, 1990), contentious and problematic (Broome, 1994) activity for the clinical psychologist.

I suspected that part of the difficulty in recognising consultation in clinical psychology practice was to do with the confusion over the definition of the term consultation. Indeed, it was the ambiguity of the term that had, at least initially, deterred me from engaging with the issue. Informal discussions with members of my training cohort suggested that they too were unsure as to the definition of the term, and that it was this uncertainty that had prevented them from further considering the topic. Subsequent conversations with the clinical psychologists on placement suggested that there appeared to be little consensus on the definition of consultation. Although I was somewhat encouraged to discover that my peers were also grappling with the ambiguity of the term, the diversity of definitions offered by the clinical psychologists on placement suggested that defining the term would be as troublesome as I had initially anticipated.
I recognised, however, that a definition was necessary if I were to engage in a thorough exploration of the role of consultation in clinical psychology practice. Similarly, Seager (1994), in a critique of the development of consultation, recognised that the definition adopted for the term would be instrumental in determining the role of consultation in clinical psychology practice. Moreover, I was aware that any robust evaluation of consultation activity would demand that the term be operationalised. I was hopeful that the research literature would be able to provide me with a definition that was both comprehensive and operational for the purpose of this paper.

In line with the conversations had with the clinical psychologists on placement, a preliminary review of the research literature produced an array of definitions for the term consultation. The diversity that existed is perhaps not surprising given that the majority of the papers I reviewed described bespoke, context-specific consultation initiatives. Indeed, it was not until I considered the definitions en masse that I was able to identify two significant shared characteristics. Irrespective of the specifics of the consultation activity described in the papers considered, each definition identified the party in receipt of the consultation, and the aim of the consultation.

The party in receipt of the consultation was most commonly identified as being either an individual patient (Joscelyne & Godwin, 2005; Partridge et al., 1995; Rosen-Webb & Morrissey, 2005) or a group of healthcare professionals (Bremble & Hill, 2004; Dowling & Manning, 2004; Frier & Sutton, 2003; Prior et al., 2003; Thirlwall & Silver, 2005). Of course, as Marzillier and Hall (2003) rightly observed, the recipient need not be limited to either patient or professional, but could also include paraprofessionals, supporters and volunteers. Equally, among the definitions offered by the papers reviewed, whole organisations were also recognised as being potential recipients of the consultation (Broome, 1994; Brunning & Huffington, 1991; Hill-Tout, 2005).

The second shared characteristic of the definitions offered by the papers reviewed comprised the aim of the consultation. Whether explicitly or implicitly stated, the aim of
the consultation was to improve the role, function or task of the individual, group or organisation identified as being in receipt of the consultation (Brunning & Huffington, 1990). Among the definitions considered, it was only the means by which this aim was achieved that differed. For example, in an exploration of the role of consultation in primary care, Elphick (2004) defined consultation as comprising the provision of support and advice, whilst distinguishing it from training and supervision. Quarry and Burbach (1998), on the other hand, proposed a model of psychological consultation in which training and supervision were seen as comprising key components. An even more inclusive definition was offered by Wagner (2000) who went as far as to propose that all intentional interactions comprised consultations.

Based on the shared characteristics identified, and appreciating the purpose of this paper, I chose to define consultation as a process that enables individuals, groups or organisations to fulfil their role, function or task better. I anticipated that this definition would accommodate the diversity of definitions offered by the papers reviewed, and make possible the identification of the roles I deemed to be universal to the majority of consultation initiatives. I was aware, however, that the adoption of this definition would necessarily limit my exploration of the role of consultation in clinical psychology practice in that it would not readily enable the identification of any of the more specific and/or idiosyncratic roles of consultation.

The roles of consultation
Having established a definition for the term consultation, this section is concerned with delineating the roles of consultation in clinical psychology practice. Three main roles are identified, each of which are presented in the sub-sections below. The significance of each identified role is substantiated academically, through research evidence, and supported in a more obviously anecdotal way, through reflections on my own experiences and observations while on placement.
Accommodating the increasing demand for psychological services

National policy documents outlining the planning and delivery of healthcare services in Britain are increasingly cognisant of the importance of psychological care and psychological factors in healthcare (Department of Health, 1999a, 2000). Mental health is recognised as one of the government’s key priority areas and the National Service Framework for Mental Health (Department of Health, 1999b) is heavily influenced by psychological considerations. Paxton and D’Netto (2001) argue that the remaining key priority areas of heart disease and cancer, although not obviously psychological in either aetiology or treatment, demand psychological input at a behavioural and lifestyle level.

Despite these national acknowledgements, however, the clinical psychology workforce is inadequately resourced to accommodate the increasing demand for psychological services. The most recent workforce statistic that I was able to obtain was for 1990. At this time, there was a national vacancy rate for clinical psychologists of 22 per cent (Marzillier & Hall, 2003). Although I was unable to obtain a more current figure, it is widely acknowledged that the shortage continues (Joscelyne & Godwin, 2005; Marzillier & Hall, 2003).

The combination of increasing demand and limited resources prompted the British government to commission a special review of the function of the clinical psychologist working within the NHS. This review led to the publication of two significant and influential reports: the Management Advisory Service (MAS) Review of Clinical Psychology Services (1989); and the Manpower Planning Advisory Group (MPAG) Report (1990). Taken together, these documents recognised that the current method of service delivery, namely the provision of direct, one-on-one therapeutic intervention, was not, in itself, sufficient to meet the growing demand for psychological services. Consultation was recommended as an effective and efficient means by which the clinical psychologist could deliver psychological services. Consultation was thus formally endorsed as a legitimate activity for the clinical psychologist and its primary role was identified as being that of accommodating the increasing demand for psychological
services.

Research papers have since been published that attest to the success of consultation initiatives both in terms of their impact on reducing existing clinical psychology waiting lists and on limiting the amount of new referrals made to the psychology service. For example, following the implementation of a consultation approach to assessment, Partridge et al. (1995) reported that the clinical psychology waiting list was reduced from 18 months to only three to four months, with clients in priority groups being seen within six weeks. Similarly, following the introduction of a consultation service for health visitors, Prior et al. (2003) observed a 30 per cent decrease in the number of new referrals made to the psychology service. Moreover, of the referrals that were made to the service, all were deemed to be complex cases (operationally defined as cases presenting with more than one problem) compared to only 44 per cent of the cases referred in the six months prior to the introduction of the consultation service.

With reference to my own experiences on placement, my service related research project was concerned with evaluating the impact of a consultation service for general practitioners (GPs) on the number, and appropriateness, of referrals made to the Community Mental Health Centre (CMHC). This consultation service provided an opportunity for the GPs working with the CMHC catchment area to discuss potential referrals with the CMHC team members before formally referring the individual identified for a psychiatric and/or psychological assessment. The results of the service evaluation demonstrated that, following the implementation of the consultation service, the number of GP referrals to the CMHC decreased and the percentage of formally received referrals accepted for an initial CMHC assessment increased. Moreover, the range of presenting difficulties was demonstrated as being more varied and, arguably, more complex in the year following implementation than in the year preceding implementation.

Given my experience of conducting this evaluation, and the apparent success of the
initiative, I was curious as to whether any similar consultation initiatives had been established within my current placement that aimed to either reduce waiting lists or limit the number of new referrals. My supervisor reported that he was unaware of any formal initiatives. He did report, however, that the referral rates among children aged between zero and five years of age had reduced substantially over the last few years. Although no evaluation of this observed reduction had been commissioned, my supervisor suspected that the reduction was largely the result of increased consultation and liaison between the clinical psychologists and the health visitors.

Responding to the demands of an increasingly competitive NHS

In order for any profession to evolve, and indeed survive, it must be responsive to the demands of the political and social context within which it operates (Tollington, 1992). The profession of clinical psychology, therefore, must be responsive to the demands of the NHS. The NHS is currently undergoing an unprecedented amount of change (Department of Health, 1999b) and, in the process, is becoming an increasingly competitive market place. Øvretveit et al. (1992) argued that, as a profession, clinical psychology has failed to respond to this changing environment and consequently is becoming increasingly marginalised within the NHS. As evidence for this, the authors observed that many clinical psychologists have lost their formal positions across all organisational levels of the NHS. This loss of position is accompanied by a loss of access to information and the loss of influence in the decision making processes. Øvretveit et al. (1992) posited the development of the consultation role as a means by which the profession could re-establish its position within the NHS and thus continue to exert an influence on overall planning of patient care within the wider healthcare system. In accordance with this assertion, Quarry and Burbach (1998) recognised that clinical psychology is not making the impact on the healthcare system that it could and, indeed, should. They argued that consultation could provide a means of ensuring that psychosocial approaches to healthcare are properly disseminated and offered as an adjunct, or even as an alternative, to the predominating medical model. Similarly, Elphick (2004) reported that an awareness of psychological skills would increase the probability of
psychological interventions rather than pharmacological treatments being offered.

Øvretveit et al. (1992) further illustrated the marginalisation of clinical psychology within the NHS by observing that managers are increasingly comparing the cost of employing a clinical psychologist with the cost of employing other ‘substitute’ mental health professionals. Worryingly, the authors stated that the conclusion of such a comparison is often that the clinical psychologist is not worth the extra cost. Broome (1994) argues that GPs too, are becoming increasingly aware of the range of mental health professionals purporting to offer ‘less costly’ non-specific therapy and counselling services.

Increasingly, other mental health professionals are being trained in psychological methods and techniques that were previously considered to be the sole domain of the clinical psychologist. Indeed, while on my adult mental health placement, I was surprised to encounter a ‘nurse cognitive behavioural therapist’. My initial reaction, upon learning of her existence within the team, was one of distrust and resentment. I had thought that the skills inherent in cognitive behaviour therapy were the preserve of the clinical psychologist and thus felt uncomfortable sharing these skills with a mental health professional operating outside of the profession of clinical psychology. It was an important lesson for me to learn that many of the skills that I had thought unique to clinical psychology were actually practiced among members of a variety of mental health professions. If the profession of clinical psychology continues to assume, and indeed emphasise, it’s clinical indispensability it will be overwhelmed by the substitute mental health professions who the managers and purchasers of services consider to be less costly alternatives (Øvretveit et al., 1992). As a profession, clinical psychology can only develop if it is capable of demonstrating its usefulness and distinctiveness in the overcrowded and competitive NHS market place (Broome, 1994; Brunning & Huffington, 1994). Consultation offers clinical psychology both a useful and a distinctive identity and as such provides the profession with a marketable commodity.

The suggestion that clinical psychology needs to be marketed sits uncomfortably with
many clinical psychologists (Quarry & Burbach, 1998). Indeed, I prefer to interpret the role of consultation in clinical psychology practice as being less about marketing and thereby implicitly endorsing a market-led system, and more about ensuring the survival of the profession. When considered in this way, I suspect that consultation would be an activity that no clinical psychologist would be willing to ignore.

**Promoting good professional practice**

The roles identified in the sub-sections above are, for the most part, concerned with the profession’s ability to accommodate and respond to external pressures of policy and organisational change. In contrast, the role outlined in this sub-section is concerned with promoting best professional practice. An examination of this role includes a consideration of the recipients’ satisfaction with the psychological consultation services received and the promotion of effective multidisciplinary working.

**Evaluating satisfaction with the consultation service**

Many of the papers reviewed were concerned with evaluating the impact of a consultation initiative. Satisfaction surveys and the use of reflecting teams were among the most common methods of evaluation. In an evaluation of a child and family consultation service, Rosen-Webb and Morrissey (2005) asked children to complete a satisfaction survey with regard to their experiences of the service. The results demonstrated a high level of satisfaction. Indeed, it was reported that all of the children that completed the survey rated the outcome as ‘really good’. Similarly, in an evaluation of a consultation service for a permanence team, Thirlwall and Silver, (2005) reported that all of the respondents agreed that it was helpful to have specific clinical psychology involvement; they would use the service again; and they would recommend the service to a colleague. When asked if they found the consultation service helpful, only two out of 25 respondents reported experiencing no positive outcome.

Following the completion of my service related research project, I was curious as to how satisfied the GPs involved in the consultation service were with the service they had
received. Anecdotal reports from both the GPs and the CMHC staff members suggested that the general satisfaction level was high. I recommended to the CMHC management that the GPs’ views of the consultation service be more formally assessed by questionnaire or semi-structured interviews.

Dowling and Manning (2004) applied a reflecting team format to review the Assertive Outreach Team members’ perspectives on the process and experiences of being in receipt of a consultation service. The general agreement was that the service was useful, enjoyable and interesting to be involved in. The reflecting team format was helpful in that it also suggested opportunities for the future development of the service.

Promotion of effective multidisciplinary working

The role of consultation in the promotion of effective multidisciplinary working has been well documented. Prior et al. (2003), for example, reported an improvement in health visitors’ perceived confidence and professional competence in treating young children experiencing emotional and behavioural difficulties. Partridge et al. (1995) reported that the consultation initiative encouraged the sharing of evolving ideas and formulations, the recognition of joint expertise and the generation of multiple possible solutions. These outcomes are all synonymous with effective multidisciplinary working. Indeed, the sharing of professional knowledge and skills and the opening up of multiple perspectives on the problem was an outcome that was common to the majority of papers reviewed (Bremble & Hill, 2004; Dowling & Manning, 2004; Frier & Sutton, 2003; Prior et al., 2003; Quarry & Burbach, 1998).

Partridge et al. (1995) reported that they were particularly surprised to observe a substantial reduction in the stress associated with making difficult and important clinical decisions. This observation was also reported by Bremble and Hill (2004). Bremble and Hill (2004) proposed that it was the transparency of the decision making process made possible by the consultation service that promoted a sense of reassurance and containment among the mental health professionals involved. Similarly, Prior et al. (2003) reported
that the health visitors experienced a decreased sense of professional isolation as a consequence of attending the consultation meetings. In particular, the health visitors reported valuing the emotional support that the consultation meetings offered.

The mental health service, within which I am currently placed, runs a voluntary weekly consultation meeting. The meeting is open to all members of the multidisciplinary team and is alternately chaired by either the consultant psychiatrist or the consultant clinical psychologist. Irrespective of the professional background of the chair, the meeting is dictated by the needs of the individuals that decide to attend. The meeting provides a space within which members of the multidisciplinary team can discuss any cases that they may be experiencing difficulty with. Informal discussions among the attendees at the last meeting I attended suggested that they valued the mutual team support that the meeting offered. The safe and confidential space created was also considered to be an importance aspect. Again, I would suggest, that team support and safety and confidentiality are basic tenants of any successful multidisciplinary team.

**Conclusion**

This paper attempted to address the role of consultation in clinical psychology practice. The first section of the paper addressed the difficulty, not only in recognising consultation as a legitimate activity for the clinical psychologist, but also in defining the term so as to enable a thorough exploration of the role of consultation in clinical psychology practice. It was argued that the clinical psychologist, and the managers and purchasers of psychological services, need to recognise that consultation already exists within the clinical psychologist’s repertoire, yet needs to be formally identified and promoted if it is to be valued.

The second section identified three roles of consultation, universal to all of the consultation initiative reviewed. These roles comprised accommodating the demand for psychological services, responding to the demands of a competitive healthcare market and promoting effective multidisciplinary working, both for the benefit of the client and the
team. Evidence for the existence of these roles was substantially both academically and anecdotal, based on my own experiences and observations while on placement. The paper concludes that consultation should be considered by the clinical psychology profession as a valuable and additional activity alongside the more traditional psychology roles of direct therapeutic work, teaching, supervision and research.
References


“The relationship to change”

PROBLEM-BASED LEARNING REFLECTIVE ACCOUNT

March 2005
Year 1
Introduction

Over a six-week period, trainees worked in their assigned case discussion groups to devise and deliver a brief half-hour group presentation on ‘the relationship to change’. The concept of problem-based learning was introduced and posited as an effective means of working collaboratively to complete the exercise. As is characteristic of the problem-based learning approach, each case discussion group interpreted the exercise differently. Our group chose to define ‘the relationship to change’ as ‘our experience and reflections on the process of transition to becoming a trainee clinical psychologist’. By defining the exercise in this way, each group member was invited to contribute and encouraged to reflect on their unique experience of change. Our group chose to use the stages of change model (Prochaska & DiClemente, 1992) as the theoretical framework within which to conceptualise change.

This brief account will reflect on the experience of being involved in the problem-based learning exercise. In particular, this account will highlight aspects of the process that both facilitated, and impeded, the capacity of the group to complete the exercise. Each aspect will be considered from the vantage of subsequent clinical experience on placement. The account is organised into seven sections, each pertaining to a different aspect of the process.

The challenge of change

Problem-based learning was an approach to learning that I had not encountered previously, in either theory or practice. Accordingly, I was initially apprehensive when I discovered that our case discussion group was to be guided by this approach. The main principles of problem-based learning appeared too significant a departure from the approach to learning I had thus far adopted and refined during my undergraduate and postgraduate studies. The suggestion that learning could be group-based and collaborative challenged my perception of learning as a necessarily solitary and competitive activity. The idea that problem-based learning exercises were constructed so as to be intentionally broad and therefore incapable of generating one predetermined right
answer left me feeling vulnerable and ill-equipped. These feelings were further augmented upon discovering that our course tutor was not to be consulted as an expert or provider of information but rather as a group facilitator.

Through the process of reflection, I was able to recognise that the feelings I experienced at this time were both a logical and valid reaction to the threat posed by the expectation that I change my approach to learning. Conceived of in this way, and considered from the vantage of subsequent clinical experience on placement, I understood these feelings as being, at least formally, analogous to the feelings a client may experience when faced with the challenge of changing some aspect of their functioning. When working clinically, it is important to recognise that clients have to contend with the challenge of change whilst simultaneously experiencing and enduring their presenting difficulty.

**Flexibility in formulation**

As is characteristic of the problem-based learning approach, the exercise presented to the group was ill-structured and ambiguous. In an attempt to make sense of the ambiguity, the first objective, as identified by the group, was to define the problem. Not surprisingly, multiple definitions were generated and it took several sessions before the group were able to agree on the definition to adopt. While the group felt that a definition was essential to focus activity and promote a shared understanding, the group were also aware that a definition would inevitably direct, and thereby restrict, potential solutions to the problem. To accommodate this tension between focus and restriction, the group decided to conceive of the definition adopted as speculative and evolving. This conceptualisation provided the group with a solid, yet flexible, foundation from which to proceed.

In clinical practice, formulation can be similarly conceived. For any presenting difficulty, multiple formulations can be hypothesised. It can take some time and several attempts before a formulation appropriate and acceptable to the client can be agreed. Even once a formulation is agreed, however, formulation is best conceived of as an ever-evolving
process and not a static and rigid outcome. Formulation should be directive enough to suggest solutions, and thereby engender hope, yet flexible enough to ensure that new information can be accommodated.

**Making the model fit**

The group felt that it was necessary that our interpretation of the exercise be grounded in theory. The adoption of a theoretical framework was considered an important means of providing both a structure and validity to our interpretation. A number of theoretical frameworks were considered and the framework that best fit our experience was adopted. The group recognised, however, that even the theoretical framework of best fit was unable to accommodate all aspects of the group's experience. In the interests of parsimony and order, the aspects that could not be accommodated by the framework were overlooked. In short, the group's experience was made to fit the theoretical framework.

Subsequent experience on placement has taught me that parsimony and order are rarely found in clinical practice. The expectation that a theoretical framework be able to account for all aspects of a client's experience is thus unrealistic. When applied clinically, theoretical frameworks should be seen as approximations only. The aspects of an individual's experience that do not fit the framework should not be ignored, as they were during the group exercise, but rather, should be used to complement the framework and thereby enhance understanding. As clinical psychologists, it is important that our desire for parsimony and order does not take precedence over the uniqueness of the client's experience. The client should not be made to fit the theoretical framework, but rather, the framework should be made to fit the client's experience.

**Roles and responsibilities**

The roles and responsibilities of each group member were allocated in the first session. This proved to be an important process for two reasons. Firstly, it provided the group with a shared understanding of the roles and responsibilities of each group member. This shared understanding provided the context for interacting and enabled the group to
effectively engage in the exercise. Secondly, the task of allocating roles and responsibilities provided the group with its first opportunity to work together collaboratively. The relative simplicity of the task and the consequent ease with which it was resolved empowered the group. The co-operative way in which roles and responsibilities were agreed set the scene for future collaboration.

In clinical practice, it is important that both clinical psychologist and client are aware of the roles and responsibilities they are expected to assume in order to work together effectively. Without a shared understanding it would be impossible for each to work collaboratively with the other. Clinical experience on placement suggests that clients often adopt passive approaches to treatment and expect healthcare professionals to adopt more active problem-solving roles. This is not a surprising observation given the dominance of the biomedical model in the delivery of healthcare. In contrast to the notion that clients are passive recipients of care, clinical psychologists are inclined to adopt more collaborative approaches to treatment and thereby expect clients to be actively involved in the process. A transparent discussion of roles and responsibilities is thus necessary to ensure that both the clinical psychologist and client have a shared understanding of what is expected. Moreover, as was experienced amongst the group, an agreement on roles and responsibilities can empower individuals and reflect future collaborative working.

The neutrality fallacy

As part of my assumed role as group chair, I was responsible for leading the group through the exercise. I was mindful of the authority and potential influence that the role of group chair bestowed. Consequently, I tried hard to assume a position of neutrality. I was careful to ensure that each group member felt that their voice had been heard and that, wherever possible, group decisions were made collaboratively. At the end of the six-week exercise, the outcome that the group had collaboratively created was not dissimilar to the outcome that I had independently contemplated in my reflective journal after only the first week. This led me to question whether, through my role as group
In clinical practice, neutrality is an impossible position to assume. The suggestion that a clinician be able to remain neutral to a client’s experience is fanciful. Even the most admirable of attempts to offset potential biases can not guarantee clinician neutrality. In fact, attempts to assume neutrality can be counterproductive in that, in assuming a position of neutrality, clinician curiosity and reflectivity would necessarily be limited. Indeed, somewhat paradoxically, the best way to promote neutrality in clinical practice is to acknowledge its impossibility.

**Learning within and between sessions**
The effective application of the problem-based learning approach requires that learning occurs both within and between group sessions. To accommodate this requirement, each group member was assigned an area of study to research independently before returning to the group to discuss the information acquired. This combination of private study and group work promoted collaborative working and provided a framework within which to focus discussion. Moreover, it proved to be an effective means of ensuring that each group member held a responsibility towards the outcome and was, therefore, committed to the process.

Clinically, the relevance of learning both within and between sessions is perhaps best exemplified by the provision of homework within a cognitive behavioural framework. As was the experience of the group, homework within a clinical context functions to promote collaborative working and provides a focus for in-session discussion. Equally, homework can empower the client thereby encouraging an engagement in the process of recovery.

**Appreciation of difference and diversity**
Difference and diversity within the group was evident at two levels. At one level, the group recognised that each member brought with them their own set of skills and attitudes. It was acknowledged that in order to work effectively as a group, the diversity
of skills and attitudes had to be respected. No one set of skills or attitudes was seen as more valid than another. Indeed, the diversity that existed amongst the group was seen to be an asset. The group members were sensible to recognise that the diversity of skills and attitudes provided a unique and rich learning environment that each member could individually benefit from.

At the second level, difference and diversity was evident in the group’s experience of change. Despite describing similar change processes, the experience of each group member was unique. While similarities in experience were apparent, no two group members shared the same experience. The ease with which each group member was able to express their experience was, in part, testament to the group’s ability to both engender curiosity and create a contained space for discussion.

Like most other healthcare professionals working within the National Health Service (NHS), clinical psychologists do not work in isolation. Typically, clinical psychologists are employed as part of a multidisciplinary team. An appreciation of the diversity of skills and attitudes is crucial when working within such an environment. Too often clinical disciplines work independently rather than together, employing philosophies that may seem incompatible. As part of our duty of care to ourselves, those we work alongside and our clients, it is imperative that we are able to negotiate multidisciplinary working.

In clinical practice, difference and diversity must also be acknowledged in relation to the presenting client. No two clients’ experience of even the same diagnosis will be identical. It is important, therefore, that the clinical psychologist remains curious to the client’s own unique experience. Moreover, the clinical psychologist must work to maintain a safe and confidential space so that the client can feel able to discuss their experience.

**Conclusion**

This brief account reflected on the experience of being involved in the problem-based
learning exercise. These reflections were considered from the vantage of subsequent clinical experience on placement. The process of writing this account provided me with a concrete opportunity to integrate personal and professional experience and make links between theory and practice. I look forward to applying the reflective and integrative skills acquired to my future academic, research and clinical work.
References
“Child protection, domestic violence, parenting and learning disabilities”

PROBLEM-BASED LEARNING REFLECTIVE ACCOUNT

March 2006

Year 2
Introduction

At the beginning of the second year of clinical training, each case discussion group was presented with a clinical vignette. As with the previous problem-based learning exercise, the objective of the task was intentionally broad and ambiguous. This breadth and ambiguity invited innumerable ways of responding to the task and suggested that there was no predetermined ‘right’ outcome. Consistent with the problem-based learning approach, the course tutor was instructed to act as a group facilitator and refrain from adopting an expert position. As such, the course tutor was responsible for guiding the group and promoting collaborative and group-based learning. This enabled the group members to recognise and value the unique knowledge and expertise of each of the group members. It was expected that the group would be able to engage with a variety of learning resources, including the personal and professional experiences of each group member.

The clinical vignette that was presented to the case discussion groups was entitled: Child protection, domestic violence, parenting and learning disabilities. The vignette was deemed appropriate for consideration as the issues it raised were thought to be relevant to all trainees, irrespective of whether they were currently placed within a learning disabilities or a children and families context. In addition to the issues explicit in the vignette’s title, the group also chose to explore the more universal issues of diversity and power.

This brief account will reflect only on the group’s consideration of the issues of child protection, domestic violence and parenting. These issues were selected for consideration because I thought them to be the most influential in terms of informing my clinical practice within a children and families context.

Child protection

Prior to considering the clinical vignette, I felt apprehensive about engaging with the issues surrounding child protection and the processes by which to assess the risk of harm
to a child. I was aware that this apprehension existed despite having had comprehensive lectures on child protection and legislation. Although I believed myself to be theoretically able to understand the issues and processes involved, I felt somewhat less confident in my ability to clinically manage the issues and to put the processes into practice. My confidence was further shaken upon realising that the issues surrounding child protection should be at the fore of my thinking whilst working within a children and families context. I therefore welcomed the opportunity to practically consider the issues within a supportive and containing academic context, prior to encountering them in a clinical capacity.

Upon reflecting on the apprehension that I had experienced when first considering the issues surrounding child protection, I was able to recognise that this apprehension was similar to that which I had experienced when I was first confronted with the issues surrounding deliberate self-harm in an adult mental health setting. My main concern in this instance had been that I would not be able to approach the topic of deliberate self-harm in a manner that was both comprehensive and compassionate. My clinical supervisor at the time had recommended that I adopt a position of curiosity and approach the issue in a direct and matter of fact way. Although this advice could perhaps be construed of as being somewhat obvious, I found the approach to be invaluable, particularly in terms of helping to contain my own anxieties surrounding the gravity of the issue.

In relation to the assessment of risk, I was pleased to discover that the adoption of a position of curiosity was a skill that readily transferred from an adult mental health setting to a children and families setting. Indeed, this approach was actively endorsed by my children and families clinical supervisor. I was interested to note, however, that the curiosity that I was encouraged to demonstrate when working within a children and families context extended beyond that which I had maintained when working within an adult mental health context. Specifically, my curiosity in relation to the assessment of risk of harm to a child extended beyond working directly with the individual concerned.
and involved the gathering of information from multiple sources. In the context of my work with children and families, multiple sources often included information obtained from family members, school teachers and professionals working in other health and social care agencies.

In reflecting on my clinical experiences of working within both an adult mental health service and a children and families service, I would argue that the opportunity to obtain information from such a wide range of sources is more accessible within a children and families context. My experiences suggested that the pathways necessary for obtaining such information appeared to be both better travelled, and more defined, than the pathways that existed within an adult mental health context. Indeed, the children and families service within which I am currently placed benefits from having a strong history of multi-disciplinary and multi-agency collaboration. In addition to enabling a comprehensive assessment of risk of harm to a child, effective multi-disciplinary and multi-agency communication has the added advantage of promoting a sense of shared responsibility regarding the protection of a child. Given my status as a trainee clinical psychologist, I was particularly appreciative of the containment that this sense of shared responsibility offered. My confidence in my ability to conduct a risk assessment and to manage the potential consequences of such an assessment was greatly enhanced by the knowledge that other professionals were both available and willing to assist.

**Domestic violence**

In comparing the group’s engagement with the clinical vignette with my subsequent clinical experiences of working within a children and families context, I was interested to note that, in both instances, the issue of domestic violence had not been a primary consideration. Upon considering the clinical vignette, the group did acknowledge that domestic violence was an issue but did not consider the potential implications of domestic violence on either the family or the professional network. Indeed, none of the group members were tasked with sourcing further information on the issue. Accordingly, the issue of domestic violence did not feature in the group’s resultant presentation. In
reflecting on this omission, I suspect that the issue was neglected, not because the group considered domestic violence to be insignificant, but rather because the group were mindful of time constraints and felt overwhelmed by the myriad of other issues to contend with.

Upon considering the issue of domestic violence in my clinical practice, I recognised that a number of the children I had been working with displayed behaviours that could be construed of as being consistent with the children having been witness to domestic violence. I had, however, formulated the presenting difficulties without explicit consideration of the issue of domestic violence. I was aware of the high prevalence rate of domestic violence and consequently became concerned about the apparent absence of the issue in my clinical work. I discussed my concerns with both the case discussion group and my clinical supervisor. I was at once both relieved and dismayed to discover that domestic violence need not be an ‘elephant in the therapy room’ for it to be missed by members of the professional network. Upon recognising this, I was prompted to re-examine the formulations that had been hypothesised for the children and families that I was working with. For the most part, the re-examination of these formulations was a theoretical exercise, involving only myself and my clinical supervisor. With one family, however, the circumstances were such that the re-examination extended beyond a theoretical consideration in supervision. In this instance, the family concerned were directly involved in the re-examination. The queries that I had concerning the existence of domestic violence in this family were initially explored by means of the family genogram.

Having re-examined the formulations that had been hypothesised for these children and their families, I was satisfied that domestic violence had not been missed in these instances. I was aware, however, that I was unable to categorically state that domestic violence did not exist among these families. I was reminded at once of the fluidity of formulation and the importance of being able to tolerate some level of uncertainty in clinical practice.
Parenting

Prior to considering the clinical vignette, I had not given the issue of parenting much consideration outside of my own personal experiences of being parented. In fact, I recognised that I had not even given my own experiences much consideration except for the fact that I had anticipated that my own approach to parenting would reflect the approach that my parents had adopted. I was interested to listen to each case discussion group member as they shared their experiences of being parented and their expectations as to their own parenting ability. Prior to hearing these accounts, I had assumed, somewhat naively, that the expectations and values that I held in relation to parenting were universal. While I had recognised that it was possible to adopt different approaches to parenting, I had assumed that these different approaches were all informed by similar expectations and values. Upon learning of the diverse expectations and values that existed within the members of the case discussion group, I became curious as to the diversity of expectations and values that I would certainly encounter in my clinical practice.

Indeed, my subsequent clinical experiences within a children and families context introduced me to a variety of parenting approaches and parental expectations and values. Moreover, I was interested to discover that this diversity not only existed between different families but was also evident within the same family. I suspect that had I not have been given the opportunity to consider this diversity within my case discussion group, I would have been less receptive to, and even intolerant of, this difference in clinical practice.

Upon reflecting on my clinical experiences of working with parents in a children and families context, I was struck by the vulnerable position that many parents experience when seeking help. Specifically, many of the parents that I had encountered in clinical practice were concerned that their approach to parenting would be exposed and criticised. I suspect that these concerns are at least partly fuelled by the current trend in ‘reality’ television programming (see for example: Super Nanny and The House of Tiny
Tearaways) which suggests that there are innumerable wrong ways to parent. I believe that much of my clinical work within a children and families context would have been less successful if I had not have recognised and acknowledged the existence of these parental concerns.

Conclusion
This brief reflective account considered the issues of child protection, domestic violence and parenting. Each issue was addressed in turn and considered both in terms of how the issue was approached by the case discussion group and how I subsequently approached the issue in clinical practice. I appreciate being given the opportunity to theoretically and practically consider these issues prior to engaging with them in a clinical capacity.
“Working with older people”

PROBLEM-BASED LEARNING REFLECTIVE ACCOUNT

February 2007

Year 3
Introduction

The third and final problem-based learning exercise was presented to each case discussion group at the beginning of our final year of clinical training. As with previous problem-based learning exercises, the task was purposefully ambiguous and provided an opportunity to integrate theory and clinical practice. The task required both independent and collaborative working and demanded that a wide range of resource materials be considered. The exercise presented was entitled: Working with older people and a case example was provided. The reason for the referral was explained and some background information was presented. In addition, a number of prompt questions were provided to suggest lines of enquiry and to guide the group’s discussions.

This brief account will reflect on the process of being involved in the problem-based learning exercise. The account will identify some of the individual and group factors that were relevant to the group’s completion of the exercise. The factors identified will also be considered in relation to the experiences that I have garnered whilst on clinical placements. To assist readability, this account has been divided into six sections. Each section pertains to a different factor.

Transferability of knowledge and skills

Having observed the title of the problem-based learning exercise, I was initially concerned that I would have little to contribute to the group’s discussions. I had just commenced my specialist placement in neuropsychology and as such felt somewhat ill-prepared to consider the issues involved in working with older people. Moreover, I was aware that three of the five case discussion group members had began their older people placements and I thus anticipated that they would have the monopoly on knowledge in the area. However, after reading beyond the exercise’s title, I was both surprised and relieved to discover that much of the knowledge and skills that I had thus far acquired were relevant to the exercise. More specifically, I observed that many of the themes central to the case were not necessarily unique to the experiences of older people but, rather, could be encountered throughout an individual’s lifespan (Alexander, 1999;
It was through this discovery that I was reminded of the transferability of knowledge and skills across client groups and across care settings. This also led me to consider, and more fully appreciate, the British Psychological Society’s recent move from a core placements model of clinical training to a core competencies format (British Psychological Society, 2002). Rather that a focus upon acquiring a range of experiences with particular client groups, the core competencies model is concerned with the development of transferable knowledge and skills.

**Just common sense?**

In recognising the wealth and relevance of the psychological knowledge that I had thus far accumulated, I was led to consider the process of socialisation (Beck, 1995; Cheshire, 2000). In particular, I became aware of how socialised I had become to thinking in psychological terms. Viewing the world through a psychological lens had become somewhat automatic and, indeed, felt like common sense.

Recognition of this position served to remind me of the necessity of tailoring conversations to suit one’s audience. Although I was cognisant with psychological thought and discourse, I recognised that many others would not be as familiar. When working with clients, and indeed other professionals, it is imperative that psychological ideas are carefully explained and that the use of jargon is minimised. To ensure that these goals are achieved, the audience’s understanding should be checked regularly and any confusion addressed. An audit of the quality of psychological services offered on my current placement was recently conducted and the ability of the psychologist to explain complex ideas in a comprehensible way was one of the issues that received the most gravitas among the client group sampled (Elphick, 2006).

**Group organisation**

In considering the case discussion group’s initial response to the exercise, I was
immediately struck by the way in which the group organised itself. During previous problem based learning exercises, the group had felt it necessary to formally elect a chairperson and a timekeeper. The formalisation of these roles aided the group’s functioning by providing a structure and order to the ensuing discussions. During this exercise, however, no such persons were elected. In fact, the group did not even engage in a conversation about the assignment of roles to individual group members. In reflection, I suspect that this process did not occur for three reasons.

Firstly, as a group, we were intrigued by the exercise presented. Moreover, based on both personal and professional experiences, each group member felt that they had valuable information to contribute. I thus suspect that our desire to contribute to the process, and our enthusiasm to get started, overrode the somewhat mundane task of formally assigning roles.

Secondly, by this stage in the group’s development, we had become familiar with our own and each others’ preferred learning styles (Kolb, 1984). In appreciating this, the group had developed an order and organisation that both reflected and accommodated our unique approaches to learning. I suspect that the process of formally assigning roles would have impinged on this organisation and would have been perceived by the group members as being too artificial and prescribed.

Thirdly, and perhaps most significantly, the group was joined by a new facilitator. Her approach to facilitation was much more ‘hands-on’ than the group had previously experienced. This change in facilitator style was experienced by the group as both enabling and containing. Essentially, the new facilitator adopted the role of both chairperson and timekeeper. As such, the assignment of these roles to individual group members was deemed to be unnecessary.

Within the context of the National Health Service (NHS), the membership of professional groups is constantly in flux. My status as a trainee clinical psychologist has provided me
with the opportunity to be a member of various professional groups, if only for a limited period of time. My experiences of professional group membership suggest that the ability of a group to manage and accommodate the arrival of a new group member is largely dependent on the characteristics of the new group member and whether or not their position is congruent with the position held by the majority of the group.

Multiple possibilities
The first case discussion group meeting was used to generate ideas around the case. A diversity of themes were generated and the ensuing discussions suggested a multitude of assessment and formulation possibilities. The multiple possibilities offered reflected the unique personal and professional experiences of each of the group members. Previously, I suspect that the generation of such a wealth of information would have overwhelmed the group and, consequently, would have impeded our progress. On this occasion, however, the different perspectives were embraced, and, in contrast to closing discussions down, the different perspectives enabled the creation of alternative and creative intervention possibilities.

I suspect that the group’s ability to manage this multiplicity of perspective was testament to our clinical experiences of both working within multidisciplinary settings and practicing systemic therapies. An appreciation of multiple perspectives is intrinsic to working effectively as part of a multidisciplinary team. Similarly, multiple perspectives are actively sought out when engaging in systemic therapies (Burnham, 2004; Monk, Winsdale et al., 1997). Of course, I appreciate that multiple perspectives are available to all clinical psychologists, irrespective of their work setting or their clinical orientation. For example, multiple perspectives are offered in supervision and, indeed, offered by the clients themselves.

Competing demands
Once the central themes were identified, and the multiple perspectives considered, each group member selected an area that they wished to explore further. During previous
problem-based learning exercises, each group member had chosen an area that they were unfamiliar with. As a consequence, much time was spent engaged in independent research. For this exercise, however, each group member chose an area that they had already encountered in clinical practice. Our familiarity with the areas chosen ensured that less time was required in independent research.

Prior to choosing specific areas of research, we recognised that each group member had multiple clinical and research commitments outside of the problem based learning exercise. It was unanimously agreed, therefore, that these other commitments were to take priority. This was the main reason that we decided upon areas of research that we were already familiar with. Although we felt somewhat dishonest in employing this strategy, we felt that it was necessary given our workloads at that time.

The notion of competing work demands reflects the reality of working as a clinical psychologist within the NHS. Increasingly clinical psychologists are involved in a diverse range of activities including the provision of psychological therapies, consultation, supervision, teaching, research and service development (Marzillier & Hall, 1999). The ability to prioritise activities and manage one’s time is fundamental to the role of a clinical psychologist. Arguably, the possession of these executive skills is as relevant to the role of a clinical psychologist as the possession of psychological knowledge and skills.

Sharing and communicating knowledge
Having invested relatively little time in independent research, we returned to discuss our research findings. Over the course of two meetings, we each took turns to present our findings to the group. Not only did this foster new learning among the group members, but it also provided the group members with an opportunity to develop their presentation skills. Whilst listening to the presentations, I recall being impressed by the breadth and depth of the psychological knowledge and skills that existed among the group members. I was also surprised to discover that we could learn a great deal from each other. This
discovery led me to feel somewhat vindicated in the use of our time management strategy. Moreover, I suspect that the sharing of knowledge in this way not only proved to be an efficient way of approaching the exercise, but also helped to foster cohesion among the group.

The ability to share and communicate knowledge is an essential component of working within an NHS setting. I have welcomed the opportunity to work collaboratively with a variety of health and social care professionals. In reflecting on the collaborative professional relationships that I have established over the course of my clinical training, I have noted that some services are better equipped than others to accommodate the sharing of knowledge. In particular, I have found that child and learning disability services are more likely to adopt collaborative approaches to care. Collaborative working has enabled more efficient and holistic approaches to care and, in the process, has provided me with an opportunity to learn about the roles and responsibilities of other professionals.

**Conclusion**

This brief account provided me with the opportunity to reflect on the process of being involved in the final problem-based learning exercise. The account invited me to consider how individual and group factors may have contributed to the group’s capacity to address the exercise. Moreover, I was able to consider the relevance of these factors to clinical practice. I adopted a reflective stance throughout the account and found the adoption of this position to be both enlightening and challenging. In view of this, I suspect that my continual personal and professional development will be enriched by the employment of a reflective stance.
References


CASE DISCUSSION GROUP PROCESS ACCOUNT SUMMARY

September 2005
Year 2
Summary
The case discussion group was devised with the intention of creating a safe and intimate space within which trainees could present and discuss cases from their clinical placements. It was anticipated that participation in a case discussion group would provide trainees with an opportunity to develop theory practice links and promote reflective practice. In keeping with these objectives, this brief account reflects on the experience of being involved in a case discussion group over the first year of clinical training. The account highlights aspects of the case discussion group process that both facilitated, and impeded, the capacity of the group to develop. The account is divided into ten subheadings, each of which corresponds to a different aspect of the case discussion group process. The impact of each aspect on the case discussion group is considered and the relevance of each aspect to clinical practice is also addressed. The ten aspects comprise: the provision of choice; initial apprehension; a fluid structure; shared characteristics; the benefits of working with diversity; objectives and outcomes; roles and responsibilities; the distinction between process and content; attendance; and consistent and appropriate resources.
CASE DISCUSSION GROUP PROCESS ACCOUNT SUMMARY

July 2006
Year 2
Summary
This brief account identifies three group processes that influenced the development of the case discussion group during the second year of clinical training. These processes were conceptualised as comprising: group composition and formation; the role of the group facilitator; and the use of action. The account describes each of these processes in turn. Each process is subsequently considered in relation to my personal experience of participating in the case discussion group and my clinical experience of facilitating a self-esteem group within an adult mental health setting. Prior to writing this account, I was somewhat sceptical about the theoretical and practical benefits of engaging with the topic. I had written on group processes previously and was dubious as to the benefit that a second consideration could offer me. I was surprised, therefore, to discover that my engagement with the topic was more than merely cursory and that I was able to reflect on my experiences both as a group participant and as a group co-facilitator.
INTRODUCING THE CLINICAL DOSSIER
This section of the portfolio comprises the clinical dossier. The clinical dossier includes summaries of five case reports and brief overviews of the clinical placements completed over the three years of training.
“Cognitive behavioural therapy with a 25 year old woman presenting with social anxiety”

ADULT MENTAL HEALTH CASE REPORT SUMMARY

June 2005
Year 1
Case report title
Cognitive behavioural therapy with a 25 year old woman presenting with social anxiety.

Presenting difficulty
Jane was referred by her GP to help her to overcome her experience of anxiety when in social situations. Jane described being fearful of doing anything on her own in public. She was able to describe a myriad of physical symptoms that accompanied this fear and reported feeling a sense of dread as if something bad was going to happen to her.

Jane reported that she had been experiencing these symptoms for six years but that they had become increasingly disruptive over the last year. Jane felt that the problem was preventing her from doing many of the activities that she had once enjoyed. Jane referred to the presenting difficulty as her ‘social anxiety’. She explained that she had encountered this term two months ago when searching the Internet. It was this discovery that prompted Jane to initiate the current referral.

Relevant personal history
Jane currently lives at home with her mother and father. She maintains a good relationship with both parents and is particularly close to her mother. Jane stated that her mother was very caring and supportive but she suspected that she had been too protective of her when she was growing up. Jane has one older brother who lives locally with his fiancée.

Jane is single, having left her partner of five years a little over a year ago. Jane recognised that her ending this relationship coincided with the onset of her current difficulties. Jane reported that the relationship had ended because she was tired of the physical and verbal aggression that her partner initiated with others while out drinking.

Jane works as a support assistant with special needs children. She enjoys her role and is proud to be involved in a vocation that she sees as worthwhile.
Risk assessment
Jane was not at risk of suicide, self-harm or neglect. Jane reported that she was not experiencing any thoughts of suicide or self-harm, nor did she have a history of suicide attempts or self-harm behaviours. Although Jane stated that she was often overwhelmed by her difficulty, she reported that the supportive relationships that she maintains with her parents protect her from thoughts of suicide or self-harm.

Initial formulation
A cognitive behavioural model of social anxiety was employed to conceptualise Jane’s difficulties. It was hypothesised that the protective relationship that Jane maintained with her mother while growing up served to shelter her from experiencing adverse social situations and suggested to Jane that she would be unable to manage alone. Jane’s sense of insecurity was further reinforced by her experience of physical and verbal aggression and the termination of her first adult relationship.

These experiences led Jane to develop the core beliefs that the world is a dangerous place and that she is powerless to protect herself. When faced with the prospect of entering a social situation alone, these core beliefs become activated and produce negative automatic thoughts and feelings of anxiety. Jane manages this experience by adopting safety behaviours and/or avoiding the situation altogether. These actions serve to maintain the difficulty as they prevent Jane from experiencing events that challenge her core beliefs.

Action plan
Research evidence, coupled with Jane’s enthusiasm for the approach, suggested that the employment of a cognitive behavioural approach was appropriate. Jane and I agreed to meet weekly for six 50-minute sessions. These sessions were broadly conceptualised as comprising three phases: a beginning; middle; and an end.

Intervention
A number of tasks were accomplished in the beginning phase of the intervention. Jane
Risk assessment

Jane was not at risk of suicide, self-harm or neglect. Jane reported that she was not experiencing any thoughts of suicide or self-harm, nor did she have a history of suicide attempts or self-harm behaviours. Although Jane stated that she was often overwhelmed by her difficulty, she reported that the supportive relationships that she maintains with her parents protect her from thoughts of suicide or self-harm.

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Intervention

A number of tasks were accomplished in the beginning phase of the intervention. Jane
was socialised to the cognitive behavioural model and her experience of anxiety was normalised by the provision of psychoeducation. A concrete and measurable goal was devised and Jane was introduced to the thought record and began to learn how to identify her negative automatic thoughts.

The middle phase of the intervention was concerned with encouraging Jane to challenge her negative automatic thoughts and generate more adaptive, alternative thoughts. A number of behavioural experiments were conducted to reinforce these alternative thoughts and a behavioural hierarchy was developed and systematically worked through.

During the end phase the issues of termination and relapse prevention were addressed. Jane’s autonomy and confidence were emphasised as was her ability to generalise the skills that she had learned across contexts. We considered potential difficulties that could arise in the future and generated possible solutions.

**Outcome**

Jane managed to achieve the goal that had been agreed during the beginning phase of treatment. Jane also reported that her family and friends had noticed a positive change in her. In particular, they had observed that she was more confident.

Outcome was formally assessed using the Hospital Anxiety and Depression Scale (HADS) and the Mind Over Mood Anxiety Index (MOMAI). Jane’s scores on the HADS anxiety subscale had reduced from 11 (indicating moderate anxiety) at the beginning of treatment to 0 (indicating no anxiety) at the end of treatment. Her scores on the MOMAI at the beginning middle and end of treatment were 11, 7 and 0 respectively. These scores suggest that as treatment progressed, Jane’s symptom experience reduced.

**Reformulation**

The initial formulation did not require any amendments. I suspect that this was in large part due to the fact that three sessions had been spent on assessment before the more
formalised intervention sessions commenced. I was also aware that Jane had presented to
the service with a coherent understanding of her difficulty, its history and development.

Critical evaluation
Jane’s motivation to change and her engagement in the therapeutic process were
significant factors in the effectiveness of the intervention.

Summary
In working with Jane I was reminded that the role of the clinical psychologist is one of
facilitating change and as such is inherently less demanding that the role the client
chooses in facing that change.
“An integrated approach, using cognitive behavioural and narrative therapy techniques, with a 24 year old woman presenting with symptoms of depression”

ADULT MENTAL HEALTH CASE REPORT SUMMARY

September 2005
Year 1
Case report title
An integrated approach, using cognitive behavioural and narrative therapy techniques, with a 24 year old woman presenting with symptoms of depression.

Presenting difficulty
Natalie was referred by the community psychiatric nurse for help with overcoming her depression and suicide ideation. Natalie referred to her depression as her ‘black cloud’ and acknowledged that it varied in intensity. She estimated that her black cloud had been with her since she was 13 years old and stated that its intensity had got worse over the last five years. The symptoms that she experienced as part of her black cloud included a lack of energy, difficulty sleeping and a short temper. She was particularly concerned with the negative effects that her temper was having on her interpersonal relationships. Consequently, Natalie stated that she would like to acquire anger management skills. She anticipated that this would go some way in helping her to overcome her black cloud.

Natalie reported that she would often respond to novel or unpredictable situations with verbal and/or physical aggression. Natalie acknowledged that these situations were often benign and recognised that an aggressive response was inappropriate, often serving to escalate the situation. Natalie stated that, rather than shouting and kicking, she would prefer to respond in a controlled manner, taking time to communicate her distress calmly and rationally.

A review of Natalie’s medical notes indicated that she had been admitted to A&E twice within the last five years. The first admission followed an overdose of paracetamol and ibuprofen and the accompanying psychiatric report suggested that Natalie had taken an overdose as a means of coping with the experience of being raped. The second A&E admission was initiated by her GP following concerns around her risk of suicide. The psychiatric report compiled at this time stated that Natalie had borderline personality disorder.
Relevant personal history
Natalie reported experiencing a childhood that was characterised by physical punishment and verbal criticism. She reported that she was made to feel that she was unable to do anything as well as her older sister. Natalie was bullied at school from the age of 13 and left school at 16 to attend college, where she studied animal care. She is currently employed as a stable-hand.

Natalie lives with her husband, Simon, and their five-year-old son, Adam. Natalie placed value on being a good mother yet was concerned about her lack of affection towards Adam. She reported that she finds it difficult to get physically close to him and is often unable to tell him that she loves him.

Risk assessment
Natalie acknowledged the initial reason for her referral yet denied any current suicide ideation. Although I was satisfied that Natalie was at low risk of suicide at the time of the assessment, I considered it imperative that risk be regularly assessed throughout our work together.

Natalie reported that she cuts her arms when her black cloud becomes too overwhelming. She conceptualised her cutting as a coping strategy and not as a means of causing harm. She estimated that she cuts, on average, twice a week. We agreed to regularly monitor the extent of her cutting.

Given Natalie’s difficulty in managing her temper, it was important that any risk arising from her temper be assessed. Particular attention was paid to the potential risk that Natalie posed to Adam. Natalie reported that she was determined that Adam be neither a recipient of, nor a witness to, her temper.

Initial formulation
The initial formulation was based on a cognitive behavioural model of anger. Although
the research evidence indicated that no one approach to anger management is any more effective than another, this model was consistent with the descriptions that Natalie had provided. Moreover, it was able to address the important considerations of regulating the physiological, cognitive and behavioural responses to anger-provoking cues and avoiding anger-provoking cues.

The model distinguishes between the expression of anger and the anger state. Natalie’s expression of anger was hypothesised as being largely overt and maladaptive. Her anger state was conceptualised as comprising physiological, emotional and cognitive components. Physiologically, Natalie experienced an increased heart rate and muscle tension as part of her anger state. She described the emotional component of her anger state as typically being of a mild to moderate intensity. It was hypothesised that the cognitive component was largely centred on the expectation that others would judge her negatively.

I hypothesised that Natalie would benefit from an inherently gentle, optimistic and respective approach to therapy. Moreover, I suspected that she would appreciate being given the opportunity to be the expert on her experience. To this end, I hypothesised that techniques borrowed from narrative therapy would augment the cognitive behavioural model.

**Action plan**

Natalie and I agreed to meet weekly for six 50-minute sessions. These sessions were broadly conceptualised as comprising three phases: a beginning; middle; and an end. I anticipated that special attention should be paid to developing a strong therapeutic relationship.

**Intervention**

In the beginning phase of the intervention, Natalie was socialised to the cognitive behavioural model of anger and was encouraged to relate the model to her own
experiences. A variety of relaxation methods were introduced to address the physiological component of her anger state.

The middle phase was concerned with encouraging Natalie to identify and challenge the cognitions that characterised her anger state. This was achieved by way of a thought diary. Natalie generated alternative thoughts that were incongruent with her overt and maladaptive expression of anger. Natalie was also encouraged to consider examples of when she had either responded adaptively to anger-provoking situations or had avoided the situation altogether. Specific focus was given to the development of an alternative story and the creation of an audience to witness this new story.

The end phase of the intervention was concerned with the consolidation of the skills that Natalie had acquired. The possibility of future work was also considered. Significantly, Natalie disclosed her experience of rape and asked that she be able to explore how the rape currently affects her. This topic was addressed in subsequent sessions but was not documented in the case report.

**Outcome**

In line with Natalie’s initial treatment goal, she reported that she was able to respond to anger-provoking situations in a controlled manner. She reported that her interpersonal relationships had improved as a result of acquiring anger management skills. She also noted that she was more willing to cuddle Adam and tell him that she loved him.

Outcome was more formally assessed using the Beck Depression Inventory (BDI). Natalie commenced treatment with a BDI-II score of 40. At the end of treatment her score had reduced to 25, suggesting that her experience of depression was in the ‘moderate’ range. Consistent with this result, Natalie reported that she felt less inclined to cut.
Reformulation

Although a cognitive behavioural model guided the development and application of a successful anger management intervention, it did not fully account for the complexity in Natalie’s presentation. It is useful to conceptualise Natalie’s presenting difficulty using a dialectical behavioural therapy framework. A formulation derived from this framework would have been able to accommodate the historical, emotional, behavioural and relational elements that characterised Natalie’s difficulties.

Critical evaluation

I suspect that the strength of the therapeutic relationship was fundamental to the success of the intervention. The strength of the relationship was facilitated by positioning Natalie as the expert on her experience. This engendered confidence and enabled Natalie to assume an active role throughout the therapeutic process.

Summary

I welcomed the flexibility and creativity that was afforded by integrating two distinct therapeutic modalities.
“Behavioural therapy intervention with a seven year old girl experiencing a fear of needles”

CHILD AND FAMILY CASE REPORT SUMMARY

April 2006
Year 2
Case report title
Behavioural therapy intervention with a seven year old girl experiencing a fear of needles.

Presenting difficulty
Harriet was referred to the service by her general practitioner for help in overcoming her fear of needles. This fear causes Harriet to experience anxiety when attending a hospital or dental appointment. At a recent dental appointment, for example, Harriet was reluctant to open her mouth for examination. She became visibly distressed and curled up into a ball in the corner. Harriet will cry herself to sleep if she is aware of a pending clinical appointment, even if the appointment is a week or so away.

When Harriet was four years old she contracted bacterial meningitis and was hospitalised for a period of ten days. She underwent a lumbar puncture and was fitted with a cannula through which she received antibiotics. The cannula refitting was described as particularly distressing and it often took up to an hour for the procedure to be successful. Harriet had to be held down by the nurses during this procedure. Harriet has since been frightened of attending doctor or hospital appointments.

Over the last eight months, Harriet had to undergo extensive dental treatment. This treatment was performed over three appointments and on each occasion Harriet had to be sedated via a cannula in her hand. Following on from this experience, Harriet’s fear of doctor and hospital appointments extended to include a fear of dental appointments as well.

Relevant personal history
Harriet’s development was reported to be normal. She had no difficulties with eating or sleeping and she walked and talked at 11 and 13 months respectively. There were no reported problems with early bonding nor were there any current scholastic or social difficulties.
Harriet has one sister, who is her fraternal twin. Harriet and her sister have a close relationship yet do have a tendency to compete with one another at school. Harriet’s parents are married and in their early forties. The family are in regular contact with both sets of grandparents.

Risk assessment
A formal risk management tool was used to assess for risk. Information was obtained from Harriet’s mother and from my initial observations. The assessment suggested that Harriet was not at risk of harm or neglect.

Initial formulation
Harriet’s fear was initially formulated using principles derived from behavioural therapy. There exists an extensive body of research to support the use of behavioural theory and intervention in children experiencing a specific phobia.

It was hypothesised that Harriet’s fear initially developed following her earlier experiences of unpleasant and distressing procedures, both in hospital and at the dentist. Harriet’s overt manifestations of her experience of anxiety elicit attention and care from her mother. The receipt of this attention and care thereby increases the likelihood that these behaviours will occur in the future and reinforces the notion that clinical appointments are unpleasant and distressing. Harriet’s refusal to attend clinical appointments further helps to maintain her fear in that it prevents her from experiencing the feared situation and from gaining an alternative perspective.

Action plan
The agreed treatment goal was for Harriet to attend a dental appointment without experiencing debilitating anxiety. Having used behavioural theory to formulate Harriet’s fear, the techniques of systemic desensitisation and flooding were presented as two means by which this goal could be achieved. Harriet and her mother unanimously decided that systematic desensitisation would be the most appropriate technique.
**Intervention**

The intervention focussed on addressing three general areas. The first area comprised the provision of psychoeducational material about the nature of anxiety. This functioned to normalise the experience of anxiety and also helped to acclimatise Harriet to the therapeutic process. Harriet’s mother’s fears and those of other family members were also considered and their coping strategies explored.

The second area addressed comprised a consideration of distraction and relaxation techniques that could be employed to ameliorate Harriet’s experience of anxiety. Harriet was able to generate three techniques that she thought would be particularly useful. The techniques adopted comprised visualisation, self-instruction and the presence of her mother.

The third and final area was concerned with exposing Harriet to the feared situation. To this end, a nine-step behavioural hierarchy was co-created with Harriet. This hierarchy began with Harriet looking at pictures of a needle and culminated in having blood taken from her arm in hospital. The hierarchy was committed to paper and Harriet draw pictures to illustrate each step.

**Outcome**

Harriet successfully completed each step in her behavioural hierarchy and the fear ratings that Harriet had ascribed to each step reduced following exposure. Harriet and her mother were subsequently able to attend a dentist appointment without Harriet experiencing debilitating anxiety.

**Reformulation**

In reflecting on the therapeutic work that was undertaken I recognised that, despite having formulated the difficulty using principles derived from behavioural therapy, I had subsequently employed a number of therapeutic strategies to supplement the systematic desensitisation programme. For example, I had used a cognitive conceptualisation of fear
to help normalise Harriet’s experience and to socialise her to the therapeutic environment. I had also used techniques derived from narrative therapy to help Harriet construct an alternative story of coping and courage.

**Critical evaluation**
Throughout the therapeutic work I was reminded to adapt my ‘adult’ expectations so that they were more in accordance with Harriet’s developmental stage. I recognised that Harriet’s attention would start to wane after one hour so made sure that sessions did not exceed 50 minutes. I was careful to use concrete language and to construct sentences that Harriet would be able to understand.

**Summary**
The involvement of hospital nurses was crucial to the success of this intervention. Without their co-operation the final three steps of the behavioural hierarchy would not have been realised.
“A neuropsychological assessment with a 52 year old woman with Down’s syndrome”

LEARNING DISABILITY CASE REPORT SUMMARY

September 2006
Year 2
Case report title
A neuropsychological assessment with a 52 year old woman with Down’s syndrome.

Presenting difficulty
Lucy was referred to the psychology service by the consultant psychiatrist for a baseline assessment of cognitive and social functioning, in order to assess for possible dementia. The request was made following concerns raised by Lucy’s mother, Deborah. Deborah was invited to attend the initial appointment. Deborah reported a myriad of recent behaviour and personality changes. In the last six months, Lucy was less likely to engage in many of the activities that she once enjoyed. Deborah described Lucy as being ‘frightened’ and more likely to ‘cling’ to family members. Lucy was also described as being more ‘stubborn’, often refusing to go to bed when asked and not responding to instructions to put items away. In the last six months, it was reported that Lucy sometimes gets ‘confused’ around the house and goes to the wrong room to retrieve an item.

A review of Lucy’s medical notes indicated that Lucy’s thyroid functioning was within the normal range and that the consultant psychiatrist had ruled out a diagnosis of depression.

Relevant personal history
Lucy was diagnosed with Down’s syndrome when she was three months old. She was walking at 18 months and experienced no difficulties with eating or drinking. Her speech was slow to develop, yet it was reported to be more advanced that the medical professionals involved in her care had anticipated. Although Lucy’s level of functioning had never been formally assessed, Deborah reported that her general practitioner (GP) had described Lucy as a ‘high grade’. Lucy is right handed.

Lucy is the second born of five siblings and lives with her mother in the family home. Lucy’s father died one year ago. Lucy was not invited to attend the funeral, and despite
the family’s recent attempts to explain her father’s absence, Lucy continues to ask after him.

Lucy has been attending the local day service for five days a week since she was 15 years old. For the past eight years she has also been attending a respite care service.

**Risk assessment**

Information on risk was elicited as per the risk assessment protocol developed by the Trust. The information provided indicated that, although Lucy was vulnerable to harm by others and self-neglect, the risk was managed in that Lucy was always supervised and her personal hygiene was attended to by those that care for her.

**Literature review**

Dementia is a general term describing a condition in which there is a global deterioration in functioning. Dementia of the Alzheimer’s type (DAT) is the most common form of dementia, accounting for between 50-80 per cent of dementias. Dementia is characterised by four main features: an acquired and unusual loss of cognitive function; involvement of multiple areas of cognitive impairment; impairment in memory; and clear consciousness.

Down’s syndrome is the most common specific cause of learning disability, accounting for approximately 15-20 per cent of the learning disabled population. Down’s syndrome is caused by an extra copy of chromosome 21, non-disjunction of chromosome 21 during meiosis or translocation of another chromosome. As such, Down’s syndrome is not an acquired condition but rather one that his present from birth.

The prevalence rates for dementia increase with age and as more people with learning disabilities survive into old age, dementia is becoming an increasingly important issue for health and social care services. Prevalence rates for dementia are at least twice as high in people with learning disabilities compared to the general population. Biological studies of DAT indicate the involvement of keys sites on chromosome 21. It is not surprising,
therefore, that people with Down's syndrome are at particular risk of developing dementia.

**Hypothesis**

Lucy’s age and diagnosis of Down’s syndrome place her at risk of developing DAT. In order for a diagnosis of dementia to be made, Lucy’s cognitive functioning and her daily living skills need to be monitored over time. Given that there is no evidence of previous assessment in these areas, the current assessment will comprise the baseline component of the diagnostic process. To ensure a compressive assessment, I anticipate that the assessment will involve the direct testing of Lucy and interviews with multiple informants who know Lucy well.

**Rationale**

The Trust within which I was working had a specific protocol for the assessment of dementia in people with learning disabilities. The protocol comprised a number of assessments including a dementia screening instrument, a life events checklist, an assessment of overall support required, an assessment of behaviours that may be causing difficulty and a cognitive ability battery.

**Findings**

Based on the current assessment, it would appear that Lucy has experienced a recent decline in her cognitive and social functioning, beyond that which could be accounted for by recent life changes. Considering her age and diagnosis of Down’s syndrome, and excluding other physical causes, it is possible that Lucy has dementia. A reassessment of her cognitive and social functioning is thus required to determine whether the observed changes are progressive or not.

**Recommendations**

Although Deborah understood that it was not currently possible to attribute the changes in Lucy’s functioning to dementia, it was recommended that she be provided with
information on dementia and guidelines on how she could monitor future changes. To this end, I met with Deborah on four occasions.

Further recommendations made stipulated that involvement of a number of health professionals including Lucy’s GP (hearing and eyesight testing), care manager (completion of a carer’s assessment), day centre and respite care staff (monitoring and management of behaviours). I spoke directly with each of the professional groups implicated to ensure that they were clear of their respective actions and to encourage their participation.

**Critical evaluation**

Although the battery approach is helpful in information exchange between clinicians and researchers, it does not allow for the tests to be individually chosen according to the individual’s presentation.

**Summary**

Neuropsychological assessment is more than mere testing. An individual’s presentation during testing and the information garnered from informants are important considerations.
“A neuropsychological assessment with a 43 year old woman with multiple sclerosis”

NEUROPSYCHOLOGY CASE REPORT SUMMARY

April 2007
Year 3
Case report title
A neuropsychological assessment with a 43 year old woman with multiple sclerosis.

Presenting difficulty
Julie was referred to the psychology service by the neurology specialist nurse for a neuropsychological assessment following concerns that her short-term memory was deteriorating. Julie attended the initial appointment with Kelly, her long-term partner of 14 years. Julie described herself as having become ‘more forgetful’ in the past few months. She reported that she frequently forgets that she has been told a piece of information and has to be reminded a number of times. Likewise, she reported that she sometimes forgets that she has performed a task (for example, making a cup of tea) and will consequently repeat the activity. Kelly was able to corroborate Julie’s description of her difficulties and also added that Julie occasionally forgets what she is saying mid-conversation and has to be prompted to continue.

Relevant personal history
With regard to her educational and vocational history, Julie left school when she was 16 years old having completed her GCSE year. Although she did not require any remedial or special education while at school, she was subsequently diagnosed with dyslexia when in her early thirties. Since leaving school, Julie has pursued a career in administration and finance and qualified as an accountant in 2001. She is currently employed as a Finance Manager. Julie is right-handed and wears reading glasses.

Julie was diagnosed with relapsing-remitting multiple sclerosis (MS) in 1990. She is under the care of the neurologist at the local hospital and is in regular contact with the MS specialist nurse. She is prescribed beta interferon and neurontin to help manage her MS.

Julie’s mother had died in July 2006. Although her mother’s death had not been unexpected, Julie had found it difficult to adjust to her absence. Julie also reported that she experiences difficulties with pain management. In particular, she was concerned with
how she could better manage the numbing, dull pain she experiences in her upper and lower limbs. She expressed a desire to learn psychological strategies to complement her pain medication.

**Risk assessment**

In view of the difficulties described during the assessment, a risk assessment was completed as per the protocol developed by the service. The results of this assessment indicated that Julie was not at risk of suicide, self-harm or neglect. Julie reported that she was not experiencing any thoughts of suicide or self-harm, nor did she have a history of suicide attempts or self-harm behaviours. Although she stated that she was often overwhelmed by her circumstances, she reported that the supportive relationships that she maintains with Kelly protects her from thoughts of suicide or self-harm.

**Literature review**

MS is a degenerative condition of the central nervous system. It is the most common neurological disease among young adults and affects approximately 85,000 people in the UK. MS is most often diagnosed in people between the ages of 20 and 40 and prevalence among women is about twice that found in men.

In MS, the immune system attacks the protective myelin sheath surrounding the axons of the central nervous system (CNS). The resultant lesions interrupt the electrical impulses that are transmitted to and from the brain. MS lesions can occur in many different parts of the CNS and can thus result in a wide array of symptoms. Common symptoms include, but are not limited to, loss of function or feeling in limbs, loss of balance, loss of bowel or bladder control, sexual difficulties, debilitating fatigue, pain and disturbances of vision.

It is only relatively recently that cognitive difficulties have been acknowledged as a symptom of MS. Estimates of the prevalence of cognitive difficulties among individuals with MS range from 40 per cent to 70 per cent. The most frequently reported cognitive
difficulties are those of short-term memory, followed by difficulties with sustaining attention and conceptual thinking and problem solving, as well as a functional language disorder.

Controlled retrospective studies do suggest a link between psychological stress and MS symptom onset. The relationship between stress and symptom exacerbation, however, is somewhat more inconclusive. For example, while most patients believe that stress can trigger MS exacerbations (Rabins et al., 1986), a number of studies neither support a link between stress and symptom exacerbation nor prospectively predict either clinical exacerbations or new inflammatory lesions based the number of recent life stressors (Mohr et al., 2000). In a review of this research, Lezak et al. (2004) propose that it may be that the intensity of a specific stressor and the disruption associated with it are the crucial mediating factors in MS.

Hypothesis
It was hypothesised that the short-term memory difficulties that Julie reported to be experiencing are a result of her MS and that her difficulties may have been exacerbated following her mother’s death. In offering this hypothesis, I was aware that individuals often interpret their cognitive difficulties as ‘memory problems’ when functions other than memory are compromised. I did not, therefore, want to assume that a problem with Julie’s short-term memory was responsible for the reported difficulties. Nor did I want to assume that Julie’s difficulties were limited to her short-term memory. To accommodate these concerns, I felt it necessary to administer a comprehensive neuropsychological assessment that addressed multiple cognitive domains.

Rationale
The neuropsychology service within which I was working had a specific battery of tests that were to be completed for all standard neuropsychological assessments. The battery consisted of a number of standardised tests that addressed a variety of cognitive domains. The domains covered were consistent with the cognitive functions commonly impaired in
MS. As such, use of the test battery was deemed appropriate in this instance. I also considered the battery approach useful in that it would promote consistency and ease of information exchange between clinicians. The tests comprising the battery included the: Wechsler Test of Adult Reading (WTAR), Wechsler Adult Intelligence Test, third edition (WAIS-III), Wechsler Memory Scale, third edition (WMS-III), Adult Memory and Information Processing Battery (AMIPB), Hayling and Brixton Tests, Delis Kaplan Executive Function System (DKEFS) and Graded Naming Test (GNT).

Findings
Based on the current assessment, it would appear that Julie’s cognitive profile is consistent with the cognitive profile often observed among individuals with MS.

Julie performed better on tasks that required non-verbal skills. Specifically, she demonstrates a high level of competence with non-verbal reasoning and problem solving skills. This result is consistent with a diagnosis of dyslexia and complements Julie’s employment as a Finance Manager.

A positive bias was observed for visual memory and new learning of visual information. Although Julie’s verbal memory was observed to be poor, the information that she does encode is retained after a delay. This suggests that Julie may experience some difficulties with attending to and concentrating on information that is presented verbally.

There is some evidence of impairment of executive abilities suggesting that Julie may experience some difficulties in planning, organising and self-monitoring. This suggests that Julie would benefit from pacing herself appropriately on tasks that require attention and concentration and implementing general principles of fatigue management.

Recommendations
The results of the neuropsychological assessment were used to devise compensatory strategies that were specific to Julie’s difficulties. These strategies were fed back to Julie
and Kelly and time was spent considering how they could be implemented both in the home and the office.

Following on from the neuropsychological assessment, I met with Julie and Kelly for three sessions on pain management. I was mindful of conducting these sessions in light of the results of the assessment so as to ensure that Julie obtained maximum benefit.

Critical evaluation
Although I initially felt somewhat constrained by the battery approach to neuropsychological assessment, I felt that in Julie’s case, the tests comprising the battery were relevant and provided a succinct summary of her abilities across a multitude of cognitive domains.

Summary
Much of neuropsychology is concerned with the identification of ‘deficit’ and ‘dysfunction’. As a trainee clinical psychologist interested in narrative therapy and social constructionism, I am resistant to this dominant discourse. Although I acknowledged the difficulties that Julie is experiencing, I intentionally focussed on the strengths and resources that Julie can draw on to help her to compensate for her observed difficulties.
Adult Mental Health

CLINICAL PLACEMENT SUMMARY

November 2004 – September 2005
Year 1
Clinical supervisor
Lin Creasey (Consultant Clinical Psychologist)

Location
Community Mental Health Centre, Sussex and Borders Partnership NHS Trust

Summary of placement experience
This placement provided me with experience of working within cognitive behavioural and narrative therapy frameworks. I was exposed to a variety of adult mental health difficulties within the context of a community mental health centre and an in-patient ward. Clinical work comprised of assessment interviews, psychometric assessments, short- to medium-term psychological interventions and consultation to the professional system. I also co-facilitated a cognitive behavioural therapy group for individuals experiencing low self-esteem.

Clinical skills and experience
Experience was gained with a range of presenting difficulties including depression, generalised anxiety disorder, social phobia, panic disorder, emetophobia, obsessive compulsive disorder, personality disorder and issues relating to sexual abuse. Two psychometric assessments were completed and a variety of standardised questionnaires were used to evaluate outcome.

Training, seminars and research
I participated in monthly cognitive behavioural therapy update seminars and a narrative therapy supervision group. I attended a training day on personality disorder and was involved in a research project aimed at changing staff attitudes towards personality disorder. I attended a presentation on the Mental Health Bill 2004 and the Mental Capacity Act 2005 and fed the information back to the psychology department. I gave a presentation on the amended procedure for incident reporting and co-facilitated a departmental discussion on cognitive behavioural approaches to anxiety disorders.
Child and Family

CLINICAL PLACEMENT SUMMARY

October 2005 – March 2006
Year 2
Clinical supervisor
Nick Kirby-Turner (Consultant Clinical Psychologist)

Location
Child and Adolescent Mental Health Service, Sussex and Borders Partnership NHS Trust

Summary of placement experience
This placement provided me with experience of working with children, their families and the surrounding professional systems. A range of therapeutic frameworks were adopted including developmental models, systemic therapy, narrative therapy, cognitive behavioural therapy and behavioural therapy. Clinical work comprised of assessment interviews, short-term psychological interventions and consultation to the professional system. I was also involved in a child development clinic and a family therapy clinic.

Clinical skills and experience
Experience was gained with a range of presenting difficulties including feeding difficulties, depression, generalised anxiety disorder, needle phobia, attachment difficulties and adjustment to chronic physical illness. Assessment and outcome information was obtained from a variety of informants using a variety of standardised measures. Psychometric assessments were conducted to assist in the diagnosis of developmental disorders.

Training, seminars and research
I attended a two-day conference on narrative therapy hosted by Michael White. I gave three case presentations to the community team and presented a fourth case to illustrate the clinical application of the Wechsler Intelligence Scale for Children - fourth edition (WISC-IV). I assisted with the development of a research protocol for the systematic collection of clinical and psychosocial data for adolescents residing at an in-patient unit and contributed to the development of a standardised protocol for assessing autistic spectrum disorder among children aged four and above.
Learning Disability

CLINICAL PLACEMENT SUMMARY

April 2006 – September 2006
Year 2
Clinical supervisor
Dr Heather Liddiard (Consultant Clinical Psychologist)

Location
Joint Community Learning Disability Team, Croydon NHS Primary Care Trust

Summary of placement experience
The placement provided me with experience of working with adults with mild, moderate and severe learning disabilities using cognitive behavioural, behavioural and systemic frameworks. The placement demanded that I worked closely with families, carers, residential homes and voluntary organisations. Clinical work comprised of assessment interviews, psychometric assessment, short-term psychological interventions and training and consultation to the professional system. I also co-facilitated a social skills group for in-patients with learning disabilities and mental health difficulties.

Clinical skills and experience
Experience was gained in working with individuals experiencing a range of difficulties including challenging behaviour, autism, psychosis, obsessive compulsive disorder, anger and executive difficulties. Psychometric assessments were conducted to assist in the diagnosis of Alzheimer’s disease and Asperger’s syndrome and a formal assessment of sexuality was completed.

Training, seminars and research
Based on the results garnered from formal observations, I organised and delivered a workshop to residential care staff on facilitating communication with people with learning disabilities. I also gave a presentation on dementia in Down’s syndrome to residential care staff. I used TalkingMats™ to evaluate the effectiveness of the social skills group and fed the results back to the unit manager. I completed two evaluations of the effectiveness of behavioural guidelines for particular individuals and presented the results to the residential homes concerned.
Specialist Placement - Neuropsychology

CLINICAL PLACEMENT SUMMARY

October 2006 – March 2007
Year 3
Clinical supervisor
Dr Claire Elphick (Clinical Psychologist)

Location
Community Neuropsychology Service, Sussex and Borders Partnership NHS Trust

Summary of Placement Experience
This placement provided me with experience of working with individuals who had experienced neurological damage either as a result of an acquired brain injury or a neurodegenerative condition. Cognitive behavioural and systemic therapy frameworks were adopted to help individuals and their families better understand and cope with their difficulties. Psychodynamic approaches to formulation were also introduced. Clinical work comprised of neuropsychological assessments, psychoeducation, short-term psychological interventions and consultation to the professional system.

Clinical Skills and Experience
Experience was gained with a variety of acquired (head injury, stroke, viral infection) and neurodegenerative conditions (multiple sclerosis, Parkinson’s disease). Clients presented with a wide range of psychological and cognitive difficulties including anxiety, anger, memory difficulties, lack of drive and executive difficulties. A wide range of neuropsychological assessments were completed using both psychometric assessments and standardised measures.

Training, Seminars and Research
I gave a presentation to the community stroke team on the significance of reliability and validity when deciding upon an appropriate outcome measure. I subsequently presented the team with a variety of measures and facilitated a discussion as to which measure would be most appropriate for use in their service. I collated the results of an in-house audit and amended my clinical practice in accordance with the feedback received from service users.
Older People

CLINICAL PLACEMENT SUMMARY

April 2007 – September 2007
Year 3
**Clinical supervisor**
Dr Ron Bracey (Consultant Clinical Psychologist)

**Location**
Community Older People Service, Surrey and Borders Partnership NHS Trust

**Summary of placement experience**
This placement provided me with experience of working with individuals aged 65 years and over. Cognitive behavioural and schema focused therapy frameworks were employed within the context of a community mental health centre and an in-patient ward. Clinical work comprised of neuropsychological assessments, psychoeducation, short-term psychological interventions and consultation to the professional system.

**Clinical skills and experience**
Clients presented with a wide range of psychological difficulties including anxiety, depression and personality difficulties. Assessment and outcome information was obtained using a variety of standardised measures. Psychometric assessments were conducted to assist with the allocation of support and to identify specific memory difficulties.

**Training, seminars and research**
I attended a two-day conference on building strength and resilience in cognitive behavioural therapy hosted by Christine Padesky. Based on the results garnered from formal observations, I organised and delivered a workshop to residential care staff on facilitating communication and managing challenging behaviour among older people experiencing memory difficulties. I assisted with the development of a dementia pack designed to provide information and advice to carers of individuals with dementia and compiled a literature review pertaining to the neuropsychological assessment of dementia.
INTRODUCING THE RESEARCH DOSSIER
This section comprises the research dossier. This dossier includes the service related research project, qualitative research project abstract, major research project and the research log checklist.
“Evaluation of the impact of a local programme to improve the interface between primary and secondary care services”

SERVICE RELATED RESEARCH PROJECT

July 2005
Year 1
Abstract

Objective: Consistent with recommendations made in the National Service Framework for Mental Health (Department of Health, 1999), a programme was developed to improve the interface between primary and secondary care services. The aim of this study was to evaluate the impact of the programme on the referral pattern of one of the general practitioner (GP) surgeries involved.

Design: The study involved a retrospective review of all consecutive referral letters between the periods September 2002 – September 2003 (pre programme implementation) and November 2003 – November 2004 (post programme implementation).

Main outcome measures: The impact of the programme was assessed in terms of the number of referrals formally received by the Community Mental Health Centre (CMHC), the proportion of referrals accepted by the CMHC for an initial assessment and the range of the main presenting problems, as ascertained by the GP.

Results: In the year following programme implementation, fewer patients were referred to the CMHC, a great proportion of those referred where accepted for an initial assessment and the main presenting problem was demonstrated as being more varied than in the year preceding programme implementation.

Conclusion: Despite the significant associations observed between the changes in the referral pattern and the implementation of the programme, it is not possible, given the data collected, to conclude that the programme was responsible for affecting the change. The influence of extraneous factors can not be ruled out.
Introduction

It is estimated that up to one quarter of routine consultations in primary care involve patients experiencing mental health difficulties (Department of Health, 1999). It is somewhat concerning, therefore, that the detection and management of psychiatric morbidity in primary care is frequently cited as being deficient (Borowsky et al., 2000; Goldberg et al., 1995). Not surprisingly, a number of initiatives have been advanced in an attempt to improve the detection and management of mental health difficulties among primary care services. Croudace et al., (2003), however, argue that the evidence for the effectiveness of such initiatives has been inconsistent. Moreover, the outcomes observed are often peculiar to the services and samples studied, thereby limiting the ability to generalise the findings across health care settings and clinical populations.

Recognising the need for improvement in this area, yet appreciating the specificity of others’ initiatives, the Dandelion Community Mental Health Centre (CMHC) developed its own bespoke programme. Consistent with recommendations made in the National Service Framework for Mental Health (Department of Health, 1999), the programme focuses on improving the interface between primary and secondary care services. More specifically, the programme aims to improve communication between the local general practitioner (GP) surgeries and the Dandelion CMHC. It is anticipated that improved communication between these agencies will lead to improvements in the detection and management of psychiatric morbidity in primary care.

The programme stipulates that two medically-trained members of the Dandelion CMHC staff attend fortnightly referral meetings at each of the five GP surgeries operating within the Dandelion CMHC catchment area. During these meetings, the GPs are invited to present potential cases for referral to the CMHC. The appropriateness of each case for CMHC referral is determined through collaborative liaison between the attending GPs and the two CMHC staff members. CMHC appropriateness is determined by considering

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1 The name of the Community Mental Health Centre has been changed to preserve the anonymity of the author.
a number of factors, including the nature and severity of the presenting problem, the perceived risk to self or others and whether or not previous psychiatric or psychological treatment has been sought. If a case is considered appropriate, the GP is invited to formally refer the case to the CMHC for an initial assessment. If a case is considered inappropriate, the GP is provided with an explanation as to why the case is inappropriate for CMHC referral and alternative options are suggested, including referral on to counselling, forensic or substance misuse services. Cases which are formally referred to the CMHC and subsequently deemed inappropriate by the CMHC for an initial assessment are referred back to the GP. The GP is provided with an explanation as to why the case is inappropriate and alternative options are suggested.

Prior to the implementation of this programme, the GP surgeries operating within the catchment area were referring patients to the CMHC without prior liaison with members of the CMHC. Moreover, members of the CMHC staff felt that the GPs had only a limited understanding of the CMHC criteria for accepting cases for an initial assessment.

Necessarily, implementation of the programme across GP surgeries was staggered. The programme was first adopted by Bridges' GP surgery in October 2003. Anecdotal reports from members of the CMHC staff suggest that the programme has been successful both in terms of improving the working relationship with Bridges GP surgery and in reducing the number of inappropriate referrals to the CMHC. This paper will present the results of a more formal evaluation of the impact of the programme on the referral pattern of Bridges GP surgery. Impact will be measured in terms of the number of CMHC referrals formally received from Bridges GP surgery, the proportion of referrals accepted by the CMHC for an initial assessment and the range of the main presenting problems, as ascertained by the GP.

Following discussions with members of the CMHC staff, and acknowledging the initial aims of the programme, three hypotheses were proposed. The first hypothesis states that

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2 The name of the GP surgery has been changed to preserve the anonymity of the author.
there will be no difference in the number of patients referred to the CMHC across the two years studied. Members of the CMHC staff expect that the programme will introduce GPs to more varied and appropriate referral pathways, including referral on to other health and social care agencies. The alternative hypothesis, therefore, states that Bridges GP surgery will refer fewer patients to the CMHC in the year following programme implementation than in the year preceding programme implementation.

The second hypothesis states that there will be no association between the date of the referral (pre or post programme implementation) and the outcome of the referral (accepted or not accepted by the CMHC for an initial assessment). It is anticipated that the programme will reduce the number of referrals that are deemed inappropriate by the CMHC for an initial assessment. The alternative hypothesis, therefore, states that a greater proportion of the referrals received from Bridges GP surgery will be accepted by the CMHC for an initial assessment in the year following programme implementation than in the year preceding programme implementation.

The third hypothesis states that there will be no association between the date of the referral (pre or post programme implementation) and the main presenting problem, as ascertained by the GP. Members of the CMHC staff anticipate that, as GPs become more familiar with the CMHC criteria for accepting cases for an initial assessment, the range of presenting problems, as ascertained by the GP, will become more diverse. The alternative hypothesis, therefore, states that the range of the main presenting problems, as ascertained by the GP, will be more varied in the year following programme implementation than in the year preceding programme implementation.

Methods
Design
The study involved a retrospective review of all consecutive referral letters to the Dandelion CMHC from Bridges GP surgery between the periods September 2002 – September 2003 (n = 115; pre programme implementation) and November 2003 –
November 2004 (n = 54; post programme implementation).

Procedure
Each referral letter was reviewed for the date of referral and the main presenting problem, as ascertained by the GP. Information on whether or not the referral was accepted by the CMHC for an initial assessment was obtained from either the CMHC documentation that accompanied each referral letter or the patient database.

Statistical analysis
All statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS) 12.0.1 for Windows.

Results
Between the periods September 2002 – September 2003 and November 2003 – November 2004, Bridges GP surgery referred a total of 169 patients to the CMHC for an initial assessment. Of the 169 patients referred, 115 (68%) were referred in the year preceding implementation of the programme and 54 (32%) were referred in the year following implementation of the programme.

Of the 115 patients referred in the year preceding programme implementation, 67 (58%) were accepted by the CMHC for an initial assessment. The remaining 48 (42%) patients were considered inappropriate by the CMHC for an initial assessment and were referred back to the GP. Of the 54 patients referred in the year following programme implementation, 44 (81%) were accepted by the CMHC for an initial assessment. The remaining 10 (19%) patients were considered inappropriate by the CMHC for an initial assessment and were referred back to the GP. A chi-square test was performed to determine whether or not a significant association existed between the date and the outcome of the referral. All necessary assumptions of the chi-square test were met; the data was categorical, each referral case contributed to only one cell of the 2 x 2 contingency table and all expected frequencies were greater than five. The chi-square test
demonstrated that patients referred in the year preceding programme implementation were significantly less likely to be accepted by the CMHC for an initial assessment than patients referred in the year following programme implementation ($\chi^2 = 8.790, df = 1, p < 0.05$). The 2 x 2 contingency table, containing observed and expected counts, is presented in Table 1 (see Appendix A).

Table 2 (see Appendix A) summarises the main presenting problem, as ascertained by the GP, across the two years studied. Irrespective of the year considered, depression, anxiety disorder and suicide/self harm were the most frequently cited main presenting problems. In the year preceding implementation of the programme, Bridges GP surgery referred patients to the CMHC for one of seven main presenting problems. In the year following implementation of the programme, patients were referred to the CMHC for one of ten main presenting problems. A chi-square test was employed to determine whether or not a significant association existed between the date of the referral and the main presenting problem, as ascertained by the GP. Only two of the three necessary assumptions of the chi-square test were met; the data was categorical and each referral case contributed to only one cell of the 2 x 10 contingency table. In order to satisfy the third assumption that all expected frequencies be greater than five, the ten referral categories were collapsed. Any referral category that contained less than ten percent of the total sample (anger, psychosis, eating disorder, trauma, personality disorder, self esteem and physical health) was subsumed by the referral category termed ‘other’. The resultant categories comprised depression, anxiety disorder, suicide/self harm and other. Collapsing the ten referral categories into only four ensured that the assumption that all expected frequencies be greater than five was met and, therefore, allowed the chi-square test to be performed. The chi-square test demonstrated that the range of the main presenting problems in the year following implementation of the programme was greater than in the year preceding implementation of the programme ($\chi^2 = 15.403, df = 3, p < 0.05$). The 2 x 4 contingency table, containing observed and expected counts, is presented in Table 3 (see Appendix A).
Discussion

In the year following implementation of the programme, Bridges GP surgery referred less than half the number of patients (n = 54) than had been referred by Bridges GP surgery during the year preceding programme implementation (n = 115). It is possible, therefore, to reject the null hypothesis that there will be no difference in the number of patients referred to the CMHC across the two years studied. The association between the number of patients referred to the CMHC and the implementation of the programme, however, could be spurious. Indeed, a number of alternative explanations could account for the reduction in referral rates in the year following programme implementation. Information on referral rates for the years prior to September 2002 was not obtained. It is not possible, therefore, to determine whether the observed reduction is a deviation from previous referral rates or a continuation of a declining trend. Equally, information on the referral rates of the four other GP surgeries involved in the programme was not obtained.

A greater proportion of received referrals were accepted by the CMHC for an initial assessment in the year following programme implementation (81%) than in the year preceding programme implementation (58%). It is possible, therefore, to reject the null hypothesis that there is no association between the date of the referral and the outcome of the referral. The association between the date and the outcome of the referral, however, could be spurious. A number of alternative explanations could be posed to account for the association. Although, theoretically, the formal criteria for accepting referrals did not change over the two years studied, members of the CMHC staff may have been, either consciously or unconsciously, more willing to accept patients referred for an initial assessment following the implementation of the programme. Equally, following programme implementation, the GPs involved may have become more apt at describing cases for referral so as to increase the likelihood of having them accepted by the CMHC for an initial assessment.

The range of the main presenting problems, as ascertained by the GP was demonstrated as being more varied in the year following programme implementation than in the year
preceding programme implementation. It is not possible, therefore, to reject the null hypothesis that the range of presenting problems, as ascertained by the GP, will be more varied in the year following implementation of the programme than in the year preceding implementation of the programme. A number of alternative explanations could be posed to account for the increase in the variation in the presenting problem in the year following programme implementation. Given the data collected, it is not possible to determine whether the increase in variation is due to the programme itself or factors extraneous to the programme. Following implementation of the programme, GPs may have felt more empowered to recognise and acknowledge a broader range of mental health difficulties. The programme may have encouraged GPs to explore the difficulty more deeply with the patient during the consultation. Patient factors could also influence the association between the date of referral and the range of the presenting problems. In the year following programme implementation, patients may have been more familiar with notions of mental distress and more willing to explore their difficulties with the GP. Equally, the observed association could merely be a reflection of the variation inherent in patients presenting to the GP.

Limitations

Despite the significant associations observed, this study is limited in its ability to drawn definitive conclusions. It is not possible, for example, to categorically state that the results obtained are a direct result of the implementation of the programme. The associations could merely be spurious and alternative explanations could be posed to account for the observed associations.

The process of collecting the data used in the study was unnecessarily time consuming. This was, in part, due to the various administrative processes employed by the Dandelion CMHC. Personnel changes within the CMHC administrative team, and the implementation of a new patient database, resulted in inconsistencies in the recording and monitoring of referrals to the CMHC. Referrals that were not accepted by the CMHC for an initial assessment were not necessarily entered on to the patient database. In terms of
ensuring the integrity of the data collected both the database and the referral letters had to be reviewed. Accordingly, it has been recommended that all future referrals, whether accepted by the CMHC for an initial assessment or not, be entered on to the database. This will ensure that data for comparison, or indeed for studies conducted independently of this, can be more readily obtained.

**Future research**

To determine the validity of alternative explanations, future research in the area should include an examination of referrals for the years prior to September 2002 and the years following November 2004. It would be useful also to examine the referral patterns of the other four GP surgeries involved in the programme.

The hypotheses that were tested in this study were developed, in part, through discussions with members of the CMHC staff. CMHC staff perspectives of the programme could be assessed more formally by way of questionnaires or semi-structured interviews. Given that the programme was concerned with improving the interface between primary and secondary care services, it would be pertinent, also, to consider the views of the primary care staff involved in the programme. Questionnaires or semi-structured interviews concerning the impact of the programme on the practices and views of the GPs involved, for example, could be an area for future research. Patient’s views of the programme could also be assessed by similar means.

**Post script**

The results of the study were verbally fed back to the Behavioural Psychotherapist responsible for managing the programme. Evidence of this is contained in Appendix B. A copy of this report was also provided to the service. A copy of the ethical scrutiny form that was completed prior to commencing the study is contained in Appendix C.
References


Appendix A: Results summarised in three tables
Table 1: 2 x 2 contingency table of observed and expected counts of the date and the outcome of the referral

<table>
<thead>
<tr>
<th></th>
<th>Accepted for initial CMHC assessment</th>
<th>Not accepted for initial CMHC assessment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation Count (%)</td>
<td>67 (58%)</td>
<td>48 (42%)</td>
<td>115</td>
</tr>
<tr>
<td>Expected (%)</td>
<td>75.5 (66%)</td>
<td>39.5 (34%)</td>
<td></td>
</tr>
<tr>
<td><strong>Post programme</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation Count (%)</td>
<td>44 (81%)</td>
<td>10 (19%)</td>
<td>54</td>
</tr>
<tr>
<td>Expected (%)</td>
<td>35.5 (66%)</td>
<td>18.5 (34%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>169</td>
</tr>
</tbody>
</table>

Table 2: Main presenting problem, as ascertained by the GP, in the year preceding programme implementation and the year following programme implementation

<table>
<thead>
<tr>
<th>Main presenting problem</th>
<th>Number (%) of patients referred pre programme implementation (n = 115)</th>
<th>Number (%) of patients referred post programme implementation (n = 54)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>72 (62%)</td>
<td>23 (43%)</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>23 (20%)</td>
<td>7 (13%)</td>
</tr>
<tr>
<td>Suicide/self harm</td>
<td>10 (9%)</td>
<td>8 (15%)</td>
</tr>
<tr>
<td>Anger</td>
<td>4 (3%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>3 (3%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>2 (2%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Trauma</td>
<td>1 (1%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>0 (0%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Self esteem</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Physical health</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>
Table 3: 2 x 4 contingency table of observed and expected counts of the date and the main presenting problem, as ascertained by the GP

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>Anxiety disorder</th>
<th>Suicide/ self harm</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre programme</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation</td>
<td>Count (%)</td>
<td>72 (62%)</td>
<td>23 (20%)</td>
<td>10 (9%)</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>Expected (%)</td>
<td>64.6 (56%)</td>
<td>20.4 (18%)</td>
<td>12.2 (11%)</td>
<td></td>
</tr>
<tr>
<td><strong>Post programme</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation</td>
<td>Count (%)</td>
<td>23 (43%)</td>
<td>7 (13%)</td>
<td>8 (15%)</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Expected (%)</td>
<td>30.4 (56%)</td>
<td>9.6 (18%)</td>
<td>5.8 (11%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>95</td>
<td>30</td>
<td>18</td>
<td>169</td>
</tr>
</tbody>
</table>
Appendix B: Evidence of feedback to service
Hi Kate

I can confirm that you provided a report of your project to look at the quality and appropriateness of GP referrals to pre and post implementation of shared care and that you fed back the results to me verbally, and that the work you did was very useful to the service.

Behaviour Psychotherapist
Community Mental Health Team
Appendix C: Ethical scrutiny form
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust’s ethical committee.

Name of Field/Placement Supervisor: ..........................................................

Signature of Field/Placement Supervisor: ..................................................

Name of Trainee: Kate Perry

Title of SRRP: Evaluation of the impact of a local programme to improve the interface between primary and secondary care services

Date: July 2005
QUALITATIVE RESEARCH PROJECT ABSTRACT

May 2006
Year 2
Abstract
Objectives: To explore childless couples’ experiences of owning pets.

Design: Given the lack of theories pertaining to the experience of pet-ownership, grounded theory was selected as the most appropriate method of analysis. This methodology was applied to the verbal accounts obtained during a one-hour focus group interview.

Participants: Four female clinical psychology trainees on a postgraduate doctoral course were recruited for participation in the study. The participants were all pet-owning individuals who lived with their partners and who were without children. Participants were recruited via an email advertisement.

Main Outcome Measure: The focus group was audio-taped and transcribed. The transcript was analysed using grounded theory. Consistent with this methodology, concepts were identified and descriptively labelled. These labels were subsequently grouped together to form higher-level and lower-level categories. Six categories were ultimately identified.

Results: A theory concerning the experience of pet ownership was generated. The central feature of the theory comprised the participants' relationship with their pets. This was informed by participants’ childhood experiences of pet ownership. The link between the relationship and childhood experiences was mediated by the process of personification. Participants’ relationship with their pets comprised both negative and positive aspects pertaining to emotions, relationships with others and practical considerations. The positive aspects worked to strengthen participants’ relationships with their pets and the negative aspects were minimized through the employment of defence mechanisms, which ultimately served to protect the relationship.

Conclusions: This study suggests that the relationship one has with a pet is central to the
experience of pet ownership. The nature of this relationship is determined by an individual’s childhood experiences of pet ownership and is strengthened by the process of personification. This study highlighted the importance of pet ownership for childless couples in terms of bringing the couple closer together and providing them with an object to care for and love.
“Constructing (dis)order: A discourse analysis of constructions of ‘personality disorder’ in British clinical psychology literature”

Major Research Project

July 2007

Year 3
ACKNOWLEDGEMENTS

I would first like to extend my thanks to Adrian Coyle. Adrian introduced me to the field of discourse analysis and agreed to supervise this project despite an already hefty workload. He was an invaluable source of knowledge and inspiration, demonstrating both a commitment to, and an enthusiasm for, the project. I doubt whether this research could have been completed without him. I would also like to thank Fiona Warren and Arlene Vetere for their early comments regarding the design of the research project and for their help in ensuring that the research was of relevance to the clinical psychology profession. In addition, I would like to thank Fiona for sharing her knowledge on the area of personality disorder and Arlene for allowing me access to her extensive library of psychology journals.

On a more personal level, I would like to extend my thanks to my mom and dad. It was their belief in me that got me to this point in the first instance. I would also like to thank Mark for putting up with me during the last six months and Lisa for persisting with her considerate phone calls and emails despite my often dull and limited responses. And finally, a big thank you to everyone at the Neptune for providing the perfect excuse to leave my work behind and go for a pint.
ABSTRACT
This study employed a critical discursive psychology approach to explore the various ways in which the clinical psychology profession constructs the concept of 'personality disorder' through an examination of clinical psychology journal articles. A total of 78 articles published in the British Journal of Clinical Psychology and Clinical Psychology between January 1999 and December 2006 containing the term 'personality disorder' were subjected to the analytic process. The analysis of the selected texts suggested that the clinical psychology profession draws upon three main interpretative repertoires in the construction of personality disorder in the texts. The three interpretative repertoires identified comprised the 'contention' repertoire, the 'complexity' repertoire and the 'toxicity' repertoire. Each of these repertoires is considered in turn. The discursive strategies used, and the rhetorical functions served by these strategies, are explored and referenced by data extracts from the texts under consideration. The implications of the operation of these repertories for the clinical psychology profession are also addressed in relation to the broader socio-political context within which the textual material is produced and the clinical psychology profession is located. The study concludes by presenting a concise, coherent conceptual framework through which the construction of personality disorder by the clinical psychology profession can be understood. The conceptual framework presented is identified as the 'serviceable other'. The adoption of this framework suggests that the clinical psychology profession constructs personality disorder in a manner that serves the material and ideal interests of the profession.
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1 PREFACE

1.1 Introducing the author

My path into clinical psychology training was somewhat atypical. Unlike other members of my training cohort, I neither studied at a British university nor was I employed as an assistant psychologist. I completed my Masters in Health Psychology at Auckland University, New Zealand, and subsequently accepted a research post at the Centre for Health Care Research based at the University of Brighton, England. This post required that I conduct independent research and provide research consultancy to healthcare professionals working within the National Health Service (NHS). The research projects that I was involved in typically demanded the use of quantitative methodologies. As a result, I became accustomed to completing research ethics proposals, managing multiple research sites, recruiting large numbers of participants and analysing unwieldy data sets. In contrast to my competence with quantitative methodologies, however, my knowledge and experience of qualitative methodologies was limited. It was thus my relative unfamiliarity with these latter approaches, and a gradual recognition of the limitations inherent in the former, that first roused my interest in qualitative research. In particular, I was intrigued by the reflexivity and creativity that qualitative methodologies offered the researcher. Indeed, the notions of reflexivity and creativity appeared to run counter to my experiences of systematically, but somewhat mechanically, applying quantitative methodologies.

Although the research post exposed me to a diversity of individuals experiencing psychological and physical distress, I commenced clinical training with a somewhat naïve view of psychotherapeutic theory and practice. Over the course of training, however, I have been introduced to a multiplicity of psychotherapeutic approaches that can be applied when working with a range of individuals. Stylistically, I am most drawn to those approaches that focus on strength and resilience and construct the individual as the expert on their experiences. On a more personal level, I am motivated to work with individuals who are often amongst the most marginalised and vulnerable. On reflection, I recognise that my propensity for working in these ways resonates with my broadly political interests.
in advocacy and social justice.

My specific interest in the area of personality disorder was prompted by my clinical training experiences of working within multidisciplinary community mental health teams. In particular, I had observed the diversity of opinions and emotional reactions\(^3\) that the term 'personality disorder'\(^4\) had generated among my mental health and social care colleagues. At best, the term had elicited pity and sympathy. At worst, the term had been used in a pejorative manner as a means of excluding an individual from accessing mental health services. I recall being confused by these responses and consequently turned to the research literature to get a better understanding of the concept and its implications for clinical psychology practice. I was somewhat perplexed on coming to realise that the diversity of opinions and reactions that existed among my colleagues was also represented in the literature (Fraser & Gallop, 1993; Gallop et al., 1989; Lewis & Appleby, 1988) and could be seen as reflecting broader policy initiatives. Indeed, prior to the publication of *Personality disorder: No longer a diagnosis of exclusion* (National Institute for Mental Health in England, 2003), individuals with a diagnosis of personality disorder were often rejected from mental health services on the grounds that the diagnosis precluded treatment. Whilst the publication of this document was intended to change this circumstance, anecdotal evidence based on my own clinical experiences suggests that individuals with a diagnosis of personality disorder continue to be excluded from mainstream mental health services.

**Reflexive Box 1: Managing an epistemological dilemma**

Within a social constructionist research report, the 'Introducing the author' section above could be seen as problematic in that it embodies a different epistemology to that contained within the main body of this account. Indeed, this section introduces the author's background experiences and purports to reveal the author's motivations for

---

\(^3\) I am mindful that, in the context of an account of professional practices, the phrase 'emotional reactions' may be interpreted as a provocation.

\(^4\) Inverted commas are used throughout this report to signify constructed ideas that are pertinent to the aim of the research.
conducting the research. The provision of a reflexive box at this juncture thus provides the author with a means of negotiating this epistemological dilemma. More specifically, this reflexive box provides an opportunity to examine the ‘Introducing the author’ text and allows for an exploration of the rhetorical functions that the text performs within the context of the research report.

The main function of the ‘Introducing the author’ text is to confer legitimacy on the author and the ensuing analysis. The text positions the author as a competent and experienced quantitative researcher who has turned to qualitative methodologies both out of curiosity and frustration. This functions to render the author as both inquisitive and critical, characteristics that are presumably desirable in a researcher. The positioning of the author as new to qualitative research could be seen to function to defend the author against any criticism pertaining to the simplicity of the ensuing analysis. Moreover, it could be read as suggesting that the author is ambitious and open to new challenges. The author is also positioned as wanting to improve services and service access for individuals with personality disorders. This could be seen to render the author as somewhat of an advocate and a campaigner, roles that draw on liberal and humanistic principles and are thus presumably intimately bound up with the profession of clinical psychology.

The operation of this reflexive box thus attempts to demonstrate the constructed nature of the ‘Introducing the author’ text by subjecting the text to a brief discourse analysis and making obvious Coyle’s (2006) assertion that it would be disingenuous of discourse analysts to demonstrate the constitutive function of the language use of others whilst making an exception for their own. Of course, it is also intended to point to the constructed nature of the entire text presented in this account. Indeed, even the text contained within this reflexive box could be subjected to discourse analysis (c.f. Ashmore, 1989). Such an analysis might, for example, interrogate the rhetorical strategy through which authorship is presented as the product of a questioning, but otherwise unified and integrated, self.

1.2 Introducing the research

This research project was thus designed to provide me with a means of combining my
research interest in the use of qualitative methodologies with my clinical and personal concerns regarding the empowerment of marginalised individuals. The area of personality disorder was selected for consideration as I considered individuals with a diagnosis of personality disorder to be particularly maligned within the current mental health system and was eager to examine further the connotations that the term 'personality disorder' engendered. To this end, a discourse analytic approach to research was adopted to explore the various ways in which the clinical psychology profession constructs the concept of personality disorder.

The account that follows summarises that research and is ordered into four main sections. Prior to outlining these sections, it is worth acknowledging that the use of the term 'account' implies a recognition that this is one possible, and hopefully plausible, way of ordering the material that might nonetheless be ordered in other ways. The introductory section contextualises the research by providing a brief overview of the constructions of personality disorder that are presently available and routinely taken up by the clinical psychology profession. The implications of these constructions are also addressed and the aim of the research is specified. The subsequent section outlines the methodology employed. This section outlines the research design and locates this within a critical discursive psychology approach. The selection of research material, analytic strategy and evaluative criteria are also described in this section. The third section comprises the analysis and incorporates what, within a more traditional research report, would be addressed in the results and discussion sections. This analysis section comprises the main body of the account and elaborates the three main interpretative repertoires identified. The study concludes with a summary whereby the three interpretative repertoires identified are drawn together into a concise, coherent conceptual framework. The limitations of the present study and implications for future research and practice are also addressed in this final section.

In accordance with the procedural conventions that have developed in relation to qualitative methodology, this account is punctuated by reflexive boxes (as has already
occurred at the end of the ‘Introducing the author’ section). In the context of this account, these reflexive boxes can be conceptualised as performing two main functions. First of all, these boxes provide the author with a means of stepping outside the main body of the account to allow for the exploration of specific issues or points of contention (Edwards & Potter, 1992). Indeed, in an attempt to emphasise their separateness, the boxes themselves are physically constructed as external to the main text. Second, these boxes attempt to make explicit the author’s contribution to the construction of meanings throughout the research process. Indeed, Kidder and Fine (1997) state that the author’s subjectivity must be ‘acknowledged, studied, interrogated and written about’ (p. 40). The provision of this preface could also be conceptualised as serving a similar function in that it attempts to orient the reader to the author’s background and motivation for conducting the research. Of course, as was outlined in Reflexive Box 1, the preface also performs a variety of rhetorical functions within the context of the research report.

2 INTRODUCTION

Personality disorder is positioned as an area of concern for professionals working within health, social care and forensic services (Department of Health & Home Office, 1999; National Institute for Mental Health in England, 2003). Indeed, numerous epidemiological studies have been conducted which purportedly attest to the high prevalence of personality disorder among samples drawn from community (Moran, 1999), primary care (Casey & Tyrer, 1990; Moran et al., 2000), psychiatric (Casey, 2000; Pilgrim & Mann, 1990) and forensic (Lader et al., 2003; Singleton et al., 1998) populations. Moreover, individuals with personality disorder are frequently represented as placing a high demand on primary care (Moran et al., 2001) and psychiatric (Saarento et al., 1997) services.

Psychological perspectives are increasingly posited as being able to contribute to our understanding of personality disorder. For instance, the recent publication of national policy implementation guidance for the development of personality disorder services in England recommended that psychological perspectives assume a prominent position.
A review of the contemporary literature pertaining to personality disorder suggests that the clinical psychology profession broadly constructs personality disorder as being embedded within psychiatric, psychological and legal frameworks of understanding. This section summarises each of these frameworks and concludes with a brief consideration of the implications of using these frameworks in the construction of personality disorder before introducing the aim of the research. This section thus aims to contextualise the research outlined in this account by providing the discursive context from within which a more nuanced analysis can be developed and its meaning understood. This section may therefore be conceptualised as representing the beginnings of the discourse analytic process.

It is important to note, however, that the overview presented here does not purport to be exhaustive of the constructions of personality disorder that are available to the clinical psychology profession. Rather, it attempts to present an outline of the constructions that are currently the most routinely taken up by the profession, as reflected in the contemporary literature.

2.1 A psychiatric framework for understanding personality disorder
A psychiatric framework for understanding personality disorder is historically the most dominant, and accordingly, a psychiatric framework has both shaped the views of others and provoked alternative or opposing perspectives (Rogers & Pilgrim, 2005). It is therefore the first to be considered.

Psychiatry is a branch of the medical profession. Psychiatric constructions of illness and disease are thus based on the medical model. The medical model holds that illness and
disease are a consequence of biological abnormalities and can be resolved by biological interventions. In an attempt to emulate general medicine, psychiatry has thus sought to distinguish between different categories of psychiatric disorders, each of which are assumed to have their own unique organic pathology (Moncrieff, 2007).

Consistent with the medical model, the categorisation of psychiatric disorders assumes that normality and abnormality are qualitatively distinct and that clear boundaries exist between categories of psychiatric disorders. The Diagnostic and Statistical Manual of Medical Disorders (DSM-IV; American Psychiatric Association, 1994) and the International Classification of Mental and Behavioural Disorders (ICD-10; World Health Organisation, 1992) are categorical classification systems that provide the criteria for the diagnosis of categories of psychiatric disorders. Contemporary psychiatric constructions of personality disorder are derived from the diagnostic criteria outlined in each of these systems. The inclusion of personality disorder in these classification systems thus presupposes that personality disorder is a category of psychiatric disorder that is discoverable by the identification of specific behavioural and/or psychological symptoms.

The DSM-IV and the ICD-10 classification systems construct personality disorder as both a homogeneous and a heterogeneous psychiatric category, as exhibiting an underlying and structural cohesion whose specific manifestations are, however, strikingly diverse. As a homogeneous psychiatric category, personality disorder is represented as a collection of enduring and inflexible behavioural and psychological symptoms that give rise to subjective distress or impairment. The construction of personality disorder as a homogeneous psychiatric category thus renders personality disorder as a separate and distinct category from other categories of psychiatric disorders whilst simultaneously maintaining an internal consistency as a unitary psychiatric category. The DSM-IV classification system further differentiates personality disorder from other categories of psychiatric disorders by locating personality disorder on Axis II of the classification system thereby distinguishing it from Axis I categories of ‘mental disorder’.
As a heterogeneous psychiatric category, personality disorder is constructed as having a number of discrete subcategories, each of which are operationally defined by a specific set of diagnostic criteria. The DSM-IV identifies ten subcategories of personality disorder, namely: antisocial; avoidant; borderline; dependent; histrionic; narcissistic; obsessive-compulsive; paranoid; schizoid; and schizotypal. The DSM-IV organises these categories into three major groups or ‘clusters’ of personality disorder. Cluster A is characterised by ‘odd and eccentric’ behaviour and includes the paranoid, schizoid and schizotypal subcategories. Cluster B refers to the ‘dramatic, emotional and erratic’ types and includes the antisocial, borderline, histrionic and narcissistic personality disorders. Cluster C is characterised by ‘anxious and fearful’ behaviour and includes the avoidant, dependent and obsessive-compulsive subcategories. The ICD-10 classification system identifies nine subcategories of personality disorder, namely: anankastic; anxious; dependent; dissociative; emotionally unstable - borderline type; emotionally unstable - impulsive type; histrionic; paranoid; and schizoid. Unlike the DSM-IV, the ICD-10 does not adopt a clustering system nor is it multi-axial in organisation.

The DSM-IV and ICD-10 classification systems are the subject of continual modification. Successive revisions have seen the numbers of subcategories of personality disorder both shrink and expand and the diagnostic criteria adjusted. Implicit in this revision process is the assumption that incremental refinements to the classification systems will lead to the more precise identification of personality disorder subcategories. Indeed, the revision process proceeds with a confidence that there exists a real and invariant external world of natural disease entities (Hoff, 1995; Pilgrim & Bentall, 1999). Accordingly, it is assumed that, as the revision process advances, the DSM-IV and ICD-10 classification systems will ultimately converge (Coid, 2003), as if the sole factor determining their contents and structures was objective knowledge (rather than socio-political considerations). Moreover, while these classification systems are routinely posited as the embodiment of scientific progression, the revision process is not grounded in empirically-derived theories but rather reflects the consensus of professionals identified as ‘experts’.
Despite the wide acceptance and utilisation of these classification systems, the DSM-IV and the ICD-10 representations of personality disorder have been contested (Livesley, 2003; Pilgrim, 2001; Widiger, 2003). Specifically, criticism has focussed on the inability of these systems to differentiate between the subcategories of personality disorder and to differentiate personality disorder from ‘normality’ and from ‘mental disorder’. In the main, however, these criticisms do not question the notion of personality disorder as a diagnosable psychiatric category that ‘exists’ independently in the world but rather challenge the reliability and validity of the categorical classification systems currently available.

Consistent with the medical model, the construction of personality disorder as a category of psychiatric disorder implies that personality disorder has an underlying organic pathology that is amenable, whether in principle or in practice, to biological interventions. Indeed, a number of aetiological factors have been posited (Paris, 1996; Zanarini, 1993; Zuckermann, 1995) and a diversity of pharmacological interventions have been applied (Bender et al., 2001; Chiesa et al., 2004). To date, however, neither a common organic aetiology nor a definitive biological intervention have been identified (Pilgrim, 2001).

2.2 A psychological framework for understanding personality disorder

Arguably, the inability of psychiatry to unequivocally identify an organic pathology and a corresponding biological intervention has created an opportunity for psychology to contribute to the understanding of personality disorder.

Academic and applied psychology are routinely constructed as scientific disciplines that are grounded in the assumption that the ‘truth’ is discoverable through observation and hypothetico-deductive reasoning (Constantinople, 1973). In the tradition of deductive scientific enquiry, therefore, contemporary psychological constructions of personality disorder are based on theories pertaining to the structure of personality. Whilst a variety of personality theories have been proposed and refined, the notion of personality nevertheless remains contested within academic psychology and finds little consensus in
terms of definition or agreed features (Pilgrim, 2001).

However, of the personality theories available to psychology, the five-factor model (McCrae & Costa, 1996) is widely regarded as the most relevant to understanding personality disorder (British Psychological Society, 2006; Widiger et al., 2002), although it was not explicitly developed for this purpose. This model locates personality characteristics as falling along five dimensions. The five dimensions are: neuroticism versus emotional stability; extraversion versus introversion; openness versus closedness to experience; agreeableness versus antagonism; and conscientiousness versus undependability. In contrast to the categorical representations of personality disorder, as exemplified by the DSM-IV and the ICD-10 classification systems, dimensional representations construct personality disorder as existing on a continuum of personality functioning. Consistent with this construction, the British Psychological Society (2006) broadly defines personality disorders as ‘variations or exaggerations of normal personality characteristics’ (p. 4).

Dimensional representations of personality disorder are concordant with the statistical notion that characteristics in any population are normally distributed. Personality disorder is thus constructed as an extreme expression of personality functioning in relation to the population average. Statistical notions are routinely invoked within academic and applied psychology and could be seen to function to construct the discipline as scientifically rigorous and position psychologists in the role of applied scientists (Pilgrim & Treacher, 1992).

In addition to the provision of dimensional representations, psychological constructions of personality disorder also reflect the diversity of psychotherapeutic approaches upon which the clinical psychology profession draws. Indeed, a number of psychotherapeutic approaches are currently contending for recognition and authority in the understanding of personality disorder. In particular, psychodynamic (Bateman & Fonagy, 2001), cognitive (Young, 1994), cognitive-analytic (Rye, 1997), cognitive-behavioural (Beck et al., 1990),
dialectical-behavioural (Linehan, 1993) and therapeutic community (Kennard, 1998) approaches are amongst the most commonly represented in the personality disorder literature (Bateman & Tyrer, 2004; British Psychological Society, 2006).

As was observed with the psychiatric construction of personality disorder, each of these psychotherapeutic approaches makes claims as to the aetiology and treatment of personality disorder. However, in contrast to psychiatric conceptualisations that assume a biological aetiology and treatment, psychotherapeutic approaches assume an aetiology and a treatment concerned with psychological phenomena, although experiential and relational factors are also implicated as contributing to aetiology. Whilst the different psychotherapeutic approaches assign primacy to different psychological phenomena, the phenomena of concern are nonetheless oriented towards internal, intra-psychic processes. Interventions are thus typically targeted at the level of the individual and are concerned with the negotiation of personal change. To date, no one psychotherapeutic approach to personality disorder has been demonstrated as being decisively superior to any other (British Psychological Society, 2006; Roth & Fonagy, 2004).

2.3 A legal framework for understanding personality disorder

The British Psychological Society (2006) and the Mental Health Foundation (O’Rourke et al., 2001) assert that personality disorder is commonly associated with the legal category of ‘psychopathic disorder’ as outlined in the 1959 and 1983 Mental Health Acts of England and Wales. Consistent with this assertion, the legal category of psychopathic disorder and the DSM-IV subcategory of antisocial personality disorder are frequently used interchangeably in the research literature (Blackburn, 1988; Dolan & Coid, 1993; Reid & Gacono, 2000). The 1983 Mental Health Act defines psychopathic disorder as ‘a persistent disorder or disability of mind (whether or not including specific impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned’ (part 1, section 1[2]). The Act classifies psychopathic disorder as one of four subcategories of the legal category of ‘mental disorder’. When ascribed to an individual, the legal category of mental disorder renders the individual as
subject to compulsory detention under the Act, assuming the treatability clause is satisfied. The inclusion of psychopathic disorder as a subcategory of mental disorder thereby renders psychopathic disorder, and personality disorder by implication, as grounds for compulsory detention.

The UK government is presently embarking on an overhaul of the 1983 Mental Health Act and numerous proposals are being considered (Department of Health, 2006). The introduction of a new legislative category termed ‘dangerous people with severe personality disorder’ (DSPD) was among the proposals presented (Department of Health & Home Office, 1999). Following a host of professional and public objections on the grounds that the category serves as a vehicle for moral and political agendas (Appelbaum, 2005), the category was subsequently discarded (Department of Health, 2002) and it seems unlikely that the category will be included in a future Mental Health Act (Department of Health, 2007). However, the DSPD category has not been abandoned completely and instead has been adopted as a criterion for entry into a new range of psychiatric services concerned with preventative detention (Maden, 2005). The DSPD concept is currently being refined but is broadly conceptualised as describing those individuals who pose a significant risk of serious harm to others as a result of their severe personality disorder (Department of Health & Home Office, 2000).

The legally-derived categories of ‘psychopathic disorder’ and ‘DSPD’ have thus resulted in personality disorder being associated with compulsory detention and risk of harm to the public. Arguably, these associations are further promoted by the fact that much of the literature pertaining to personality disorder includes some reference to either in-patient or forensic services. Indeed, authoritative government and professional guidelines on the management of personality disorder include sections pertaining to in-patient and forensic settings (British Psychological Society, 2006; National Institute for Mental Health in England, 2003). Moreover, the suggestion that personality disorder requires ‘management’ could be seen to imply a politico-legal agenda concerned with containment and social control (Harper, 2001) whilst also pointing to a scepticism surrounding
treatability.

2.4 Implications
As outlined above, a review of the literature pertaining to personality disorder suggests that the clinical psychology profession broadly constructs personality disorder as being embedded within psychiatric, psychological and legal frameworks of understanding. The current application of these frameworks to the concept of personality disorder is, of course, not without consequence. Moreover, all three frameworks have implications for shaping future clinical psychology theory, practice and research. In particular, each of these frameworks can be represented as (re)producing a reified, static and decontextualised account of personality disorder.

Psychiatric, psychological and legal frameworks of understanding represent personality disorder as reflecting some underlying ontological reality. In other words, personality disorder is constructed as if it has a concrete or material existence that is definable and discoverable. Irrespective of the framework adopted, each constructs personality disorder as consisting of a collection of behavioural and/or psychological features that are observable and measurable. The observation and measurement of these features demand that personality disorder is constructed as an entity that is more or less unified and stable across time and context. This construction endures despite the incremental process of theory and policy development that assumes the concept to be awaiting further refinement.

In the main, each framework presumes the collection of behavioural and/or psychological features to reside within the individual. Psychiatric, psychological and legal frameworks of understanding construct these features as, respectively, abnormal, extreme or dangerous. Accordingly, action, whether in the form of treatment or detention, is focussed firmly on the individual in a manner that could be seen to remove responsibility from the effects of wider, collectively-driven, socio-political factors. Indeed, a restricted focus on the individual has been observed by other researchers concerned with examining
the implications of the concepts of ‘psychopathology’ (Parker et al., 1995) and ‘psychological distress’ (Burr & Butt, 2000) more generally.

2.5 Research aim

Whilst a review of the literature identified the clinical psychology profession as drawing upon what can broadly be conceptualised as psychiatric, psychological and legal frameworks for understanding personality disorder, a comprehensive exploration of how the clinical psychology profession constructs personality disorder had not previously been undertaken. It is this gap which the research outlined in this account intended to address. Accordingly, the overall aim of this research was to explore the various ways in which the British clinical psychology profession constructs the concept of personality disorder through an examination of clinical psychology journal articles. This was deemed to be a significant area of research given that descriptions or constructions of the world sustain some patterns of social action and exclude others (Burr, 2003). The decision to focus on clinical psychology journal articles was based on the premise underpinning evidence-based practice (National Health Service Executive, 1996) that the research literature both reflects and informs clinical psychology practice (Marzillier & Hall, 1999). Indeed, journal reading has been identified as one of the key components of the scientist-practitioner role (Kennedy & Llewelyn, 2001), a role that is routinely posited as central to the practice and identity of the clinical psychology profession (Huey & Britton, 2002).

Reflexive Box 2: Constructing a constructionist introduction

In many respects, the construction of this introduction section proved to be one of the more troublesome aspects of the research process. Given my background in quantitative research methodologies, I had assumed that the introduction would involve the reeling off and summarising of the ‘facts’ as they pertained to the area of personality disorder. Accordingly, my early attempts at compiling the introduction section reflected this assumption. It was not until I commenced the analysis proper that I recognised that summarising the ‘facts’ was incompatible with a social constructionist epistemology. Rather, the compilation of a compatible introduction required that I critically consider
how personality disorder is represented in the literature and examine the assumptions inherent in those representations. Needless to say, viewing the personality disorder literature through a social constructionist lens took some adjusting to and, at times, felt somewhat unnatural. I found it particularly difficult to stand back from, and untangle, a psychological framework for understanding personality disorder. I suppose that the difficulty that I experienced in doing this could be conceptualised as reflecting my successful socialisation into the clinical psychology profession or into psychology more generally. However, I would hope that this professional socialisation does not prevent me from asking questions and challenging assumptions. The process of writing this introduction section thus proved to be a valuable and timely lesson on the importance of sustaining curiosity and critical thought, particularly in relation to one’s own profession.

3 METHOD

3.1 Design

The exploratory nature of the research aim demanded that a qualitative research orientation be adopted (Willig, 2005). The overall design adopted for the research outlined in this account is based on a critical discursive psychology approach (Wetherell, 1998) to psychological research. This approach is posited as a form of discourse analysis and is grounded in a social constructionist epistemology (Burr, 2003). These aspects of the research design are elaborated later in this section.

3.2 Selection of texts

In the context of this research, clinical psychology journals were deemed to be an appropriate data source as they constitute naturalistic records that form part of the social structure of the clinical psychology profession (Webb et al., 1966). The British Journal of Clinical Psychology and Clinical Psychology (formerly Clinical Psychology Forum) were chosen for consideration on the basis that they are the most intensively and widely read journals among British clinical psychologists (Law et al., 2004) and the majority of contributors to these journals identify themselves as clinical psychologists. It is recognised, however, that a data set drawn from the British Journal of Clinical
Psychology and Clinical Psychology is not necessarily representative of wider opinion within the clinical psychology profession. Rather, the focus on these journals had a more modest intention, that of providing an opportunity to sample and analytically engage with a range of the discursive strategies that are readily available to the profession.

The specific texts selected for analysis comprised all journal articles containing the term 'personality disorder' published in the British Journal of Clinical Psychology and Clinical Psychology between January 1999 and December 2006. January 1999 was selected as the date from which to start data collection as it denoted the beginning of the year in which the consultation paper Managing people with severe personality disorder: Proposals for policy development was published (Department of Health & Home Office, 1999). December 2006 was selected as the date after which to terminate data collection as this ensured that the analytic process and subsequent write-up could be completed within the specified time frame.

**Reflexive Box 3: Defending against a potential limitation**

Whilst the search term 'personality disorder' allowed for the incorporation of articles containing the terms 'personality disorders' and 'personality disordered', it did not allow for more oblique references to personality disorder. As a consequence, the search criteria could be seen to somewhat limit the scope of the analysis in that the criteria only allow for a consideration of articles that make explicit reference to personality disorder. When designing the research project, due consideration was given to how this limitation could be overcome. Following discussions with research supervisors, it was suggested that the search criteria be widened to include alternative conceptualisations of personality disorder. Specifically, it was suggested that the search criteria be widened to include the terms 'trauma', 'emotional difficulties' and 'personality difficulties' although other permutations could also be incorporated. The inclusion of additional terms within the search criteria was, however, deemed to be impractical given the time frame for completing the project. Moreover, it was acknowledged that a near limitless number of alternative terms could be included and one would still be liable to neglect an oblique
By virtue of her status as a postgraduate research student, the author had permission to view the *British Journal of Clinical Psychology* online. This allowed for the search to be conducted electronically, thereby ensuring that all instances of the term 'personality disorder' were identified. The author did not have online access to *Clinical Psychology*. As a consequence, the entire corpus of articles published in *Clinical Psychology* during the selected time frame was hand searched for instances of the term 'personality disorder'. In an attempt to capture all instances of the term, all of these articles were hand searched twice.

The search criteria generated a total of 78 journal articles. The references for these articles are contained in Appendix A. Inevitably, this data set included articles where personality disorder was deemed to be of only peripheral concern to the objective of the article and articles where personality disorder was deemed to be a main focus. This distinction between articles was employed in an attempt to render the subsequent analytic process more manageable. It is acknowledged that the processes involved in making this distinction were somewhat arbitrary and subjective on the part of the author. Nevertheless, what was involved may reasonably be described as based on considered judgement rather than casually held opinion. Of the 78 articles considered, 15 were identified as having personality disorder as a main concern. Depending on the journal from which the articles were sourced, all articles were either printed out or photocopied in preparation for coding and analysis.

**Reflexive Box 4: Sampling in discourse analytic research**

In contrast to quantitative approaches to psychological research, qualitative approaches are not concerned with securing a large and representative sample. Within discourse analytic approaches in particular, the focus is on gathering sufficient texts to discern the variety of discursive strategies that are commonly employed (Coyle, 2006). Discourse analytic approaches to sampling have tended to draw on the concept of saturation, as...
borrowed from grounded theory (Gill, 1992). Saturation refers to the point at which the texts gathered fail to generate new information. In relation to the present research, the sampling of articles published prior to January 1999 was deemed to add to the analytic task without sufficiently contributing to the analytic outcome (Coyle, 2006).

3.3 Theoretical framework

Discourse analytic approaches were identified as providing the conceptual tools necessary for an analysis concerned with the construction of professional knowledge (Burr, 2003). Broadly conceptualised, discourse analysis is concerned with the close study of patterns of language in use (Taylor, 2001a). Text and talk thus comprise the linguistic material with which discourse analysis is typically concerned. Unlike other qualitative approaches to psychological research, discourse analysis is neither a coherent paradigm (Coyle, 2006) nor a standardised set of methodological procedures (Billig, 1987). Rather, discourse analysis represents a broad research orientation that incorporates a multiplicity of theoretical assumptions and methodological techniques.

Despite this theoretical and methodological diversity, discourse analytic approaches share an epistemology that is grounded within a social constructionist framework (Burr, 2003). Discourse analytic approaches to research thus maintain a critical stance in relation to taken-for-granted knowledge about the world and ourselves. The contrast with a positivist approach is both ontological and epistemological. Positivism assumes one world, whereas constructionism posits that there are many. In maintaining this position, discourse analytic approaches view linguistic material not as reflecting psychological and social phenomena but as constructing them (Coyle, 2006; Potter & Wetherell, 1987).

Traditionally, discourse analysis has been associated with the fields of sociology and cultural and media studies. More recently, however, its influence has extended to include the field of psychology (Potter & Wetherell, 1987). Indeed, discourse analysis is increasingly represented in a wide range of psychological journals, conference presentations and doctoral research projects (Antaki et al., 2003). In tracing the influence
of discourse analysis on psychology, Antaki et al. (2003) assert that discourse analysis has ‘introduced new methods of research, new ways of conceptualising research questions and new ways of understanding the nature of psychology itself’ (p. 2).

Within the field of psychology, two approaches to discourse analysis have emerged as the most dominant (Coyle, 2006; Willig, 2005). These approaches have been termed discursive psychology and Foucauldian discourse analysis. Although these two approaches share a common concern with the role of language in the constitution of knowledge, they identify with different intellectual traditions and address different types of research questions (Willig, 2005).

3.31 Discursive psychology
Discursive psychology is grounded in conversational analysis (Garfinkel, 1967) and ethnomethodology (Sacks, 1992). It is an analytic approach that is interested in the use of language in everyday contexts. Discursive psychology is concerned with the identification of discursive strategies and the exploration of the action orientations or rhetorical functions of linguistic material in local interactional contexts (Edwards, 1997; Potter, 1996). ‘Discursive strategies’ refer to the linguistic practices or features deployed by the language user. ‘Action orientations’ or ‘rhetorical functions’ refer to the social functions that certain discursive strategies might be oriented to and serve within a particular discursive context. On the basis of these concerns, discursive psychology is commonly conceptualised as representing a fine-grained, micro-level approach to the analysis of linguistic material.

3.32 Foucauldian discourse analysis
Foucauldian discourse analysis has its roots in post-structuralist theorising and was particularly influenced by the work of Michel Foucault (Willig, 2005). It is an analytic approach that developed in response to concerns raised about the inability of discursive psychology to address the wider social and political context within which linguistic material is produced. Foucauldian discourse analysis thus represents a more global,
macro-level approach to analysis. It is concerned with identifying the discourses available to a certain culture at a specific point in time. In this context, discourse can be defined as a system of statements that constructs an object (Parker, 1992). Foucauldian discourse analysis is particularly concerned with the subject positions (Davies & Harré, 1990) that certain discourses invite and the role of discourses in the wider socio-political processes of legitimisation and power (Foucault, 1982). The analytic focus on social and political structures, however, has been criticised for failing to attend sufficiently to the local interactional context (Willig, 2005).

3.33 Critical discursive psychology

In recent years, these two approaches to discourse analysis have become increasingly differentiated as scholars and researchers have been propelled to assert their allegiance to either camp. Wetherell (1998), however, argues that the conceptual differentiation of these two approaches is counterproductive and calls for a more integrated approach to discourse analysis that can respond to the criticisms of both discursive psychology and Foucauldian discourse analysis. To this end, a third approach, termed critical discursive psychology, has emerged (Edley & Wetherell, 1999; Wetherell, 1998).

A critical discursive psychology approach to research permits the exploration of both micro- and macro-level analytic concerns. Critical discursive psychology is concerned with the identification of discursive strategies and the exploration of rhetorical functions, as borrowed from discursive psychology, yet also attends to the broader discourses that are drawn upon in order to produce a particular account. In critical discursive psychology, these broader discourses are referred to as interpretative repertoires and are conceptualised as less monolithic and more fragmented than the post-structuralist concept of discourses. This is incidentally expressed through the distinction between the term ‘interpretative repertoires’ and the Foucauldian term ‘regimes of truth’. In particular, interpretative repertoires are conceptualised as placing more emphasis on human agency within the flexible deployment of language (Edley, 2001). Critical discursive psychology can thus be conceptualised as adopting a ‘two-sided’ approach to analysis that recognises
that individuals are both the producers and the products of discourse (Barthes, 1982; Edley & Wetherell, 1999).

In the context of the research outlined in this account, a critical discursive psychology approach was deemed to be the most appropriate given the research aim. It was anticipated that the adoption of this approach would enable an exploration of the constructions of personality disorder, as grounded in the journal articles under consideration, whilst simultaneously enabling an examination of the broader socio-political framework within which the journals are produced and the clinical psychology profession is located. The application of a critical discursive psychology approach was deemed to hold the promise of offering a novel and challenging perspective which would invite new ways of understanding the concept of personality disorder.

**Reflexive Box 5: Constructing the choice of discourse analytic approach as legitimate**

It is important to acknowledge that while the choice of discourse analytic approach was, in the main, driven by the research aim, it can also be seen as a tactical decision (Harper, 1994) that reflected my clinical and academic preferences. Clinically, a critical discursive psychology approach appealed to me because I felt it to be compatible with my typically integrative approach to clinical practice. Generally speaking, I am averse to the dogmatic endorsement and application of one type of psychotherapeutic approach. Rather, I value the richness and breadth that comes with a consideration of a variety of theoretical perspectives and an adherence to the value of theorising, understood as an ongoing process rather than theory as an established body of knowledge. I thus anticipated that the synthetic approach of critical discursive psychology would enable a rich and broad analysis. From an academic perspective, I conceptualised a critical discursive psychology approach as representing a harmonious middle-ground in that I considered it to be an approach that was neither too pedantic and intricate (c.f. discursive psychology) nor too esoteric and disconnected (c.f. Foucauldian discourse analysis).
3.4 Analytic strategy

Despite the assertion that the analysis of discourse needs only to be informed by scholarship and the development of a discourse analytic mentality, the analytic process outlined in this account loosely followed the guidelines for discourse analysis outlined by Potter and Wetherell (1987), and later adapted by Wetherell (1998) and Coyle (2006). This process involved the repeated reading of the sections of the textual material that allowed for an engagement with the research aim. These sections of text thus comprised those that demonstrated consistent and variable patterns of language use in the construction of personality disorder. A form of thematic coding of surface content, albeit mindful of rhetorical functions and other discourse analytic concerns, was employed to organise the data into thematic units that could then be subjected to a more specific discourse analysis. Often the same extract would be included in several themes. Consistent with a critical discursive psychology approach, these themes were conceptualised as representing interpretative repertoires. The analysis was attentive to the range of discursive strategies used to develop the interpretative repertoires identified and render them more persuasive. The rhetorical functions that the particular strategies performed were considered and refined based on the textual material under examination. The implications of the operation of the repertoires for the clinical psychology profession were considered in relation to the broader social and institutional frameworks within which the material is produced. The analytic process thus moved recursively between micro- and macro-level analytic concerns, with the latter being grounded in the former (Walton et al., 2004).

Reflexive Box 6: Rhetorical function versus intentionality

Discourse analysis does not purport to make claims regarding the intention of the language user. Thus when considering the rhetorical functions that particular discursive strategies might perform, the analyst is not presuming to have access to, or to seek to recover, intentionality on the part of the language user. In the context of discourse analytic research, therefore, function does not imply intentionality. Indeed, discourse analysis recognises that language use may have consequences that the language user may
In order to render the analytic process (as summarised above) more manageable, it was first applied to those articles where personality disorder was deemed to be only a peripheral concern. Although all of these articles were read once or twice as a whole, only the paragraphs that contained the searched term were subjected to the analysis. In some instances, the surrounding paragraphs were also considered to aid interpretation (Potter & Wetherell, 1987). The themes that emerged from this analysis subsequently informed the analysis of the 15 articles for which personality disorder was deemed to be a main focus. Every paragraph of these articles was subjected to the analytic process.

3.5 Evaluative criteria
Arguably, the method of reporting discourse analytic research provides the most useful means of evaluation (Coyle, 2006). All interpretations offered in this account are thus supported by referenced data extracts from the texts under consideration. It is presumed that the provision of referenced extracts will help to demonstrate how the analytic conclusions were reached by pointing to the features and implications identified by the author, thereby enabling the reader to make an informed judgement as to the appropriateness of the interpretations. However, should the reader require a more structured and concrete means of evaluation, Yardley (2000) offers four criteria for the evaluation of qualitative research. Although not specifically developed for the evaluation of discourse analytic research, these criteria have been applied to discourse analytic research previously (Walton et al., 2004). The criteria offered by Yardley (2000) comprise: a sensitivity to context (i.e., an acknowledgment of the theoretical, epistemological and socio-cultural context within which the research is produced); commitment (i.e., prolonged engagement with the topic, competence and skills in the methods used and immersion in the data) and rigour (i.e., completeness of the data collection, analysis and interpretation); transparency (i.e., all relevant aspects of the research process are disclosed, including the author's subjectivity) and coherence (i.e., the fit between the research aim, epistemology, method and analysis); and impact and
importance (i.e., new ways of understanding the topic under consideration are advanced). The reader is invited to be attentive to these criteria when reviewing the ensuing analysis.

Should the reader require additional criteria, specific to the evaluation of discourse analytic research, Antaki et al. (2003) identify six analytic shortcomings which discourse analytic research should avoid. In summary, these shortcomings comprise: under-analysis through summary (i.e., merely summarising the text using the analyst's own words); under-analysis through taking sides (i.e., the analyst takes a position in relation to the text under analysis); under-analysis through over-quotation or through isolated quotation (i.e., quotations are used as a substitute for analysis); under-analysis through the spotting of features (i.e., the identification of discursive features is used as a substitute for analysis); circular identification of discourses and mental constructs (i.e., the identification of discourses or mental constructs in a form that replicates what it purports to critique); and false survey (i.e., extrapolating from the linguistic material under consideration to the world at large). Whilst engaged in the analytic process, the author sought to avoid these shortcomings.

**Reflexive Box 7: Evaluation of discourse analytic research**

The criteria of reliability, validity and replicability traditionally used to evaluate psychological research can not be meaningfully applied to the evaluation of discourse analytic research (Taylor, 2001b). Indeed, social constructionist approaches to research conceptualise these criteria as comprising part of a positivist scientific discourse that privileges objectivity and neutrality (Burr, 2003). One way in which discourse analytic researchers can accommodate this tension is through the acknowledgment of their own subjectivity or speaking position (Burman, 1994). To this end, the preface to this research account, and to some extent the material contained within the reflexive boxes, are intended to make the author's speaking position more transparent and thereby render the analytic process more accountable.
4 ANALYSIS

The readings of the texts suggested that three main interpretative repertories are routinely drawn upon in the construction of personality disorder in the texts. These interpretative repertories have been identified (through the author's own interpretative procedures) as the 'contention' repertoire, the 'complexity' repertoire and the 'toxicity' repertoire. This section examines each of these interpretative repertories in detail. To enable a detailed examination, this section is divided into three sub-sections, with each sub-section pertaining to the examination of one of the repertories.

Each sub-section commences with a descriptive overview of the interpretative repertoire under consideration. This overview is punctuated with brief data extracts from the texts that were subjected to the analytic process. These extracts were selected on the basis that they reflect a range of discursive strategies and point to a variety of rhetorical functions. The salient features of the repertoire are subsequently explored and illustrated by reference to the brief data extracts. This is followed by a consideration of the implications of the operation of the repertoire for the clinical psychology profession. Where implications are considered, however, there is a conscious shift in the object of enquiry, that is away from the purported subject matter of the texts and towards issues of professional practice, occupational conventions and the material and ideal interests of practitioners. Each sub-section concludes with the presentation of an extended data extract that represents one example of how the features of the repertoire are interrelated in the data set. For each repertoire, the extended extract was selected on the grounds that it embodies a range of the key features of the repertoire.

The analysis section concludes with a summary of the three repertories identified and a final data extract is provided to illustrate how the three repertories work together in the construction of the category of personality disorder.

To enhance readability, the data extracts cited are numbered sequentially, indented from the left- and right-hand margins and enclosed within quotation marks. Information
pertaining to the origin of the extracts is provided in brackets at the end of each extract. Where textual material has been omitted from an extract, this is indicated by the use of empty square brackets. In those instances where textual material has been added to an extract in order to assist with reader comprehension, the additional material is enclosed within square brackets.

4.1 The ‘contention’ repertoire

4.11 Descriptive overview

The contention repertoire concerned the construction of personality disorder as a category of ‘thing’ that is in some way troublesome and thereby the subject of disagreement. The operation of the contention repertoire was most frequently discerned among the articles published in Clinical Psychology and was only rarely discerned among the articles published in the British Journal of Clinical Psychology. This distinction is perhaps not surprising when one considers the focus or scope of the journals under consideration, as is made manifest in the journals’ criteria for contribution. Clinical Psychology provides a forum for the publication of research and for the discussion of current events and issues relevant to the clinical psychology profession. The British Journal of Clinical Psychology is concerned with contributing to the ‘discovery’ of psychological ‘knowledge’ as ascertained through empirical scientific enquiry. Arguably, any suggestion of contention could be seen as potentially questioning this ‘knowledge’.

Across the data set, the operation of the contention repertoire was both explicit and implicit. The explicit operation of the contention repertoire was observed where authors made specific reference to either “controversy” (Extract 1), “criticism” (Extracts 2) or “debate” (Extract 3) in relation to the categorisation or clinical management of personality disorder.

EXTRACT 1: “The diagnostic delineation of this group remains highly problematic [ ] there remains a group of highly distressed and problematic people who generate considerable controversy about how best to meet the
health and social care needs with which they present.” (Clinical Psychology: Leiper, 2000, p. 13).

EXTRACT 2: “There has long been serious criticism in the literature that ‘personality disorder’ (PD) is a derogatory label that may result in therapeutic neglect (Gunn & Robertson, 1976).” (Clinical Psychology: Webb, 2005, p. 3).

EXTRACT 3: “This bases a whole set of provisions that could have a fundamental effect on the delivery of mental health services in this country on a highly debatable diagnostic entity ‘Dangerous people with Severe Personality Disorder’.” (Clinical Psychology: Harper, 2001, p. 21).

Where specific reference to controversy, criticism or debate was absent, the contention repertoire was more obliquely discernable. In these instances, the implicit operation of the repertoire was discerned as functioning through one of three main constructions. In the first, it was discerned where alternative categorisations of personality disorder were constructed. In the main, these categorisations were represented as providing alternatives to the dominant psychiatric (Extracts 4 and 5) or legal (Extract 6) categorisations of personality disorder.

EXTRACT 4: “The Borderline Personality Disorder literature, if you disregard the insulting and nonsensical term itself, actually implies that it makes more sense to regard such people as suffering from traumas with psychological consequences than illnesses with biological causes, and to develop interventions accordingly.” (Clinical Psychology: Johnstone, 2001, p. 30).

EXTRACT 5: “to run a weekly group for clients with long-standing emotional difficulties attending the local day hospital.” (Clinical Psychology: Messari & Crocker, 2000, p. 18).
EXTRACT 6: “If the ‘DPSD [dangerous people with severe personality disorder] population’ could be readily identified, many of these people would be described as ‘psychopaths with high risk of reoffending’.” (Clinical Psychology: Cohen & Baldwin, 1999, p. 3).

In Extract 4, the author constructs individuals with borderline personality disorder as more appropriately conceptualised as “suffering from traumas with psychological consequences” than from “illnesses with biological causes”. A psychological conceptualisation is thus posited as an alternative to a psychiatric categorisation based on the medical model.

In Extract 5, the authors refer to “clients with long-standing emotional difficulties”. While this category is not explicitly contrasted with another, the authors subsequently make reference to the “borderline personality disorder” literature when describing how the group was established (p. 18) and evaluated (p. 20). Thus, although not explicitly stated, it is reasonable to suggest that the category of “clients with long-standing emotional difficulties” is constructed as an alternative to the psychiatric category of borderline personality disorder.

In Extract 6, the descriptive category of “psychopaths with high risk of reoffending” is constructed as an alternative to the legally-derived category of the “DPSD population”. These categories are constructed as seemingly equivalent. Indeed, the authors subsequently use these two categories interchangeably throughout the article.

The implicit operation of the contention repertoire was also discerned where personality disorder was constructed as having a multiplicity of conceptualisations (Extracts 7 and 8), any of which could presumably be applied and the meaning understood.

EXTRACT 7: “People’s concepts may therefore be diverse and their understandings may differ from the clinical diagnostic meaning of ‘personality
disorder’. ” (British Journal of Clinical Psychology: Markham & Trower, 2003, p. 244).

EXTRACT 8: “When describing personality disorder it is useful to refer to Tredget (2001).” (Clinical Psychology: Flynn & Bartholomew, 2003, p. 17).

In Extract 7, this multiplicity is represented by the authors’ claim that personality disorder has a diversity of meanings in addition to the familiar “clinical diagnostic meaning”. In Extract 8, multiplicity is constructed through the claim that a variety of descriptions are available, of which the description offered by “Tredget (2001)” is just one.

The third, and final, construction through which the implicit operation of the contention repertoire was discerned concerned the apparent denigration of the psychiatric (Extracts 9 and 10) or legal (Extract 11) categorisations of personality disorder.

EXTRACT 9: “The intellectually redundant term ‘personality disorder’ is a good example of a pathologising and limited categorisation of people.” (Clinical Psychology: Bostock, 2003, p. 37).

EXTRACT 10: “Most clinicians would agree that there is a cluster of core features which can be valuably identified as a unified disorder known as borderline personality disorder, though the term is both confusing and stigmatizing.” (Clinical Psychology: Bell, 2002, p. 16).

EXTRACT 11: “The whole issue of the use of mental health legislation to control so-called dangerous people with severe personality disorders (DSPD) is flawed, and the response of clinical psychologists to the DCP [Division of Clinical Psychology] survey concerning this issue reflected this concern.” (Clinical Psychology: Taylor et al., 2003, p. 36).
The phrases “intellectually redundant” (Extract 9) and “confusing and stigmatizing” (Extract 10) are used in a pejorative manner to describe the categories of “personality disorder” and “borderline personality disorder” respectively. In Extract 11, the use of the prefix “so-called” could be read to imply that some sort of contention is being constructed in relation to the category of “dangerous people with severe personality disorders”.

4.12 Salient features

In each of the data extracts provided above, the explicit (Extracts 1-3) and implicit (Extracts 4-11) operation of the contention repertoire was rendered more persuasive through the use of a range of discursive strategies, which in turn, served a variety of rhetorical functions. The most prominent and consistently discerned features of the contention repertoire are summarised below.

The use of extreme case formulations (Pomerantz, 1986) can be discerned in Extracts 1, 2 and 3. Extreme case formulations typically serve to render an account more rhetorically effective through the use of overstatement or exaggeration (Edley & Wetherell, 1999). For example, the use of the terms “considerable” (Extract 1), “serious” (Extract 2) and “highly” (Extract 3) serve to work up the respective levels of “controversy”, “criticism” and “debate”.

The narrative organisation of an account can function to increase the plausibility of a particular construction by embedding it in a sequence whereby what is being constructed becomes expected or even necessary (Potter, 1996). The effect of such a narrative organisation can be discerned in Extracts 1 and 6. In Extract 1, the “controversy” is constructed as expected given the “highly distressed and problematic people” under consideration. In Extract 6, the ‘if - then’ narrative arrangement could be seen to increase the plausibility of the contention by rendering it as expected, should the first condition be satisfied.
Although not explicitly achieved through narrative organisation, contention is also rendered as in some way expected, or at least as long-standing, in Extract 2. In this extract, the author uses the phrase “long been” to describe the “serious criticism” and includes a reference to work published some thirty years ago (i.e., “Gunn & Robertson, 1976”). The construction of the contention as long-standing can also be discerned in Extract 1, where the author’s use of the term “remains” could be seen to imply that the contention surrounding the “diagnostic delineation” persists despite efforts to render it unproblematic.

The use of emotive or evocative language can be discerned in Extracts 2 and 4. In Extract 2, the author claims that personality disorder is a “derogatory label that may result in therapeutic neglect”. The terms “derogatory” and “neglect” are persuasive and unequivocal and therefore likely to evoke strong negative effects in the reader. Moreover, the notion of neglect is in direct contrast to the notions of care and support as advocated by the mental health profession (Department of Health, 1999). In this instance, therefore, the author’s reference to “neglect” could be seen to represent a contrast structure (Smith, 1978) in that some form of contrast or difference is being constructed between what is currently occurring (i.e., “therapeutic neglect”) and what should presumably be occurring (i.e., therapeutic care and support).

In Extract 4, the author describes “Borderline Personality Disorder” as an “insulting and nonsensical term”. The terms “insulting” and “nonsensical” are powerful and visceral in that they make an appeal to the reader’s humanity and common sense respectively. Moreover, the use of this phrase could be seen to function to construct the provision of any alternative as difficult to undermine (Potter, 1996).

The use of inverted commas around the term “personality disorder” (Extracts 2, 7 and 9) and the use of quotation marks around the terms “Dangerous people with Severe Personality Disorder” (Extract 3) and “DPSD population” (Extract 6) function to work up the contention. The use of inverted commas and quotation marks in each of these extracts
could be read to imply that the authors recognise the contention and are thus employing the terms with some caution.

An example of systematic vagueness can be discerned in Extract 3. Systematic vagueness, or the provision of only limited detail, typically serves to construct an account that is less vulnerable to being undermined or contested (Potter, 1996). In Extract 3, the author’s use of the phrases “whole set of provisions”, “fundamental effect” and “delivery of mental health services” could be seen to provide just enough material to sustain some argument without providing descriptive claims that can open it to undermining. Consistent with this interpretation, the author does not go on to substantiate these points in the remainder of the article.

The construction of consensus (Potter, 1996) can be discerned in Extracts 10 and 11. The construction of consensus or collaboration typically functions to render an account more rhetorically effective through emphasising agreement across a variety of individuals (Potter & Edwards, 1990). The use of the phrases “most clinicians” (Extract 10) and “the response of clinical psychologists” (Extract 11) constructs consensus among clinicians and clinical psychologists respectively. The reader, who presumably identifies as either a clinician, clinical psychologist or both, is thereby primed to concur with the majority. Moreover, the phrase “the response of clinical psychologists” makes no allowance for any alternative response.

4.13 Implications

Throughout the data set, the operation of the contention repertoire, whether explicitly or implicitly, enabled a psychological framework of understanding to be posited as more legitimate to the understanding and clinical management of personality disorder than either a psychiatric or legal framework of understanding. Indeed, the contention repertoire served to undermine psychiatric and legal constructions of personality disorder by rendering them as in some way problematic or unsatisfactory. In relation to the clinical psychology profession, therefore, the operation of the contention repertoire could
be seen to be consistent with Bowers’ (1988) assertion that a central agenda for professionals is to prove that their profession has a special and distinctive contribution to make on an issue.

Similarly, Tollington (1992) maintains that in order for any profession to evolve, and indeed survive, it must be responsive to the demands of the social and political context within which it operates. The profession of clinical psychology, therefore, must be responsive to the demands of the NHS. The NHS is currently undergoing an unprecedented amount of change (Department of Health, 1999) and, in the process, is becoming an increasingly competitive market place. Øvretveit et al. (1992) argue that the clinical psychology profession has failed to respond to this changing environment and consequently is becoming increasingly marginalised within the NHS. The operation of the contention repertoire could thus be seen to render the area of personality disorder as a means through which the clinical psychology profession can exert some force, thereby providing the profession with a marketable commodity. This is, of course, not to say that members of the profession are guided only by material interests. Rather, such initiatives can be said to represent an effort to combine both material and ideal concerns.

The operation of the contention repertoire also functions to construct personality disorder as an area of scientific enquiry that is in need of further refinement and clarification. The contention repertoire does not, therefore, challenge the ontological status of personality disorder as a ‘thing’ that ‘exists’ independently in the world. Rather, the contention repertoire appears to be intimately bound up with the empiricist positivist scientific notion of the ‘discovery’ of ‘truth’, a notion implicit in contemporary clinical psychology (Pilgrim & Treacher, 1992).

4.14 Extended extract

Having outlined the salient features of the contention repertoire, and having considered the implications of the operation of the repertoire for the clinical psychology profession, Extract 12 provides one example of how several of these features can work together to
mobilise the contention repertoire and render it persuasive.

EXTRACT 12: “The policy notion of dangerous people with severe personality disorder (DSPD) has been debated fiercely since the government announced its existence in October 2000. It has caused offence on two main fronts. First, those mental health workers who routinely accept the broad legitimacy of ‘personality disorder’ have noted that DSPD bears no relationship to their existing clinical discourse. Second, a variety of parties have been angered by the civil liberty implications of preventative detention for people who have committed no offence.” (Clinical Psychology: Pilgrim, 2002, p. 5).

In this extract, contention is firstly constructed in relation to the legally-derived category of “dangerous people with severe personality disorder”. The author constructs this category as a “policy notion” that has been “debated fiercely” since its introduction. The operation of the contention repertoire is this extract could thus be identified as explicit, as was observed in Extracts 1-3 above. The construction of dangerous people with severe personality disorder as a “policy notion” could be read to imply that the concept has limited utility within mental health practice. Consistent with this interpretation, this construction positions the government and mental health practitioners as possessing conflicting and incompatible objectives.

The operation of the contention repertoire is rendered more persuasive by the use of the term “fiercely” when constructing the debate. Indeed, as was observed in Extracts 1-3, the use of this term represents an extreme case formulation in that it functions to work up the extent of the debate. Moreover, the use of the term “fiercely” could be read as evocative in that it evokes images of combat and battle. In keeping with this interpretation, the evocation of such images is consistent with the suggestion that the author is constructing the government and mental health practitioners as pitted against one another.
The contention repertoire is further developed through the construction of the debate as multifaceted. Specifically, the author constructs the debate as pertaining to "two main fronts". The use of the term "main" implies that any number of other fronts are also the subject of debate yet that author has only selected two of these for particular consideration. The construction of "two main fronts" could therefore be seen to render the debate as ubiquitous. The construction of ubiquity could be interpreted as being similar to the construction of the contention as expected and long-standing, as illustrated in Extracts 1 and 2.

In constructing the first main front, the author claims that the category of dangerous people with severe personality disorder "bears no relationship" to "existing clinical discourse". Here, the author could again be seen to be constructing a divide between the objectives of government and the objectives of mental health practitioners. The strength of this front is worked up by the assertion that the debate is evident among those mental health workers who routinely accept the "broad legitimacy" of personality disorder. Indeed, the author constructs the contention as existing even among those who could be regarded as being among the most likely to support the legitimacy of the concept.

Thus, in addition to the construction of contention regarding the category of dangerous people with severe personality disorder, the author also points to contention surrounding the category of "personality disorder" more generally. The author constructs personality disorder as being "broadly legitimate". As was discerned in Extract 2, this could be conceptualised as representing a contrast structure in that some difference is being constructed between the broadly acceptable category of personality disorder and the entirely unacceptable category of dangerous people with severe personality disorder. Moreover, the author's use of inverted commas around the term personality disorder could be seen to further reinforce the contention.

In constructing the second main front, the contention is worked up by contrasting the views of the government with the views of "a variety of parties". Here, the government is
constructed as concerned with “preventative detention” whilst the variety of parties are concerned with “civil liberty implications”. The author’s use of the term “a variety of parties” could be seen to construct the parties as diverse and independent of one another. The implication that the parties are in agreement with regard to the civil liberty issue, in spite of their diversity and independence, further works up the contention. Indeed, as was observed in Extracts 10 and 11, the strength of the contention could be seen to be bolstered by the construction of consensus among a disparate range of individuals.

The use of emotive and evocative language in this extract is also worth noting and could be read to develop the construction of personality disorder as an area of contention by rendering the account as more dramatic and vivid. Specifically, the author’s use of the terms “caused offence” and “angered” accentuate the contention by rendering it as in some way personal to the reader. These terms are both forceful and visceral. Moreover, the author’s reference to civil liberties further evokes the personal by rendering the contention as pertinent to any reader who values the fundamental humanistic principles of justice and equality, the implication being, of course, that the majority of readers would value such principles. Readers are therefore primed to align themselves with the “variety of parties”.

The implications of the operation of the contention repertoire are not necessarily made explicit by the provision of this extract alone. However, when one considers both the title of the article from which the extract was selected: “DSPD: From futility to utility” (p. 5) and the conclusion ultimately offered by the author: “The most powerful group for now, is ruling politicians” (p. 7), it is plausible to suggest that the operation of the contention repertoire serves as a call to action for psychologists to claim professional dominance over the contested category of DSPD. Indeed, the author’s claim that “Somebody has to do it. Why not us [psychologists]?” (p. 7) strengthens this interpretation.

While Extracts 1-11 pointed to the isolated use of specific discursive strategies and rhetorical functions in the operation of the contention repertoire, Extract 12 provided an
opportunity to demonstrate how a selection of these features can work together to construct an account that is rhetorically effective. More specifically, the examination of Extract 12 demonstrated how extreme case formulations, contrast structures, emotive language and the construction of expectedness and consensus are interrelated and collaborate to render the operation of the contention repertoire in the construction of personality disorder as persuasive and credible.

4.2 The ‘complexity’ repertoire

4.2.1 Descriptive overview

The complexity repertoire concerned the construction of personality disorder as a category of ‘thing’ that is in some way severe or complicated. The operation of the complexity repertoire was routinely discerned across the data set and was frequently discerned among the articles where personality disorder was referenced only once or twice.

As was observed with the operation of the contention repertoire, the operation of the complexity repertoire was both explicit and implicit. The explicit operation of this repertoire was observed where authors made specific reference to severity or complexity. References to severity and complexity were typically oriented towards the degree or range of difficulties presumed to comprise the category of personality disorder (Extract 13) or were associated with longevity and resistance to treatment or cure (Extract 14).

EXTRACT 13: “People diagnosed with a personality disorder treated in public mental health services tend to be at the severe end of the spectrum and have complex needs and problems (O’Brien and Flote, 1997).” (Clinical Psychology: Flynn & Batholomew, 2003, p. 17).

EXTRACT 14: “Long-term work is both necessary and effective for patients with long-standing, complex, apparently intractable problems diagnosed as ‘borderline personality’.” (Clinical Psychology: Mitchell & Brownescombe
Where specific reference to severity or complexity was absent, the complexity repertoire was more obliquely discernable. In these instances, the implicit operation of the repertoire was discerned as functioning through one of two main constructions. In the first, it was discerned where the category of personality disorder was constructed as grounds for exclusion from some activity. In the main, this activity consisted of either participation in research studies (Extracts 15-17), access to mental health services generally (Extracts 18-20) or access to psychology services specifically (Extracts 21 and 22).

EXTRACT 15: "Many evaluations of other approaches, such as cognitive-behaviour therapy, are conducted on patients who form a diagnostically homogeneous group, and patients with more than one diagnosis or diagnosed with personality disorders are routinely excluded." (Clinical Psychology: Mitchell & Brownescombe Heller, 1999, p. 36).

EXTRACT 16: "Participants who were suicidal or had borderline personality disorder were excluded due to ethical concerns." (British Journal of Clinical Psychology: Sturman & Mongrain, 2005, p. 509).

EXTRACT 17: "Potential participants in this group were included only if they did not have a serious history of drug or alcohol abuse, and did not have a diagnosis of personality disorder." (British Journal of Clinical Psychology: Kinderman et al., 2003, p. 4).

In Extract 15, patients "diagnosed with personality disorders" are juxtaposed with "patients with more than one diagnosis" and both are constructed as "routinely excluded" from evaluation studies. Similarly, in Extracts 16 and 17 the diagnostic categories of "borderline personality disorder" and "personality disorder" respectively are constructed
as criteria for exclusion from the studies described in the articles. These categories are juxtaposed with "participants who were suicidal" (Extract 16) and participants with "a serious history of drug or alcohol abuse" (Extract 17).

EXTRACT 18: "Suggestions to exclude people attributed with PD [personality disorder] from using mental health services have followed, based on the intractability of their problems and the need to ration scarce resources such as hospital beds (Ooi, 1997)." (Clinical Psychology: Webb, 2005, p. 3).

EXTRACT 19: "the desire to justify keeping out of hospital people whom the staff find difficult, on the grounds that they are 'personality disordered' rather than 'mentally ill' (Castillo, 2000)." (Clinical Psychology: Johnstone, 2001, p. 28).

EXTRACT 20: "We [clinical psychologists] often see the gaps that need filling and often end up filling the gaps and therefore overworking. We often end up conducting consumer surveys, seeing the people with diagnoses of personality disorder, and doing staff training on what we would see as relevant topics." (Clinical Psychology: Brown et al., 1999, p. 10).

In Extracts 18 and 19, the category of personality disorder is constructed as the basis for exclusion from "using mental health services" (Extract 18) and for "keeping out of hospital" (Extract 19). In each of these extracts, the reasons offered for the exclusion can be seen to draw upon the complexity repertoire. Specifically, individuals with a diagnosis of personality disorder are excluded due to the "intractability of their problems" (Extract 18) or are excluded on the basis that the category of personality disorder comprises "people whom staff find difficult" (Extract 19).

Extract 20 constructs the category of personality disorder as comprising one of three "gaps that need filling". The authors' claim that filling these gaps can lead to overwork
could be seen to imply that the gaps equate to work roles that are not part of standard practice and are roles which other mental health professionals are reluctant to assume. While the authors do not provide a reason for the existence of the gaps, it is plausible to suggest that the “seeing the people with diagnoses of personality disorder” gap exists as a consequence of the condition’s severity or complexity.

EXTRACT 21: “Due to the limitations of the psychology service offered to service users within Trafford, a diagnosis of personality disorder does not meet the current criteria of those eligible for psychological intervention.” (Clinical Psychology: Flynn & Bartholomew, 2003, p. 18).

EXTRACT 22: “Many group therapists would advocate no more than one diagnosed borderline [personality disorder] patient per group.” (Clinical Psychology: Dickerson et al., 2000, p. 32).

In Extract 21, a “diagnosis of personality disorder” is constructed as ineligible for “psychological intervention”. The authors do not offer an explanation for this ineligibility save for describing the psychology service as having “limitations”. Thus whether such limitations are understood to be cognitive or material is not considered. In Extract 22, some form of severity or complexity is being constructed by the authors’ claim that therapeutic groups should comprise “no more than one diagnosed borderline patient”. Indeed, the authors subsequently go on to construct the “borderline patient” as having “suffered extreme deprivation, neglect and abuse” (p. 32).

The second construction through which the implicit operation of the complexity repertoire was discerned comprised the construction of personality disorder as either requiring new healthcare services over and above the services presently available (Extracts 23 and 24) or as an area requiring additional or ‘expert’ consultancy and support (Extracts 25 and 26).
EXTRACT 23: “Managers’ agendas include improving in-patient services, reducing suicides and developing services for people with personality disorders.” (Clinical Psychology: Kennedy et al., 2003 p. 22).

EXTRACT 24: “In addition, there is an increasing demand for effective services for people with personality disorders and those who misuse substances. There are no established medical models that can ‘cure’ people in these categories.” (Clinical Psychology: Frankish, 1999, p. 30).

In Extract 23, the development of “services for people with personality disorders” is constructed as one of three priorities for management. This could be read to imply that personality disorder services are currently non-existent or that present service provision is in some way inadequate. In Extract 24, personality disorder services are presumably presently available but are constructed as ineffective and in need of attention and improvement.

EXTRACT 25: “They [psychiatrists] have needs for consultancy and advice around, for example, risk carrying, personality disorders, psychoneurological assessment and psychological treatment provision.” (Clinical Psychology: Kennedy et al., 2003, p. 22).

EXTRACT 26: “Personality disorder is a very broad field so for people to have expertise in personality disorder would be quite some exceptional person.” (Clinical Psychology: Webb, 2005, p. 4).

In Extract 25, personality disorder is constructed as one of a list of areas in which psychiatrists require “consultancy and advice” on. In Extract 26, personality disorder is constructed as a “very broad field”, thereby implying some sort of complexity. The complexity is further worked up by the assertion that it would require “quite some exceptional person” to be knowledgeable about the area.
4.22 Salient features

In each of the data extracts provided above, the explicit (Extracts 13 and 14) and implicit (Extracts 15-26) operation of the complexity repertoire was rendered more persuasive through the use of a range of discursive strategies, which in turn, served a variety of rhetorical functions. The most salient and consistently discerned features are summarised below.

The use of the three part list (Jefferson, 1990) can be discerned in Extract 14. Three part lists are used to summarise some general class of things and typically function to bolster an account through presenting a position beyond the listed individual examples. In this instance, personality disorder is constructed as “long-standing”, “complex” and “apparently intractable”, the implication here being that this list of severe and complicating features could continue beyond the three examples provided.

The juxtaposition of the category of personality disorder with other presumably severe or complex categories of psychopathology was frequently discerned. In Extract 15, patients diagnosed with personality disorders are juxtaposed with “patients with more than one diagnosis”. One function of this juxtaposition could be to infer that a diagnosis of personality disorder is as severe or complex as having multiple psychiatric diagnoses. Similarly, in Extracts 16 and 17, the category of personality disorder is juxtaposed with “participants who were suicidal” and “a serious history of drug or alcohol abuse” respectively thereby rendering the categories as in some way equivalent. Some form of equivalence is also constructed where personality disorder is constructed as requiring new healthcare services. In these instances, the category of personality disorder is juxtaposed with “in-patient services” and “reducing suicides” (Extract 23) and “those who misuse substances” (Extract 24).

In addition to the construction of equivalence, the use of a contrast structure can also be discerned in Extract 15. In this extract, the authors construct patients diagnosed with personality disorders and patients diagnosed with more than one condition as in some
The use of systematic vagueness was routinely observed where personality disorder was constructed as grounds for exclusion from some activity. In these instances, systematic vagueness could be seen to render the exclusion of individuals with personality disorder as in some way expected or standard. For example, in Extracts 15, 17, 20 and 22, the authors fail to justify the reasons for the exclusion. This omission could be seen to render the exclusion as standard practice and indeed necessary. Where reasons for exclusion are provided, these are sufficiently vague. For example, reasons for exclusion included "due to ethical concerns" (Extract 16), "the intractability of their problems" (Extract 18), "people whom the staff find difficult" (Extract 19) and "limitations of the psychology service" (Extract 21). Each of these reasons could be seen to convey just enough material to sustain the application of the exclusion criteria without providing detail that could leave the exclusion of individuals with personality disorder vulnerable to challenge.

The construction of personality disorder as grounds for exclusion is further rendered as expected or standard through the use of isolated temporal qualifying terms. In Extract 15, patients with personality disorders are constructed as "routinely" excluded and in Extract 20, the use of the term "often" can be seen to work up the extent of the exclusion. Similarly, in Extract 13, the use of the phrase "tend to be" could be seen to render expected the severity and complexity of the problems experienced by people diagnosed with personality disorder. In considering the use of these terms, it is plausible to suggest that they could be conceptualised as representing stake inoculations (Potter, 1996). Stake inoculations typically serve to head off or minimise the imputation of stake or interest on the part of the author. In these instances, therefore, the use of these terms could be seen to function to divert any accusations of bias in relation to applying absolutes and therefore failing to acknowledge variability in action (Extracts 15 and 20) and
The construction of consensus can be discerned in Extracts 15 and 22. The use of the phrases “many evaluations” (Extract 15) and “many group therapists” (Extract 22) constructs consensus among researchers and group therapists respectively. The reader, who presumably identifies as either a researcher or therapist or both, is thereby primed to concur with the majority. The construction of consensus is also discerned in Extract 20 through the use of the collective pronoun “we”. The use of the term “we” in this extract could also be read to be colloquial and inviting, thereby rendering readers as more likely to position themselves alongside the “we”.

It is also worth noting that in Extract 20 the use of the terms “often” and “we” are frequently repeated. This technique could be seen to represent an anaphora which is a discursive strategy characteristically employed in poetry, where repetition of key words or phrases is seen as giving dramatic emphasis to the point being made (Gray, 2004).

The operation of the complexity repertoire is rendered more persuasive through the construction of authority and expertise. For example, “managers” (Extract 23) and “psychiatrists” (Extract 25) are constructed as requiring assistance in relation to the development and provision of services for individuals diagnosed with personality disorder. Management and psychiatry are routinely regarded as holding the power and ‘expertise’ within mental health service development and provision (Rogers & Pilgrim, 2005). The claim that even they require some form of support could therefore be seen to construct the area of personality disorder as severe and complex.

Reference to the views of managers and psychiatrists could be seen to represent examples of footing (Goffman, 1981) which refers to the range of relationships that an author may have with a description. In these instances, the authors can be seen to be the animators of someone else’s words (Wetherell, 2005a), namely the words of managers and psychiatrists. By citing the views of managers and psychiatrists, the authors are able to
distance themselves from the description or claim thereby rendering the operation of the complexity repertoire as impartial and therefore more persuasive.

4.23 Implications

Throughout the data set, the operation of the complexity repertoire, whether explicitly or implicitly, provides the clinical psychology profession with the capacity to either reject or accept the category of personality disorder as an area worthy of psychological consideration and investigation. The suggestion that the operation of this repertoire renders either of these positions possible could be read as being somewhat paradoxical. However, this apparent inconsistency is not necessarily surprising when one considers Edwards’ (1991) assertion that the categorisation of an object is frequently organised in a way that renders it adaptable to the situated requirements of the description. Thus, depending on the context within which the complexity repertoire operates, the category of personality disorder can be rendered as either irrelevant or relevant to the profession.

Where the operation of the complexity repertoire renders the category of personality disorder as irrelevant, this allows the clinical psychology profession to absolve itself from any form of responsibility in relation to the understanding and management of personality disorder. In terms of research activity, the rejection of the category of personality disorder can be seen to reflect an empiricist positivist scientific discourse that views complexity and heterogeneity as confounding variables that obstruct a ‘true’ and ‘pure’ result. In terms of clinical practice, the rejection of the category of personality disorder on the grounds of complexity can be seen to enable the clinical psychology profession to non-problematically maintain its touted position as being able to provide evidence-based interventions that reduce psychological distress and enhance psychological well-being (British Psychological Society, 2001). Moreover, this can be seen to reflect the purportedly out-dated psychiatric practice of rejecting individuals with a diagnosis of personality disorder on the grounds that they are untreatable (National Institute for Mental Health in England, 2003).
Where the operation of the complexity repertoire renders the category of personality disorder as relevant, this allows the clinical psychology profession to position itself as being particularly well-suited to the understanding and management of personality disorder. In these instances, the operation of the complexity repertoire could be viewed as serving a similar function to the contention repertoire in that it provides the profession with an area of enquiry that it can claim 'expertise' in. Indeed, the equivocation demonstrated by psychiatry could be seen to provide the clinical psychology profession with a unique opportunity to lead in the area. Consistent with this assertion, the British Psychological Society (2006) advocates that clinical (and forensic) psychologists should assume the roles of clinical leaders in relation to the understanding and clinical management of personality disorder.

Moreover, the construction of complexity can be seen to be compatible with the practice of psychological formulation. Formulation is heralded as an activity that is unique to psychology (Kinderman, 2001; Marzillier & Hall, 1999) and is identified as one of the four core features of modern clinical psychology practice (British Psychological Society, 2001). Formulation involves the summation and integration of information obtained during an assessment process and is purported to be able to accommodate and connect a multiplicity of factors (British Psychological Society, 2001). The operation of the complexity repertoire could thus be seen to be compatible with the notion of formulation in that it constructs the category of personality disorder as comprising multiple factors.

Although arguments have been advanced for the abolition of the psychiatric practice of diagnosis in favour of the psychological practice of formulation, where the category of personality disorder is concerned, formulation is typically posited as being able to complement, and augment, the practice of diagnosis rather than usurp it entirely (Aveline, 1999; British Psychological Society, 2006). Thus, in contrast to the operation of the contention repertoire, which serves to position a psychological framework of understanding personality disorder as more legitimate than either a psychiatric or legal framework, the operation of the complexity repertoire could be seen to render the clinical
psychology profession as capable of working collaboratively alongside psychiatry. The implication that the clinical psychology profession can, at once, be in competition with and in collaboration with psychiatry is consistent with assertions that the profession remains uncertain about its position in relation to psychiatry (Diamond, 2002; Pilgrim, 1997).

4.24 Extended extract

Having outlined the salient features of the complexity repertoire, and having considered the implications of the repertoire for the clinical psychology profession, Extract 27 provides one example of how several of the features can work together to mobilise the complexity repertoire and render it persuasive.

EXTRACT 27: “Moreover, approximately a quarter of people with AN [anorexia nervosa] fulfil the criteria for avoidant personality disorder (Diaz-Marsa et al., 2000; Grilo, Levy, Becker Edell, & McGlashan, 1996; Skodol et al., 1993). From early adulthood, people with avoidant personality disorder exhibit a pattern of pervasive behavioural, emotional and cognitive avoidance. In particular, they pull away from intimacy and close interpersonal relationships. These difficulties pre-date the onset of the disorder [anorexia nervosa] which suggests that avoidant personality disorder traits may be a risk factor as well as contributing to the maintenance of the disorder (Troop, Holbrey, & Treasure, 1998; Troop & Treasure, 1997). These avoidant traits also persist after recovery. In a recent study (Holliday, personal communication), some of the pro-anorectic beliefs were found to be associated with particular personality traits characteristic of people with an avoidant personality disorder; namely, restricted emotional expression, intimacy and identity problems.” (British Journal of Clinical Psychology: Schmidt & Treasure, 2006, p. 350).

In this extract, references to severity and complexity are oriented towards both the range
of difficulties presumed to comprise the category of avoidant personality disorder and the longevity and resistance to treatment of the condition. More specifically, the operation of the complexity repertoire can be discerned where the authors construct the category of avoidant personality disorder as "pervasive", as evident since "early adulthood" and as having traits that "persist after recovery". The operation of the complexity repertoire could thus be identified as explicit, as was illustrated in Extracts 13 and 14.

The juxtaposition of personality disorder with anorexia nervosa could be seen to construct some sort of equivalence between the two categories. Indeed, both categories of disorder are constructed as sharing a number of features. However, as was observed in Extract 15, the two categories are also contrasted with one another and it is the use of the contrast structure that serves to work up the complexity. In particular, anorexia nervosa is constructed as transient and amendable to recovery, while avoidant personality disorder is constructed as "pervasive" and as having traits that "pre-date" anorexia nervosa and that "persist after recovery" from anorexia nervosa.

The description of the characteristics that comprise the category of avoidant personality disorder could be seen to represent an example of systematic vagueness. For example, "a pattern of pervasive behavioural, emotional and cognitive avoidance" conveys just enough information about the condition without providing detail that could leave it vulnerable to challenge. Moreover, where the authors offer more detail in relation to the characteristics of the condition (i.e., "pull away from intimacy and close personal relationships") this too could be seen as an example of systematic vagueness. Intriguingly, the use of systematic vagueness in these instances could be seen to reflect the ambiguous diagnostic criteria outlined in the DSM-IV classification of avoidant personality disorder.

As was observed in Extracts 15, 17, 20 and 22, the use of systematic vagueness could also be seen to construct complexity as in some way expected or standard. The limited detail provided when constructing the features and characteristics of the category of
avoidant personality disorder could be read as implying that the reader is already familiar and cognisant with the category or that the category has a self-evident validity, thereby rendering the provision of detail as unnecessary.

Two instances of the use of the three part list can be discerned in this extract. In the first instance, the authors construct the category of avoidant personality disorder as “a pattern of pervasive behavioural, emotional and cognitive avoidance”. In the second instance, the authors construct the condition as characterised by “restricted emotional expression, intimacy and identity problems”. In both of these instances, as was observed in Extract 14, the use of the three part list functions to work up the complexity by implying that the list of features or characteristics could continue beyond the items listed.

In considering the use of the terms “approximately”, “suggests” and “may have”, it is plausible to suggest that these terms could be conceptualised as representing stake inoculations, as was discerned in Extracts 13, 15 and 20. In this extract, the use of these terms functions to divert any accusations of bias away from the authors, thereby protecting them against the charge of failing to acknowledge variability in the empirical research studies that are being referred to. Moreover, the provision of multiple references to empirical research could also be seen to serve a similar function, although it is recognised that this practice is consistent with the usual conventions for contributing to scientific journals.

In terms of implications, the authors construct the category of avoidant personality disorder as an area worthy of psychological consideration when working with individuals with anorexia nervosa. Indeed, the authors construct the category of avoidant personality disorder as having a dual influence on anorexia nervosa in that it is constructed both as a “risk factor” and as “contributing to the maintenance of the disorder”. The adoption of this position could be seen to be consistent with the location of personality disorder on Axis II of the DSM-IV which implies that while categories of personality disorders may not necessarily be amenable to treatment per se, they nonetheless demand consideration
when working with other categories of psychopathology.

While Extracts 13-26 pointed to the isolated use of specific discursive strategies and rhetorical functions in the operation of the complexity repertoire, an examination of Extract 27 demonstrated how the strategies of juxtaposition, contrast structures, systematic vagueness, three part lists, stake inoculation and the construction of expectedness or familiarity can work together to render the operation of the complexity repertoire in the construction of personality disorder as persuasive and credible.

4.3 The ‘toxicity’ repertoire

4.3.1 Descriptive overview
The toxicity repertoire concerned the construction of personality disorder as a category of ‘thing’ that is in some way harmful. The operation of the toxicity repertoire was routinely discerned across the data set. Indeed, of the three interpretative repertoires identified, the toxicity repertoire was the most frequently discerned among the texts considered.

Across the data set, the operation of the toxicity repertoire was discerned as functioning through one of two constructions. In the first, the category of personality disorder was constructed as in some way detrimental to the individual diagnosed with personality disorder. More specifically, the operation of the toxicity repertoire was discerned where the category of personality disorder was constructed as being associated with poor therapeutic outcome or prognosis, (Extracts 28 and 29), with risk of harm to self (Extracts 29-31) or with the occurrence of other categories of psychopathology (Extracts 29 and 31).

EXTRACT 28: “outcome in bereavement therapy was worse for patients with severe personality disorders, and also for those whose loss was their mother, who had high levels of self-blame, or who were judged to have high levels of guilt and hostility.” (British Journal of Clinical Psychology: Llewelyn & Hardy, 2001, p. 9).
EXTRACT 29: “People with BPD [borderline personality disorder] have high rates of morbidity and mortality. They tend to improve with time, though this may take 10 to 20 years (McGlashan, 1986; Paris, 1993). However, nearly 10 per cent complete suicide (Paris, 1993). Of those who improve, their recovery is probably incomplete.” (Clinical Psychology: Bell, 2002, p. 10).

EXTRACT 30: “As much as 75% of those who meet criteria for this disorder [borderline personality disorder] report at least one incident of parasuicide (Gardner & Cowdry, 1985) and many report multiple incidents (Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994).” (British Journal of Clinical Psychology: Startup et al., 2001, p. 115).

EXTRACT 31: “People with these difficulties are at increased risk of several other mental health problems, including depression and anxiety, suicide and parasuicide, and misuse and dependence on alcohol and other drugs (Kendall, 2002).” (Clinical Psychology: Flynn & Bartholomew, 2003, p. 17).

Extracts 28-31 above illustrate the variety of associations frequently equated with the category of personality disorder. These associations are constructed as ‘existing’ in addition to a diagnosis of personality disorder and can be read as being in some way undesirable. Indeed, when considered en masse, these associations could be seen to construct a toxic, if not lethal, circumstance for the individual diagnosed with personality disorder.

The second construction through which the operation of the toxicity repertoire was discerned concerned the construction of personality disorder as in some way harmful, or at best challenging, to the healthcare professionals (Extracts 32-36) or services (Extracts 36 and 37) that come into contact with individuals diagnosed with personality disorder.

EXTRACT 32: “O’Brien and Flote (1997) clearly state that caring for people
with personality disorder has been related to tension, exhaustion, burnout and high staff turnover.” (Clinical Psychology: Flynn & Bartholomew, 2003, p. 17).

EXTRACT 33: “As group facilitators we were at times overwhelmed by the enormity of the destructive forces in these people’s lives, and felt frustration and hopelessness about our ability to affect any change. At times we experienced a strong urge to counteract these feelings by blaming the clients for not wanting or not being ready to change.” (Clinical Psychology: Messari & Crocker, 2000, p. 19).

EXTRACT 34: “Several respondents mentioned that the difficulties which staff experienced meant that specialist support and supervision was a priority in containing the patients within the service and mitigating the damaging effects on staff morale.” (Clinical Psychology: Leiper, 2000, p. 16-17).

EXTRACT 35: “Group leaders were alternatively criticised, attacked, ignored or idealized, as were subsets of the group. It was an intense struggle for the leaders to provide containment via the course structure to prevent the group experience from being overwhelming, without themselves being perceived as over-controlling, abusive and unhearing.” (Clinical Psychology: Dickerson et al., 2000, p. 31).

In Extract 32, “caring for people with personality disorder” is constructed as being associated with “tension, exhaustion, burnout and high staff turnover”. In Extract 33, personality disorder is constructed as being associated with overwhelming “destructive forces” that can result in “frustration and hopelessness”. However, despite the construction of these challenges, or indeed because of them, healthcare professionals and group facilitators respectively are constructed as “caring” (Extract 32) and attempting to “affect any change” (Extract 33).
In Extract 34, "specialist support and supervision" are constructed as necessary in order that the "damaging effects on staff morale" be mitigated. In Extract 35, the authors construct the group leaders as having been "criticised, attacked, ignored or idealized" whilst engaged in "an intense struggle" to "provide containment". The actions of individuals with personality disorder are thus constructed as impeding the therapeutic process.

EXTRACT 36: “This is important since staff’s responses are said to be extreme and intense to patients with a diagnosis of BPD [borderline personality disorder], and such responses can disrupt care systems and ultimately be detrimental to the well-being of both patients and staff.” (British Journal of Clinical Psychology: Markham & Trower, 2003, p. 246).

EXTRACT 37: “Patients diagnosed with severe personality disorders in particular, tend to establish excessive and inappropriate dependence on clinical services, without any noticeable improvement taking place (Chiesa et al., 1996).” (Clinical Psychology: Mitchell & Bownescombe Heller, 1999, p. 38).

In Extract 36, “patients with a diagnosis of BPD” are constructed as eliciting “extreme and intense” responses in staff. These responses are thus constructed as disruptive to “care systems” and the “well-being of both patients and staff”. In this extract, therefore, patients with a diagnosis of BPD could be seen to be constructed as fuelling a cycle of exacerbation that is harmful to all concerned.

In Extract 37, “patients diagnosed with severe personality disorders” are constructed as high consumers of “clinical services”. This consumption is constructed as “excessive and inappropriate” thereby rendering it as harmful or unwelcome in some way. Indeed, the authors refer to the level of consumption as a “dependence” and construct it as occurring despite any “noticeable improvement taking place”.

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In each of the data extracts provided above, the operation of the toxicity repertoire was rendered more persuasive through the use of a range of discursive strategies, which in turn, served a variety of rhetorical functions. The most prominent and frequently discerned features of the toxicity repertoire are summarised below.

The combined use of quantification rhetoric (Potter et al., 1991) and systematic vagueness can be discerned in Extracts 29 and 30. In Extract 29, quantitative rhetoric is used to work up the association between people with BPD, improvement over time and suicide. The author uses both absolute (i.e., “10 to 20 years”) and relational (i.e., “10 per cent”) numerical quantities to construct these associations. The provision of numeric formulations in this extract could be seen to render the account as more precise and scientific thereby lending credibility to the construction of the associations. The precision of the numeric formulations could be seen to be somewhat muted, or rendered as systematically vague and therefore resistant to challenge, by the provision of a range of years (i.e., ‘from between’ 10 to 20 years) and the prefixing of 10 per cent with the term “nearly”. However, it is plausible to suggest that the presentation of numeric formulations overshadows these qualifiers. Indeed, when one considers the extract at a glance, it is the numeric formulations that stand out, thereby working up the extent of the toxicity.

In Extract 30, quantification rhetoric is used to work up the association between borderline personality disorder and parasuicide. In this extract, there is variability in the ways in which the quantities are visually presented. To begin with, a numerical, relational quantity (i.e., “75%”) is used. This is followed by the alphabetical presentation of an absolute quantity (i.e., “one incident”) and then the alphabetical presentation of a vague, unspecified quantity (i.e., “multiple incidents”). It is reasonable to suggest that the variety in presentation renders the information presented in figures more visible so that it stands out. Moreover, the vagueness inherent in the term “multiple incidents” could be seen to convey just enough material to sustain the association without providing
descriptive claims that can open it to undermining.

Extracts 29 and 30 also make use of extreme case formulations to render the operation of the toxicity repertoire more persuasive. In Extract 29, the author associates borderline personality disorder with “high” rates of morbidity and mortality. In Extract 30, the use of extreme case formulations is discerned irrespective of whether quantities are presented numerically (i.e., “as much” as 75%) or alphabetically (i.e., “at least” one incident and “many” report multiple incidents).

The use of extreme case formulations can also be discerned in Extracts 28 and 37. In each of these extracts, the diagnostic category of personality disorder is prefixed by the term “severe”. The category of severe personality disorder does not formally correspond to either a psychiatric or legally-derived category but could be read as consistent with a dimensional representation of personality disorder as advocated by a psychological framework of understanding. In any case, the use of the term “severe” could be seen to work up the construction of toxicity. For example, in Extract 28, severe personality disorder is juxtaposed with “high” levels of other presumably negative characteristics, and in Extract 37, “severe personality disorder” is constructed as associated with “excessive” and “inappropriate” dependency on services.

Extreme case formulations can also be discerned in Extracts 33, 35 and 36. In Extract 33, the authors refer to the “enormity” of destructive forces and construct the urges as “strong”. In Extract 35, the struggle experienced by the group facilitators is constructed as “intense”. In Extract 36, staff feelings are constructed as “intense and extreme”. In each of these instances, the use of extreme case formulations to construct the strength of the negative reactions of professionals to individuals with personality disorder renders the operation of the toxicity repertoire more persuasive.

The construction of toxicity is also rendered as in some way expected or even necessary. For example, in Extract 32, the use of the term “clearly” could be read to imply that the
ensuing statement is a ‘fact’ that is well recognised and unequivocal. In Extract 33, the narrative organisation of the account could be seen to render the “frustration and hopelessness” as expected given the “enormity of the destructive forces”. Similarly, in Extract 36, the narrative organisation of the account constructs staff responses as leading to the disruption of care systems and “ultimately” to the well-being of both patients and staff.

Arguably, the use of emotive or evocative language is the most salient of the discursive strategies used to develop the toxicity repertoire. Indeed, emotive or evocative language can be discerned in the majority of the extracts provided in this sub-section. Most notable of these, are the extracts pertaining to the purportedly harmful effects of personality disorder on healthcare staff and services (Extracts 32-37). For example, the phrases “tension, exhaustion, burnout and high staff turnover” (Extract 32), “frustration and hopelessness” (Extract 33), “damaging effects on staff morale” (Extract 34), “intense struggle” (Extract 35), “detrimental to the well-being” (Extract 36) and “excessive and inappropriate dependence” (Extract 37) are dramatic and unequivocal in their evocation of risk of harm to others.

4.33 Implications

Throughout the data set, the operation of the toxicity repertoire constructs the category of personality disorder as an object of enquiry that is harmful and therefore must either be controlled or protected against in some way. Notions of control are typically evoked where the category of personality disorder is associated with harm to the individual diagnosed with personality disorder. In these instances, the profession of clinical psychology is positioned as having a duty in relation to promoting harm reduction by providing the individual with some means of control over the toxic aspects of their condition. Notions of protection are typically evoked where the category of personality disorder is associated with harm to others. In these instances, the profession of clinical psychology is positioned as having a responsibility towards protecting or defending itself, and the service within which it operates, from harm.
When considered within the broader socio-political context, the evocation of control and protection can be seen to resonate with the notions of clinical and ethical responsibility. Indeed, in an era of quality (National Health Service Executive, 1998), accountability and evidence-based practice (National Health Service Executive, 1996), notions of clinical and ethical responsibility are becoming increasingly familiar rhetoric for practitioners working within the NHS.

While control and protection can be seen to be necessary means for ensuring that the clinical and ethical responsibilities of the clinical psychology profession are upheld, they can also be seen to be intimately bound up with a moral discourse that is concerned with what is (and thereby what is not) deemed to be acceptable forms of conduct. The role of the clinical psychology profession in the provision of control and protection thus implicates the profession in maintaining, and thereby endorsing, culturally- and politically-sanctioned forms of social and moral order. Indeed, it has been argued previously that the clinical psychology profession was founded upon, and continues to be benefit from, the propagation of the prevailing moral and social agendas (Michie, 1981; Pilgrim & Treacher, 1992).

4.34 Extended extract
Having outlined the most salient features of the toxicity repertoire, and having considered the implications of the repertoire for the clinical psychology profession, Extract 38 provides one example of how several of the features can work together to mobilise the toxicity repertoire and render it persuasive.

EXTRACT 38: “over-general recall may have for some borderline [personality disorder] patients at least, an adaptive function acting to protect the individual from the build-up of the kinds of thoughts, memories, and feelings that spiral to cause self-harm. This would seem to be consistent with the common clinical experience that re-exposure of borderline individuals to the specific details of their traumatic experiences often leads to extreme
escalations of parasuicidal behaviour if those individuals have not previously learned means of controlling parasuicidal urges (Linehan, 1993).” (British Journal of Clinical Psychology: Startup et al., 2001, p. 117).

In Extract 38, the operation of the toxicity repertoire can be discerned where the category of borderline personality disorder is constructed as associated with risk of harm to self. More specifically, borderline patients are constructed as associated with “self-harm”, “parasuicidal behaviour” and “parasuicidal urges”. The authors construct these associations as requiring some form of protection or control, thereby rendering them as harmful to the individual.

The use of emotive or evocative language can be discerned throughout this extract and can be seen to work up the toxicity by implying some sort of volatility or unpredictability in terms of presentation. In particular, the authors’ use of the terms “build-up”, “spiral”, “extreme escalations” and “urges” could be seen evoke a sense of being out-of-control, thereby rendering individuals with borderline personality disorder as in some way harmful to themselves (if not protected and controlled).

The use of these terms could also be seen to evoke a sense of inevitability in relation to self-harming and parasuicide behaviours. The construction of inevitability could be conceptualised as serving a similar function to the construction of expectedness. Consistent with this interpretation, and as was observed in Extracts 33 and 36, the construction of toxicity is rendered as in some way expected or even necessary through the use of narrative organisation. For example, the authors construct the “spiral” into self-harm as being in some way inevitable given the “build-up” of thoughts, memories, and feelings.

The construction of expectedness can also be discerned where the authors refer to the “common” clinical experience that “often leads” to parasuicide behaviours. Moreover, the evocation of consistency could also be seen to render the construction of toxicity as
expected or standard. Indeed, the evocation of commonality and consistency could be seen to imply that the reader is familiar with the toxicity of the condition.

Similarly, the use of systematic vagueness in this extract could be seen to assume that the reader is familiar with the concepts and experiences being constructed and that these have a self-evident validity. In particular, systematic vagueness can be discerned where the authors refer to the “kinds of thoughts, memories, and feelings”, thereby rendering the construction as impervious to undermining.

The use of an extreme case formulation can be discerned where the authors construct escalations in parasuicidal behaviour as “extreme”. The use of this term here can be seen to function to exaggerate the toxicity of the category of borderline personality disorder by rendering it as in some way extra-ordinary and as existing outside of ‘normal’ experiences.

In terms of implications, this extract can be seen to render individuals with personality disorder as in need of some form of control or protection from the toxic aspects of the condition. The provision of a reference to work published by “Linehan, 1993” could be read to suggest that clinical psychologists are positioned as being able to offer the individual a means of control.

While Extracts 28-37 pointed to the isolated use of specific discursive strategies and rhetorical functions in the operation of the toxicity repertoire, Extract 38 provided an opportunity to demonstrate how the use of emotive language, systematic vagueness, extreme case formulations and the construction of expectedness or familiarity can work together to render the operation of the toxicity repertoire in the construction of personality disorder as persuasive.

4.4 Collective consideration

While the three main interpretative repertoires identified were presented individually to
aid reader comprehension, this should not be read as suggesting that the repertoires are mutually exclusive of one another. Rather, the contention, complexity and toxicity repertoires can be seen as actively working together to construct the category of personality disorder. Extract 39 is thus provided as one example of how all three repertoires can operate together within the same text. This extract is provided to illustrate the collaborative operation of the repertoires only, as the length of this report precludes a more through examination in terms of discursive strategies and rhetorical functions.

EXTRACT 39: “However, a much wider group of severely distressed and disturbed people exist who pose little danger but where there appears to be a growing psychiatric view that health service intervention of any kind is not warranted and should be withdrawn (Cawathra and Gibb, 1998). This group seems to produce confusion and polarization of views about a suitable clinical response and an appropriate service design, with opinions veering between legalistic control, moralistic rejection and anxiety-laden efforts to help and protect.” (Clinical Psychology: Leiper, 2000, p. 13).

In Extract 39, the operation of the contention repertoire can be discerned where reference is made to “a growing psychiatric view”. The use of this phrase implies that other, alternative views are also available, albeit less dominant and accessible. The construction of contention is also discerned where the author constructs a “confusion and polarization of views”, thereby implying some form of controversy in relation to the clinical management of personality disorder. The operation of the complexity repertoire can be discerned where the author constructs individuals with personality disorder as “severely distressed and disturbed people”. The use of this phrase implies some form of severity and complexity in terms of clinical presentation. The operation of the toxicity repertoire can be discerned where the author constructs individuals with personality disorder as causing difficulties both in terms of “clinical response” and “service design” and as eliciting certain reactions and behavioural responses among healthcare professionals including efforts to “help and protect”.

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Thus, whether operating in isolation or together, the readings of the texts suggested that contention, complexity and toxicity repertoires are routinely drawn upon by the clinical psychology profession in the construction of personality disorder in the texts.

5 CONCLUSION

5.1 Constructing order

The application of a social constructionist epistemology to the study of personality disorder assumes that the category of personality disorder is socially constructed and that its construction sustains some patterns of social action and excludes others (Burr, 2003). Based on an analytic engagement with 78 articles selected from the British Journal of Clinical Psychology and Clinical Psychology, the analysis presented in this account identified three main interpretative repertoires that are routinely drawn upon in the construction of personality disorder in the texts. These repertoires were identified as the contention repertoire, the complexity repertoire and the toxicity repertoire.

The construction of personality disorder by the clinical psychology profession was made explicit through the identification of a variety of discursive strategies and rhetorical functions. The use of these strategies in rendering an account as persuasive is not unique to the construction of personality disorder and will be familiar to theorists and researchers working within a linguistic or discursive academic framework. However, more significantly, the identification of these strategies points to the construction of personality disorder as an active, ongoing linguistic activity and hence as a dynamic process rather than as a more-or-less stable structure. Indeed, the category of personality disorder is constructed into 'existence' and does not reflect some underlying ontological 'reality', as assumed by a positivist epistemology.

An exploration of the implications of these repertoires for the clinical psychology profession suggests that their operation is less a function of the category of personality disorder per se and more a function of the material and ideal interests of the clinical psychology profession. To this end, and in an attempt to bring some semblance of order
and cohesion to this account, the construction of personality disorder, as discerned in the texts considered, can be conceptualised as representing the ‘serviceable other’ (Morrison, 1992).

The notion of the serviceable other was first advanced by Morrison (1992) in an examination of how White authors construct African Americans. Morrison asserts that White authors construct African Americans as the type of person required for Whites to have the identity they wish for themselves. Sampson (1993) makes a similar claim regarding the positioning of women, gay men and lesbians and members of the third world, all of whom he constructs as having become serviceable to the dominant groups’ interests, fears and desires. In *Orientalism*, a wide-ranging, ambitious and influential work by Edward Said (1985), it is argued that the very notion of the ‘Orient’ is constructed by the West in a manner that serves to buttress a sense of the West’s superiority.

In the context of the present analysis, therefore, the construction of personality disorder as the serviceable other can be seen to serve the situated interests, fears and desires of the clinical psychology profession at a particular point in time. Conceptualised in this way, the construction of personality disorder by the clinical psychology profession can be seen to reveal more about the profession than about personality disorder per se.

Reflexive Box 8: Rhetorical functions of providing a conceptual framework
The provision of a conceptual framework through which the construction of personality disorder can be understood could be construed as being somewhat problematic in the context of a discourse analytic research report. Indeed, the provision of such a framework can itself be seen to be a social construction that serves a number of rhetorical functions. For instance, the framework could be seen to provide the author with a means of drawing seemingly disparate aspects of the research together into a coherent and ordered whole, thereby rendering any inconsistency invisible. The provision of a coherent framework could also be seen as compatible with the academic and linguistic conventions of
compiling a closing summary and as (hopefully) satisfying the evaluative criteria of examiners. Moreover, the construction of the ‘serviceable other’ framework as esteemed and influential could be seen to confer legitimacy and respectability on the research outlined in this account.

5.2 Limitations

Despite an increasing interest in the use of qualitative methodologies within psychological research, it remains difficult to conduct qualitative research and for it to be regarded as credible (Coyle, 2006). Indeed, among mainstream psychological research, the randomised controlled trial (RCT) still remains the gold standard upon which all other approaches to research are judged (Roth & Fonagy, 2004). Moreover, the word limits routinely imposed on research papers submitted to academic journal (and research theses submitted for postgraduate degrees) are not conducive to the citing of large data extracts.

Among qualitative approaches to research, discourse analytic approaches appear to be among the most vulnerable to criticism and debate [see for example Garety’s (1994) and Walkup’s (1994) criticism of Harper (1994)]. Given the relatively recent introduction of discourse analysis to psychology this circumstance is perhaps not surprising.

Reflexive Box 9: Constructing resolve in the face of controversy

The positioning of discourse analysis as slightly outside of mainstream psychological approaches to research appealed to me as it suggested both promise and interest. However, when faced with the controversy that surrounds the field, this promise and interest was, at times, difficult to sustain. My ability to tolerate the controversy was, in part, aided by my participation in a university-based discourse analysis group. This group convened regularly throughout the academic year and provided an opportunity for the group members to present and discuss discourse analytic research. Participation in the group helped to foster a sense of solidarity in relation to discourse analytic research and thereby strengthen my sometimes waning commitment to the analytic process and the field of discourse analysis more generally.
Regardless of the intentions of the researcher, the impact of research is hard to anticipate and its publication can affect those involved in unpredictable ways (Prilleltensky & Nelson, 2002). Whilst this research project did not directly involve participants, the producers of the extracts cited in this research report could be seen to have a stake in how their extracts are presented and subsequently interpreted. However, as indicated in the method section, discourse analytic research does not purport to reveal the 'true' inner states of language users. The reader is thus reminded that the analysis contained within this account is concerned with discursive strategies, rhetorical functions and implications rather than the intentions and motivations of the individuals who produced the extracts.

As already noted in Reflexive Box 3, the search term ‘personality disorder’ did not permit the identification of articles where personality disorder may have been referenced more obliquely. It is possible that more oblique references would have drawn on different interpretative repertoires than those identified in this account. If the search term had have been widened this may have enabled greater variability within the texts under consideration. Similarly, articles were only considered for selection if they were published in the British Journal of Clinical Psychology and Clinical Psychology between January 1999 and December 2006. It is reasonable to assume that a consideration of articles published in other academic journals or articles published outside of the specified time frame would also give rise to a different research account. For example, data could have been collected from articles published in personality disorder specific journals or articles published prior to 1999.

In acknowledging these limitations, it is important to emphasise that the results of this research can not be generalised beyond the texts subjected to the analytic process. Moreover, although this project sought to examine the various ways in which the clinical psychology profession constructs personality disorder, the results should not be read as representing the clinical psychology profession at large. Indeed, the diversity of perspectives within the profession is recognised and this study does not purport to lend one voice to that diversity.
5.3 Implications for future research and practice

As far as the author was aware, at the time of writing, no other discourse analytic researcher had formally, analytically engaged with the concept of personality disorder. Although this suggested that the area was fruitful for enquiry, it did present limitations in terms of comparison. However, it is anticipated that the present research can contribute to the growing body of discourse analytic research concerned with the taken-for-granted concepts that comprise the mainstay of contemporary clinical psychology practice. In particular, it is anticipated that the research can add to the literature pertaining to the social construction of depression (Pilgrim & Bentall, 1999), paranoia (Harper, 1994), psychotic experiences (Harper, 2001) and schizophrenia (Boyle, 1990). These studies, whilst concerned with different objects of enquiry, challenge the notion that these categories of psychopathology 'exist' non-problematically and point to the wider socio-political functions that are served by their construction. In doing so these studies can be seen to align themselves to the fields of critical and community psychology which seek to challenge the practice of psychology as inherently individualistic and decontextualised.

Whilst this research was concerned with examining textual material, discourse analytic approaches can also be applied to talk. Future research could investigate how healthcare professionals (including clinical psychologists) discuss personality disorder, for example by analysing transcripts of case conferences or team meetings wherein personality disorder is of central concern. Further research could also be oriented towards a detailed examination of the political and historical context of the emergence of the concept of 'personality disorder'.
REFERENCES


Mental Health Act, 1983. Available at www.markwalton.net/guidemha/index.asp


of personality to determine the prevalence of personality disorder in psychiatric in-
patients. Psychological Medicine, 20, 985-992.


Zuckermann, M. (1995). Good and bad humours: Biochemical bases of personality and
APPENDIX A: Alphabetised list of articles subjected to the analytic process


Gilbert, P. & Gerlsma, C (1999). Recall of shame and favouritism in relation to


RESEARCH LOG CHECKLIST

July 2007
Year 3
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
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<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
<td>✓</td>
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<tr>
<td>4</td>
<td>Formulating specific research questions</td>
<td>✓</td>
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<td>5</td>
<td>Writing brief research proposals</td>
<td>✓</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
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<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
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<tr>
<td>9</td>
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<td>12</td>
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<td>Writing patient information and consent forms</td>
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<td>14</td>
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<td>15</td>
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<td>Choosing appropriate quantitative data analysis</td>
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<td>21</td>
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<tr>
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