

Volume I of II

A Repertory Grid Study Investigating Factors Associated with Treating People Diagnosed with Borderline Personality Disorder (BPD): The Construct of Illness and the Therapeutic Relationship.

A thesis submitted to the University of Hertfordshire in partial
fulfilment of the requirements of the degree of Doctor of Clinical
Psychology.

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June 2015

(Excluding title page, acknowledgements, table of contents, list of tables, list of
figures, footnotes, references and appendices).

ACKNOWLEDGEMENTS

I would firstly like to extend my utter gratitude to those who agreed to take part in this research project and, in particular, to those living with a diagnosis of Borderline Personality Disorder. Your resilience and determination inspires me to not only be the best clinician I can be, but to be mindful of the importance of questioning the status quo and maintaining hope that things can and always do change.

A special thanks to my supervisor, David Winter, who initially sparked my interest in Personal Construct Psychology – an extremely validating framework for accepting people as unique. I'd also like to thank you David for your continuing support and guidance during a challenging project. In a similar vein, I'd like to thank my field supervisor and mentor, Tim Acton. Your teaching and belief in me has been more valuable than I can put into words.

Finally, I'd like to thank my parents for their unlimited support, encouragement and patience. I'd like to dedicate this project to you both.

And to Dr George Kelly. I couldn't agree more. There is an infinite number of ways people can construe events. This means that the future can always be different and hopeful.

"No one needs to paint himself into a corner; no one needs to be completely hemmed in by circumstances; no one needs to be the victim of his biography" (Kelly, 1955; p. 15).

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ABSTRACT

People diagnosed with Borderline Personality Disorder (BPD) have been subjected to stigma and told that their difficulties are untreatable. Although recovery is now understood to be possible for this client group, much controversy exists around whether BPD is, in fact, an illness. The implications of this belief have not yet been explored from the perspective of the client. Furthermore, little research has attempted to deconstruct what constitutes the therapeutic alliance for people diagnosed with BPD and their clinicians from a Personal Construct Psychology (PCP) perspective.

The present research study therefore aimed to explore what impacts on the recovery of people diagnosed with BPD. This included investigating the impact of the construct of illness and the therapeutic relationship. The research employed a correlational and non-randomised design, using a cross-sectional approach. The Repertory Grid technique was used among a sample of 20 clients diagnosed with BPD and their clinicians. Relevant questionnaires were also administered to ascertain BPD symptomatology and the perceived quality of the therapeutic relationship.

Among findings, a *statistically significant* correlation is presented for the association between a poor therapeutic relationship and increased BPD symptoms. Evidence (in the form of a *borderline significant* correlation) is also revealed to suggest that clients diagnosed with BPD construe fewer benefits from psychological therapy when they consider the well – ill construct to be more important (i.e. superordinate). The results provide new information with regard to the treatment of people diagnosed with BPD.

CHAPTER ONE: INTRODUCTION

1.1 Introduction to the Literature Review

This introduction to my Major Research Project (MRP) presents a literature review of the most relevant areas applicable to my research questions (for the literature search strategy employed, see Appendix A). I start by presenting an aetiological and historical overview of the terms 'Personality Disorder' and 'Borderline Personality Disorder' (BPD), including controversies and treatment models. I then consider BPD from a 'Personal Construct Theory' (PCT) perspective, the theoretical position of my present research. I consider how this perspective offers a helpful and meaningful way of understanding those diagnosed with BPD.¹ The introduction goes on to consider two factors which may be particularly important when treating this client group.

Firstly, I explore the concept of identity for people with BPD, including whether clients identify themselves as ill and what the implications of this may be (a novel research area). I then review the concept of recovery, including the importance of the therapeutic relationship (a highly researched area). I conclude by presenting a rationale for the PCT approach with complex clients and the current context of the National Health Service (NHS). This leads on to the presentation of research questions and hypotheses.

1.2 The Personality Disorder (PD) diagnosis

The British Psychological Society (BPS) defines Personality Disorder as a description of "enduring characteristics of a person that impair their well-being or social functioning" (Alwin *et al.*, 2006; p. 2). The American Psychiatric Association (APA) similarly defines Personality Disorder as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of an individual's culture" (APA, 2000; p. 629). Individuals with a diagnosis of Personality Disorder therefore experience a great deal of distress as they try to function and feel accepted by society. Their difficulties often stem from struggling to understand and manage intense emotions, which then impacts on their relationships. It is estimated that approximately 40% of people being treated in a psychiatric inpatient service

¹ Although this research project will refer to people *with* Personality Disorder and Borderline Personality Disorder, the author believes the diagnosis to be a social construct and therefore something that people are *diagnosed with* (rather than something one necessarily has or embodies).

(Crawford *et al.*, 2007) and 10% of people in community mental health services (Alwin *et al.*, 2006) will have a diagnosable Personality Disorder.

According to the American Diagnostic and Statistical Manual (DSM-V) of mental health and behavioural conditions, there are ten sub-types of the Personality Disorder diagnosis (APA, 2013). There has been much controversy around the discriminative validity of these ten sub-types, particularly due to a perceived overlap in presenting symptoms (Zimmerman, 1994). The argument for a non-categorical but *dimensional* way of understanding Personality Disorders (including *healthy* personalities) has therefore emerged in recent years, as a more valid and normalising approach to human personality (Blackburn *et al.*, 2004; Clark, Livesley & Morey, 1997; Tackett *et al.*, 2009; Tyrer *et al.*, 2011). Livesley (2007; 2012) has further argued for a completely alternative 'common factor' model of Personality Disorder, where the 'core pathology' to be acknowledged is reduced to chronic disturbances of self and interpersonal relationships.

Such perspectives on the Personality Disorder label are situated within a wider context of long-standing discussions surrounding the clinical meaningfulness and utility of mental health diagnoses. It has been argued that diagnoses are not helpful and instead refer to the Medical Model's² attempt to arbitrarily categorise the human experience (Sartorius, 2002). The Personality Disorder construct has fuelled considerable debate due to its sub-type homogeneity, co-morbid presentation and attempt to fundamentally pathologise one's personality (Segal & Coolidge, 1998). The Personality Disorder diagnosis has received further controversy as individuals were once told they could not be treated, subsequently experiencing exclusion from NHS services after being labelled with this clinically futile 'dustbin diagnosis' (Horn, Johnstone & Brooke, 2007).

1.1.1 Historical NHS Treatment

Despite the daily struggles people with Personality Disorder face, the NHS has historically failed to acknowledge and treat this client group. The Mental Health Act (1983) in England and Wales highlighted a prevailing understanding that Personality Disorder was *untreatable*. Individuals given this diagnosis would therefore learn not to expect much from services, evoking a sense of isolation and hopelessness. Bateman & Fonagy (2000) initially responded to the criticism mental health services were facing. They initiated a systematic

² The *Medical Model*, as referred to in this research project, refers to the establishment and maintenance of objective truths with regard to the existence of particular mental illnesses.

literature review to investigate what the evidence said about effective treatment. They concluded that, though the evidence presents a number of methodological issues (reviewed later in this chapter) psychotherapeutic treatment can be effective for people diagnosed with Personality Disorder.

Bateman & Tyrer (2002) continued to add weight to the increasing realisation that individuals with Personality Disorder were capable of recovery. They highlighted the potential for people diagnosed to learn how to better manage their emotions and effectively manage relationships, but noted the lack of good quality research evidence into treatments. They therefore rigorously questioned the efficacy of the limited evidence behind treatments for Personality Disorder. They concluded that previous research into such treatments was often limited by sample size, lack of follow up and outcome measures. They subsequently suggested features they felt would be necessary in the delivery of any effective treatment for Personality Disorder. This particularly concerned psychological therapy, which they argued must be well structured and theoretically coherent to both client and therapist (Bateman & Tyrer, 2002).

The Department of Health's innovative document, 'Personality Disorder: No longer a diagnosis of exclusion' went on to nationally acknowledge the neglectful treatment of people diagnosed with Personality Disorder in the NHS (National Institute for Mental Health for England; NIMHE, 2003a). It was no coincidence that this document was published when the strong prevalence of individuals with Personality Disorder was being recognised. The Department of Health then published the 'Personality Disorder capabilities framework: Breaking the cycle of rejection' later that same year (NIMHE, 2003b). This document acknowledged the lack of staff understanding which existed around the diagnosis, presenting guidelines for clinicians to more effectively address the needs of this client group.

Crawford *et al.*, (2007) took the literature further by initiating eleven specialist Personality Disorder UK pilot studies. They intended to identify the organisational and therapeutic factors that result in high quality, effective care for people with Personality Disorder. The evaluation of the pilot sites resulted in a number of recommendations for future NHS treatment. This included the need for long-term interventions, tailored to the individual, involving one-to-one and group therapy. This was thought to be particularly important for individuals diagnosed with the sub-type 'Borderline Personality Disorder,' and why the National Institute for Health and Care Excellence (NICE) issued management and treatment guidelines soon after (NICE, 2009).

1.1.2 Borderline Personality Disorder (BPD)

Borderline Personality Disorder (BPD) first appeared in the DSM-III edition of the American diagnostic system (1980) and remains one of the ten sub-types of the Personality Disorder diagnosis according to the DSM-V (APA, 2013). It is the most frequently diagnosed of the Personality Disorders and, curiously, most frequently diagnosed among women (Bjorklund, 2006). The term 'Borderline' itself was originally selected for a group of clients who were more severe than those with neurosis, but not quite as severe as those with active psychosis (Stern, 1938). Today, the DSM-V maintains that individuals need to meet any five of nine criteria to warrant a diagnosis of BPD (also attracting criticism due to the multiple ways one can diagnose BPD). These criteria refer to a fear of abandonment, unstable relationships, identity disturbance, impulsivity, suicidal ideation, self-harm, affective instability, transient paranoia and difficulty managing anger (APA, 2013).³

Individuals diagnosed with BPD are often the focus of research interest and NHS service development. This is because they present frequently to mental health services, with a high level of clinical need and risk (Comtois *et al.*, 2004; Hueston, Mainous & Schilling, 1996). Presenting difficulties include the maladaptive ways people with BPD try to cope with intense emotions; including substance misuse, self-harm and suicide attempts. A lot of these behaviours can be understood in the context of childhood, as a large proportion of people given the BPD diagnosis report such behaviours help them cope with the effects of childhood sexual and physical abuse (Nehls, 1998; Zanarini *et al.*, 1989) and equally damaging emotional abuse and neglect (Bremmer, Vermetten & Mazure, 2000). Research suggests early abusive environments have also resulted in people with BPD presenting to services with very negative self evaluations (Barnow *et al.*, 2009; Rusch *et al.*, 2007).

Estimates suggest less than 1% of people in the UK meet the criteria for a diagnosis of BPD. Within psychiatric communities, research has claimed up to 10-15% of outpatients and 25% of inpatients will meet the diagnostic criteria (Widiger & Weissman, 1991). Studies further suggest that 60-70% of people with BPD will attempt suicide, with a number engaging in repeated attempts and approximately 10% actually committing suicide (Paris, 2010; Ansell *et al.*, 2015).

³ The tenth edition of the International Classification of Diseases and Related Health Problems (ICD-10) system in Europe refers to this diagnosis as 'Emotionally Unstable Personality Disorder' (World Health Organization, 2011). However, for the purposes of continuity and more extensive literature utilising this term, the 'BPD' diagnosis will be referred to throughout this research project.

1.1.3 Psychological Models of BPD

Psychological theories and models have emerged to develop our aetiological understanding of those diagnosed with BPD. The most evidenced and utilised understanding predominantly stems from the original Bio-social Model (Cloninger, 1987). In Dialectical Behaviour Therapy (DBT), Linehan's bio-social model (1993; 2014) argues that people with BPD are born with a genetic predisposition to a sensitive emotional temperament (Rutter, 1987). Her model suggests that this predisposition to 'affective instability' interacts with an early and abusive 'invalidating environment' – leaving the person prone to intense emotional experiences which they struggle to understand, trust and manage (Crowell *et al.*, 2009; Linehan, 1993; 2014). The Transactional Model of BPD similarly asserts the key feature of emotional dysregulation. This is explained by the interplay of transactions between an individual's emotional sensitivity and invalidation from caregivers (Fruzetti, Shenk & Hoffman, 2005).

Mentalisation Theory suggests that people with BPD also present with marked difficulties when it comes to processing and effectively responding to their own and others' thoughts and emotions. This leads to them experiencing problems in their relationships, where they struggle to understand and respond to their own and others' intentions (Bateman & Fonagy, 2009, 2010; Fonagy & Bateman, 2006). The theory suggests that such difficulties stem from early harmful and abusive relationships, where trying to make sense of the other (i.e. 'mentalise') was experienced as too frightening by the child (Bateman & Fonagy, 2004; Fonagy, 2000).

Bowlby's (1969, 1982) Attachment Theory additionally provides support for the relational difficulties people diagnosed with BPD face. The theory highlights the devastating impact of not only overtly abusive experiences (i.e. physical and sexual abuse) but also more subtle and equally damaging forms of abuse (i.e. emotional abuse and neglect). The theory suggests the presence of abuse or chronic unavailability from a key attachment figure (e.g. a parent) is likely to contribute to the development of an insecure attachment style (Dallos, 2004; Fonagy, 2000). For people diagnosed with BPD, Attachment Theory therefore suggests the child (and later adult) internalises an impending fear of abandonment due to early experiences of being let down by primary caregivers (MacDonald, Berlow & Thomas, 2013; Meyer & Pilkonis, 2005). If the person's hypersensitivity to abandonment is triggered, this can then lead to dysfunctional behaviours (such as reactive overdoses and threats of

suicide) as the individual struggles to cope and communicate their needs effectively (Fonagy, Target & Gergely, 2000; Liotti, Cortina & Farina, 2008).

1.2 Personal Construct Theory (PCT)

Personal Construct Theory offers another framework for understanding BPD. This theory was first introduced by George Kelly (1955) in the United States and brought to the UK by Don Bannister and Fay Fransella in the 1970s (Bannister & Fransella, 1986). Central to Kelly's theory is the 'fundamental postulate' which states that a "person's processes are psychologically channelized by the ways in which he anticipates events" (Kelly, 1955; p. 46). Kelly therefore stressed that one's psychological experiences are directly linked to how one makes sense of their past and subsequently anticipates future events (Raskin, Weihs & Moranco, 2005).

PCT states that people make sense of the world in this way, by categorising their experiences into conceptual 'constructs.' Kelly (1955) introduced a construct as a descriptive, dichotomous scale which consists of two, opposite poles. Kelly gave a rationale for the conceptualisation of two poles, explaining that a construct can only exist in relation to an established opposite.⁴ By assigning events to either pole of a construct, individuals are able to construe the world by contextualising their experiences. Constructs are subsequently unique to the individual, representing both cognitive and emotional processes of meaning making (despite criticism of PCT being overly cognitive; Procter, 2009).

Kelly asserted that, if a person's predictions about the world are borne out, the individual is validated and does not need to revise their system of constructs. However, if a person's predictions are invalidated, the individual is required to review and expand their constructs. Kelly therefore referred to humans as *scientists* who continually strive to make sense of and predict the world. He argued that people are *forever in process* as they continue to have 'experience cycles' where they review and adjust their construct systems accordingly (Raskin, Weihs & Moranco, 2005). Kelly (1955) consequently asserted that "all of our present interpretations of the universe are subject to revision and replacement" (p. 15). However, Kelly believed that psychological disorders occur when the individual continues to implement the same constructs, in spite of persistent invalidation (Walker & Winter, 2007).

⁴ For example: *good*, as a construct pole, is only good because we are aware of *bad*.

1.2.1 Repertory Grids

The repertory grid technique has been made use of in more than 90% of PCT research (Winter, 1992). Kelly (1955) proposed the grid as a *tool of the trade* to help clinicians understand their clients' construing (Bannister, 1965; Fransella, 2003a). The repertory grid is essentially a PCT interview, where the individual is asked a series of questions to elicit their construct systems (Bell, 2005). It has been evidenced to be a useful tool when exploring constructs at a lower level of awareness and those demonstrated by people with complex mental health presentations (Boker *et al.*, 2000; Leitner, 1981). However, despite their clinical utility, there has been a decline in published grid research since the 1980s. Available research has also been limited in generalisability due to reduced sample sizes (Winter, 1992). Such trends have been despite repertory grids providing opportunities to gather client-directed data (overcoming limitations of questionnaires) and to quantitatively analyse construct relationships (overcoming limitations of qualitative interviews).

Unfortunately, when it comes to investigating BPD, repertory grid research has historically focused on associated symptoms and not the diagnosis in its entirety (De Bonis *et al.*, 1995; De Bonis *et al.*, 1998; Golyunkina & Ryle, 1999; Ryle, 1967). This has included grid studies which have addressed the construction processes of survivors of sexual abuse (Gauthier & Saucier, 1991; Harter, 2000; Freshwater, Leach & Aldridge, 2001), people who have attempted suicide (Parker, 1981) and those suffering with post-traumatic stress (Sermpezis & Winter, 2009; Sewell, 1996; Sewell *et al.*, 1996). This is likely to be partially due to the height of grid research occurring during the 1970s and the introduction of the BPD DSM-III diagnosis in 1980.

Furthermore, the author is aware of only one unpublished grid study to date (White, 2014) which has exclusively sought to explore the construct systems of individuals diagnosed with BPD (note, Appendix A details this literature search). White (2014) reported BPD symptomatology to be associated with construing the self very differently over time and construing current relationships similarly to early relationships. Although her study presented a small sample size (of ten participants), White (2014) highlighted the clinical utility of conceptualising BPD from a PCT perspective. The present research study sought to build on White's findings by investigating the *impact* of identity and relationship difficulties with regard to treating this client group.

1.2.2 PCT and BPD

Interestingly, Kelly (1955) opposed the idea of psychiatric diagnoses, stating that they are “all too frequently an attempt to cram a whole live struggling client into a nosological category” (Kelly, 1955; p. 775). Other personal constructivists have similarly criticised diagnoses and, specifically, the BPD *pre-emptive label* (Gillman-Smith & Watson, 2005). They argue the BPD diagnosis inherently implies a criticism of one’s core being, identity and experiences that make up one’s personality (Winter, 1992). Kelly himself warned against the psychiatric community’s attempt to “pigeonhole our observations of the human personality” (Kelly, 1955, p. 335). Proponents of PCT therefore argue this theory to alternatively offer a more helpful and less pejorative way of understanding the complexities of those labelled with BPD (Ellis, Costigan & Watkinson, 2005; Winter *et al.*, 2003).

Winter *et al.* (2003) put forward a PCT model for understanding people diagnosed with BPD. They suggest that individuals may experience unstable interpersonal relationships due to their tendency to ‘pre-emptively construe,’ ‘slot-rattle’ between ends of a construct (similar to Beck’s ‘black and white’ thinking; 2001) and maintain their positions on superordinate constructs which promote valuation of self and others. They further suggest people with BPD present as impulsive due to their tendency to make quick decisions (a foreshortening of Kelly’s ‘Circumspection Pre-emption Control’ cycle⁵). The constructivist model of BPD also offers an explanation for the intense and unstable emotions people report. It suggests that the individual has a difficulty with re-construing following construct invalidation, which includes rapidly moving between *tight* and *loose* construing, i.e. movement from very precise to very variable ways of making sense of experiences (Gillman-Smith & Watson, 2005).

In fact, Kelly (1955) redefined the traditional psychological concepts of emotions⁶. For those diagnosed with BPD, constructivists therefore argue these individuals to experience Kellian ‘hostility.’ This is where they repeatedly attempt to extort validation for their construct system, despite persistent challenges and failings (e.g. the use of suicidal gestures; Lester, 1968; Winter *et al.*, 2003). Chiari *et al.* (1994) additionally suggested that individuals who have such difficulties have likely experienced restricted early opportunities for Kellian ‘aggression.’ This is where an individual seeks to expand on their construct system. Instead,

⁵ *Circumspection* is the first stage of decision making, and involves a consideration of all of the possibilities for one’s decision. *Pre-emption* is the next stage where the individual narrows down and selects the most viable (or superordinate) possibility. The final *Control phase* is where the individual chooses one pole of a construct and acts upon their decision (Kelly, 1955).

⁶ Kelly (1955) referred to emotions as *constructs of transition*, where the individual has an experience which leads to a shift in one way of construing the world (or self) to another.

they suggest Kellian 'threat' (a fear of one's core constructs being changed) and 'guilt' (a sense of dislodgement from one's core role structure) characterise the early attachment relationships for this client group (Chiari & Nuzzo, 2005).

1.2.3 Construing the Self and the Other

PCT further suggests that those diagnosed with BPD will have difficulties with the 'sociality corollary,' where they struggle to accurately construe the construction processes of others (Kelly, 1955). This is possibly why they 'slot-rattle' in relationships (Winter *et al.*, 2003) where they become more inclined to view themselves and others in more extreme, similar or dissimilar ways – what the psychoanalytic research has traditionally termed 'splitting' (Kernberg, 1975; Vater *et al.*, 2015). Cleaver (1989) explored the experience of women who had attempted suicide from a PCT perspective (cited in Winter, 1992). He suggested that such extreme and polarised constructions provide people with a clearer sense of self-identity (an on-going struggle for people diagnosed with BPD; Winter, 1992). Repertory grid research has also highlighted how extreme, dissimilar construing of the current, future and ideal self continues to reduce hope and maintain poorer psychological health for clinical and non-clinical populations (Boldero *et al.*, 2005; Freshwater, Leach & Aldridge, 2001; Ribeiro, *et al.*, 2012). This raises questions regarding how people with BPD construe themselves and others, and what the impact of this may be on their presenting symptoms.

Fransella (1977) originally spoke of *the self and the stereotype* with regard to individuals' tendency to negatively construe others who present with similar mental health problems (cited in Winter, 1992). PCT literature has since emerged which suggests that some people may therefore dissociate themselves from others who report similar difficulties; including people with Agoraphobia (Bannister, 1965), people who stutter (Fransella, 1970) and people with alcohol problems (Hoy, 1977). It is possible that people with BPD may be even more inclined to distance themselves from the notorious BPD stigma and therefore those diagnosed with similar difficulties. Vater *et al.* (2015) additionally report that people with BPD tend to view themselves distinctly differently (and predominantly more negatively) than others with similar conditions. This likely reflects the fundamental difficulties people with BPD face when it comes to understanding their psychological functioning and developing a healthy sense of their own identity.

1.3 Identity

Identity is among the broadest of concepts when it comes to understanding what is meant by *the self* (Stets & Burke, 2002). Psychologists, sociologists and anthropologists have posed multiple perspectives and theories with regard to what constitutes and maintains an individual's sense of identity. The majority of views originate from Erikson (1963, 1968). In his work, Erikson regards identity as both a personal construction (developed through personal connections with social groups) and a social construction (developed through the internalisation of societal appraisals; Westen & Heim, 2003).⁷

The PCT literature highlights the importance of social relationships for the development of self construction (Dagnan, Trower & Gilbert, 2002). Kelly (1955) referred to a system of 'core constructs' when conceptualising individual identity. He suggested that the concept of self is crucial to this system, which is continually developing through social interactions. It is during these interactions where an individual defines themselves as either similar or dissimilar from the other. From what we know about people diagnosed with BPD, it seems likely that their emotional and interpersonal difficulties will affect this self-construing and subsequent ability to develop a strong sense of identity.

1.3.1 Identity and BPD

It is perhaps not surprising that one of the nine DSM-V criteria is that individuals with BPD have what Erikson characterised as 'identity disturbance' (Westen & Heim, 2002). The DSM describes such an identity as characterised by a chronic, unstable self-image or sense of self (APA, 2013). Research has additionally supported the concept of 'identity diffusion' or 'identity disturbance' to be one of the central features of BPD (Jorgensen, 2006, 2010; Jorgensen *et al.*, 2009) and proposes these identity difficulties to be markedly different from those experienced by other client groups (Dammann *et al.*, 2011).

It has also been suggested that childhood abuse may be a key contributing factor in the development of identity disturbance for people with BPD. Westen & Heim (2002) suggest that childhood abuse disrupts and restricts the development of the multiple aspects of one's adult self. This supports Ryle's (1997) Multiple Self States Model (MSSM) which asserts that people with BPD develop few dominant *self-states*, resulting in a reduced repertoire for relating to people across contexts. This may explain why people with BPD often report feeling as though they don't 'fit in' with others (Horn, Johnstone & Brook, 2007).

⁷ The present research cannot do justice to the wealth of available literature on identity but will aim to consider it from the perspectives of PCT and BPD.

De Bonis *et al.* (1995) published the first repertory grid study of people given the BPD diagnosis. Although the authors acknowledge limitations with poor diagnostic tools and generalisability, they found evidence for identity difficulties among people diagnosed with BPD. Such difficulties included being less able to coherently define themselves compared to people with Schizophrenia. Buckley-Walker, Crowe & Caputi (2010) additionally conducted a grid study to explore identity and recovery. Although they failed to elicit participants' more personal and unique constructs regarding recovery (choosing to instead supply the constructs themselves) the research provides further evidence for the usefulness of repertory grids when it comes to exploring the impact of identity.

1.3.2 The Illness Identity

Fransella (1972) argued, from a PCT perspective, that mental health difficulties can become such a core part of identity that a loss of symptoms can feel like a loss of one's core sense of self (cited in Winter, 1992). The Green model of recovery (2004) suggests that a key process in recovering from severe mental health problems should therefore involve the individual *immersing* themselves in their illness to learn more about symptoms, management and life meaning (Wisdom *et al.*, 2008). Some literature has gone further in suggesting that identifying with one's mental health condition can bring therapeutic benefits. Mizock, Russinova & Millner (2014) report a qualitative identity theme from their analysis of 30 interviews regarding acceptance and mental health. This theme acknowledges the need to incorporate mental health into the *overarching sense of self* when it comes to wellbeing and recovery. However, the authors do not elaborate on the possible hazards of over-identifying with mental health problems.

Others have alternatively argued a preoccupation with mental health problems to lead to an *illness identity*, where the person over-identifies with being *ill* and experiences subsequent damaging changes to their beliefs and sense of self (Barker, 2002; Charmaz, 1995; Estroff, 1989). Literature stemming from the renowned Social Identity Theory (Tajfel & Turner, 1979) and Self-categorisation Theory (Turner, *et al.*, 1987) now highlights the need to explore possible health consequences of such an identity (Tarrant & Butler, 2011). Research here has specifically evidenced a link between perceived symptoms and those who self-categorise as *suffering* from a health condition (St Claire & He, 2009; St Claire, Clift & Dumbleton, 2008). Yanos, Roe & Lysaker (2010) additionally propose a model for the impact of an *illness identity* on the prognosis of recovery. They suggest the harbouring of an illness

identity to positively correlate with hopelessness, low self-esteem and suicidal ideation (Korsbek, 2013). Self-Regulation Theory (Leventhal & Nerenz, 1985; Leventhal, Nerenz, & Steele, 1984) offers an interpretation of this relationship, as it postulates the subjective experience of ill-health symptoms are influenced by how one *categorises* symptoms. This suggests that individuals' experiences of mental health are influenced by how they make sense of their symptoms e.g. Well or ill? Psychological or medical? Hopeful or hopeless? Sells, Stayner & Davidson (2004) further reiterate how categorising symptoms as an *illness* poses a greater threat to mental health recovery when a person's pre-illness identities are lost in the often long and pathologising process.

The PCT literature has also acknowledged the possible detrimental impact of an illness identity. Gara *et al.* (1987) suggested an elaborated and clearly defined *psychiatric patient* identity will negatively impact on daily functioning for people with Schizophrenia. Repertory grid findings produced by Large (1985) additionally suggest that the construing of health difficulties as a medical *illness* may bring a reduced ability to think psychologically. Large (1985) used repertory grids to explore constructions of illness attitudes among people experiencing chronic pain. He found that individuals who no longer construed their health problems as a physical illness (post-therapy) were more likely to report an increased importance regarding the emotional components of health. Nyklicek, Majoor & Schalken (2010) more recently reported similar findings, where they found individuals who think psychologically (and not medically) about their mental health difficulties were more likely to report less symptoms following therapy. The authors acknowledge the limitations of not inferring causation from their design, but propose an internalised Locus of Control may have been a mediating factor which resulted in improved treatment motivation (Norman & Bennett, 1996; Rotter, 1954).

The renowned Self-fulfilling Prophecy attempts to further explain the potentially unhelpful consequences of identifying oneself as *ill*. This phenomenon asserts that individuals are likely to display behaviours which maintain their societal label (Merton, 1948). A socially constructed label such as *mentally ill* may therefore lead to individuals exhibiting more features of their so-called illness. Literature has further suggested a *self-fulfilling link* between increased symptomatology and being diagnosed with Schizophrenia (Krauss, 1968) and Chronic Fatigue Syndrome (Huibers & Wessely, 2006). It is subsequently possible that people with BPD, who identify as ill, may be more likely to show symptoms of mental health difficulties.

Unfortunately, people with BPD may be further inclined to adopt new (even pathologising) identities, due to already living with a fragile sense of who they are (White, 2014). The harbouring of a more appealing illness identity may then present another serious obstacle to their recovery, as they become less able to think psychologically about their difficulties. Research also suggests that over-identifying with highly stigmatised clinical populations (like BPD) may lead to self-stigmatisation (Corrigan & Watson, 2002). Aviram, Brodsky & Stanley (2006) propose that self-stigmatisation can then lead to a self-fulfilling increase in self-critical and destructive tendencies. Self-stigmatisation has also been found to be associated with more severe symptoms among people with Eating Disorders (Cooper, 2006), Schizophrenia (Kim, Ann & Kim, 2010) and Obsessive Compulsive Disorder (Moritz *et al.*, 2012). Although the direction of causality is hard to infer, a possibility for the correlation between negative self-evaluations and poorer psychological health includes a sense of hopelessness regarding getting better.

So far, this section of the chapter has outlined some of the potential consequences of developing an *illness identity* and, particularly, for those diagnosed with BPD. It has been assumed that such an identity may imply an adherence to a medical or biological understanding of mental health, where the individual believes their BPD diagnosis *exists* as an *illness*. This is opposed to the diagnosis representing psychological sequels to early adversity. A more comprehensive account of the implications and evidence behind a medical understanding of BPD is later discussed. This firstly requires us to address the question of whether or not the BPD diagnosis is, in fact, an illness and why this question matters.

1.4 Is BPD an Illness?

The medical community has traditionally felt the need to label human experiences to validate the presence of real mental health and distress. Historically, individuals who would now qualify for a BPD diagnosis were therefore referred to as having a 'disorganised personality' (Kernberg, 1967) and then a 'clinical syndrome' in an attempt to medicalise and presumably develop appropriate treatment (Grinker, Werble & Drye, 1968). Although the term 'disorder' has remained since its establishment in the DSM-III (APA, 1980), such changes reflect the transient and societal nature of psychiatric diagnoses. Additionally, and more confusingly, current literature continues to synonymously refer to BPD as both a medical illness and psychological disorder. Kendell (2002) highlights how the ICD, DSM and World Health Organisation (WHO) have steered away from providing clear definitions which differentiate

these terms. He concludes that the implications of such ambiguity have also been surprisingly neglected by the literature.

However, over one hundred years ago, Karl Jaspers originally shared the belief that “what is ‘ill’ in general depends less on the judgement of the doctor than on the judgement of the patient and on the dominant views in any given cultural circle” (Jaspers, 1913; p. 652). Szasz (1960) then took this further by radically arguing for the complete abolition of the concept of mental illness. He adopted a strong social constructionist perspective in arguing that mental health symptoms are reflective of basic problems in living. He stated these problems are highly dependent on ethical and cultural norms and not objective, physical symptoms of ill health. He subsequently argued that only conditions which present with objective, physical traits, uninfluenced by cultural norms, can be seen as illnesses amenable to medical treatment.

Ausubel (1961) critiqued these claims, in his paper ‘Personality disorder *is* disease.’ He argued that it is *potentially dangerous* for Clinical Psychology to disregard the concept of mental illness purely as an attempt to escape the professional dominance of medicine. He instead argues that the term ‘mental illness’ does not suggest a pure medical cause for behavioural symptoms but is a “generic term under which these symptoms can be subsumed” (p.72). However, despite this assertion, Ausubel (1961) interestingly concludes medical approaches to treating Personality Disorder should be implemented irrespective of a clear understanding of the disorder’s aetiology, claiming “*if* inadvertent impairment of the neural substrate of personality can have distortive effects on behaviour, directed manipulation of the same substrate *may* have therapeutic effects” (p. 74).

Schulz & Goldberg (1984) advocated a similar argument in their paper ‘Is Borderline Personality Disorder an illness?’ They assert that the biological parameters of BPD need to be established and stress the need to search for differences between ‘Borderlines’ and others. They pose what they term ‘illness evidence’ by highlighting the chronicity, presenting distress and use of medical interventions for BPD. The mention of this evidence being interpreted through other social, cultural or psychological perspectives is completely neglected. Schulz & Goldberg (1984) therefore push the arbitrary divide between those who are *ill* and *well* further, as they claim biological studies to be “further evidence that the patients [with BPD] are suffering from an illness and not just a disorder of will” (p. 557). This statement contributes to the BPD stigma, as it implies an element of choice over psychological distress if this is not understood to be an illness. Much more recently, Bolton

(2010) warned against such perspectives, where he asserted distress to be too often medicalised by higher powers.

1.4.1 Implications for the Medical Profession

The importance of drug therapy in validating the existence of a clinical syndrome has, unfortunately, been long-standing (Kendell, 2002; Klein, 1968). Kendell (2002) highlights that the medical profession often require evidence of a single, effective treatment to validate the existence of *real* pathology. He hypothesises that more conclusive evidence for treating Personality Disorder would have a decisive influence on Psychiatrists' attitudes (although neglects to comment on the evidence that will be most valued e.g. medication trials). This may subsequently enable staff to approach the BPD diagnosis in a similar way to Schizophrenia – according to some, a *real* illness which clients have no control over due to neurochemical causes (Bradley & Westen, 2005; Feather & Johnstone, 2001; Lequesne & Hersh, 2004; Markham, 2003).

Kendell (2002), however, neglects to explore the implications of such a restricted approach towards validating and treating BPD. In particular, this approach assumes a Medical Model belief in the natural categories of illness and therefore fails to acknowledge the potentially endless number of ways of making meaning out of experiences (a personal constructivist perspective; Kelly, 1955). The DSM can also be thought of as providing little causal explanation or context for the BPD diagnosis. This is opposed to (or in conjunction with) psychological formulation, which offers an arguably more ethical and useful understanding of psychological distress (Division of Clinical Psychology, 2010; Fransella & Dalton, 2000).

It is important to note that Kelly did not assume PCT was any better than its predecessors or, indeed, the Medical Model (Bannister & Fransella, 1971). Of course, implying his theory to be somehow inherently correct contradicts the very notion that there are multiple truths. Instead, what Kelly emphasised was the meaningfulness of truths and our ability to access these by taking a *credulous* approach (Fransella, 2003a). Kelly essentially encourages the questioning of the clinical usefulness of any chosen way of understanding mental distress. Current popular discourses around illness and healthcare (e.g. a diagnosis) can therefore be one of many approaches to understanding psychological difficulties. However, the implications of the BPD diagnosis not being a straightforward mental illness need to be carefully considered from the client perspective.

1.4.2 Implications for People Diagnosed with BPD

Unfortunately for some, the possibility that BPD is not an illness may be difficult to accept. Indeed, it may be hard to simultaneously accept BPD as a fictive medical diagnosis but the distress as real (Wirth-Cauchon, 2001 cited in Bjorklund, 2006). This is despite criticism of the diagnosis being nothing more than a fundamental judgement of one's core being (Walker, 2004). Clinical health models of ailment can alternatively help to explore the secondary gains that may be associated with BPD. For example, by exhibiting an external Locus of Control, one can attribute health difficulties to forces outside their control (Norman & Bennett, 1996; Rotter, 1954). Therefore, if the individual believes medication will ease their BPD symptoms, they may have evidence to demonstrate that they are not responsible for controlling them (as some pejorative attitudes would leave them to believe; Bradley & Westen, 2005; Lequesne & Hersh, 2004). This possibly explains why some people with BPD choose the medical care-pathway as their preferred form of treatment (Rogers & Acton, 2012). However, as suggested earlier in this chapter, by viewing *psychological* difficulties as *physical* difficulties, individuals may be restricting their psychological understanding and impeding their recovery.

It therefore feels important to develop our understanding regarding how people with BPD view the aetiology of their own condition, including how this subsequently impacts on their ability to benefit from non-medicalised treatments. In his theory of health and suffering, Eriksson (1994) differentiates between people suffering due to an illness or life circumstances (Perseus *et al.*, 2005). In highlighting the different ways of viewing the aetiology of one's emotional pain, Erikson questions whether treatment approaches need to be compatible with the way an individual views their distress. Desrosiers, Saint-Jean & Breton (2014) completed a study on the reasons for drop-outs among adolescents with BPD traits. Among their findings, they found that differences in opinions regarding the cause of mental health difficulties can affect individuals' willingness to commit to and perceive benefits from psychological therapy. They pose the question "why continue a therapeutic process if it did not correspond to what was believed to be the problem?" (p. 10) suggesting treating psychological conditions (such as BPD) requires the individual to accept the psychological causes of their difficulties. After all, in their systematic review of the BPD treatment literature, Bateman & Tyrer (2002) reiterate the need for effective psychological treatment to make theoretical sense to both client and therapist. It is possible that, without this mutual understanding, the therapeutic relationship and subsequent prognosis through treatment may also suffer.

1.4.3 The Need for Psychological Mindedness

Barnicot *et al.* (2012) recently initiated a systematic literature review into the factors which impact on therapeutic change for people with BPD. They found poorer therapy outcomes to be associated with people who were taking psychiatric medication. They offered one potential hypothesis for this finding, where they suggest that these clients may have a strong belief in the pharmacological amelioration of their BPD symptoms. This reiterates the importance of people needing to have some level of psychological understanding when it comes to perceiving benefits from psychological treatments.

Applebaum (1973) first conceptualised Psychological Mindedness (PM) as involving “a person’s ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experiences and behaviour” (p. 36). PM has since been consistently shown to positively correlate with successful therapy outcomes (McCallum *et al.*, 2003; Piper *et al.*, 1994; Piper *et al.*, 2001). Researchers have attempted to deconstruct and explain these benefits further. Some evidence suggests PM is important to the success of therapy because it requires the individual to develop strong mindfulness skills (Beital, Ferrer & Cecero, 2005) and an internal Locus of Control (Beitel, Ferrer & Cecero, 2004). Although the literature presents methodological limitations (such as differences in the operationalisation of PM and the use of non-clinical samples), research clearly suggests that being able to think psychologically about one’s difficulties is important to one’s therapeutic recovery.

1.5 BPD and Recovery

The concept of recovery was initially dominated by discourses around physical health and symptom reduction, with very little literature around what it personally means to recover from severe mental health problems (Spaniol, Gagne & Koehler, 1997). However, following the emergence of the survivor movement in the 1980s (Deegan, 1988), the concept of recovery has become a popular and political ‘buzz word’ which is no longer “merely the absence of disease or infirmity” (WHO, 2006; p 1). Recovery has instead been described as a highly individualistic, meaningful and unique process in the field of mental health (Pettie & Triolo, 1999; Slade, 2009).

For people with BPD, the idea of recovery has been a particularly contentious concept. Originally deemed untreatable, individuals diagnosed with BPD were then confusingly confronted with the message that recovery is possible (Zanarini *et al.*, 2006). However, the battle for treatment was not yet over for this client group. Instead, the renowned BPD stigma appeared to continue to interfere with access to effective healthcare (Fallon, 2003; Horn *et al.*, 2007; Rogers & Dunne, 2011). Furthermore, professionals today continue to disagree over the composition of medical and psychological approaches which make up the most effective treatment for this client group.

1.5.1 Medication

As can be expected, the traditional Medical Model was initially drawn on for the treatment and management of people with BPD. Many systematic literature reviews have reported on a vast amount of research studies searching for the biological and neurochemical aetiology of BPD, with little conclusive evidence (Ingenhoven *et al.*, 2010; Nehls, 1988). A Cochrane review in 2010 concluded that, although there has been evidence for the medical efficacy of treating BPD, this has only been for specific symptoms. Thus, drug treatment for the BPD condition has not been sufficiently evidenced in research (Stoffers *et al.*, 2010). Ripoll (2013) conducted another extensive literature review into the psychiatric medical treatment of BPD. He argues the lack of conclusive medical evidence to be due to significant methodological issues in trials, highlighting poor quality study designs and short drug trials. This supports similar arguments which have suggested the lack of an effective BPD medical intervention to be purely due to poor methodological designs (Bellino, Paradiso & Bogetto, 2008; Mercer, Douglass & Links, 2009). Interestingly, such studies fail to attribute methodological problems (such as participant attrition) to the possibility that participants do not experience subjectively useful benefits during these medication trials.

Paris & Black (2015) warned against the danger of the BPD diagnosis buying into a medical system that may lead to treatment becoming predominantly medical and not therapeutic. However, they do not account for the possibility that some clients may perceive medical and drug interventions to also have a therapeutic value themselves (as suggested by Rogers & Acton, 2012). Despite this as a possibility for some, there remains a fundamental lack of conclusive, high-quality evidence when it comes to the effectiveness of medication. Furthermore, this client group has faced a history of heavy medical interventions, psychotropic medication and polypharmacy (Stoffers & Lieb, 2015). This has even been in comparison to others diagnosed with what are believed to be more neurochemical mental

health conditions (Bender *et al.*, 2001; Bender *et al.*, 2006). Unfortunately for people diagnosed with BPD, research additionally suggests physicians to find this client group difficult to treat and form rapport with, due to their general unresponsiveness to prescribed medication (Galop *et al.*, 1993).

1.5.2 Psychological Therapy

A body of evidence has instead emerged for the effectiveness of psychotherapies when it comes to treating BPD. Stoffers *et al.* (2012) recently completed a literature review of 28 studies, going back several decades. They conclude that the evidence-base, though also presenting methodological limitations, suggests psychological therapies to be most effective with regard to treating this client group. Some therapies in particular have developed an evidence-base for the effectiveness of specific approaches, most notably DBT (Linehan, 1993, 2014; Neacsiu, Rizvi & Linehan, 2010; NICE, 2009; NICE, 2015; Stepp *et al.*, 2008). BPD treatment effectiveness has additionally been highlighted by Mentalisation Based Therapy (MBT; Bateman & Fonagy, 2004, 2006, 2009), Transference-focused Psychotherapy (Clarkin *et al.*, 2007; Levy *et al.*, 2006), Schema Focused Therapy (Farrell, Shaw & Webber, 2009; Giesen-Bloo *et al.*, 2006; Kellogg & Young, 2006), Cognitive Analytic Therapy (CAT; Ryle & Golyunkina, 2000; Ryle, 1997; Ryle, 2004) and Personal Construct Psychotherapy (Gillman-Smith & Watson, 2005; Metcalfe, Winter & Viney, 2007; Winter *et al.*, 2000; Winter *et al.*, 2003).

The evidence for the effectiveness of different psychotherapies suggests individual differences in how this client group respond to therapy. Barnicot *et al.* (2012) carried out a systematic literature review into the specific factors which predict BPD symptom change (as defined by the DSM-IV) during psychological therapy. From a final number of 33 research articles, they found two factors to predominantly impact on the individual's recovery. These included more severe symptoms at the start of treatment and a strong therapeutic alliance. Although the review includes varying effect sizes, different data analyses and a reductionist operationalisation of therapy effectiveness (i.e. parasuicidal symptoms), the findings suggest a continued need to explore what constitutes therapy benefits for people diagnosed with BPD. Unfortunately, individual differences which constitute therapeutic effectiveness are still largely unknown (Barnicot *et al.*, 2012; Lenzenweger, 2010).

In understanding what leads to effective therapy outcomes, there is also an argument for understanding what impedes successful therapy (largely neglected by the literature,

Chalmers, 2005; Lucock *et al.*, 2003). A recent Cochrane review (2012) examined 28 randomised studies investigating psychological treatment for people with BPD. The review similarly concludes with an urgent need for research to specifically address what kinds of treatment work for what kinds of people (Stoffers *et al.*, 2012). This could enable the earlier identification of clients who may benefit from particular treatments, and could also identify those “who may be at risk of poor outcomes and may therefore require altered treatment strategies” (Barnicot *et al.*, 2012; p. 401). A clearer idea of those who may be more *appropriate* for certain kinds of psychological therapy is not only in line with the philosophy of the WHO (2000), but also supports the NHS in its need to provide the most cost-effective healthcare.

1.5.3 Health-economic Factors

Gabbard *et al.* (1997) initially expressed interest into the impact of providing psychotherapy for severe psychiatric disorders on NHS costs. BPD was among the severe psychiatric disorders identified. A total of 41 articles were retrieved from 1984-1994, which all included a psychotherapeutic technique and subsequent cost-effects. Two independent reviewers concluded that psychotherapy appears to have beneficial consequences on the costs associated with treating severe psychiatric patients. Since then, others have continued to point out the financial and societal costs associated with BPD (Soeteman *et al.*, 2008) and therefore the cost-benefits of psychotherapeutically treating this client group (Ansell *et al.*, 2007; Brazier *et al.*, 2006; Van Asselt *et al.*, 2007). It is therefore no coincidence that the Department of Health (2009) released ‘Recognising complexity: Commissioning guidelines for Personality Disorder services’ at a time where the public costs of managing people with Personality Disorder were becoming increasingly evident. Of particular interest, the commissioning document specifically highlighted the importance of the therapeutic relationship as a *critical success factor* when treating this client group in the NHS.

1.6 The Therapeutic Relationship

The importance of the therapeutic relationship when it comes to successful therapy outcomes has long been documented (Krupnick *et al.*, 1996; Martin, Garske & Davis, 2000; Norcorss, 2010; Orlinsky, Grawe & Parks, 1994). There is evidence to suggest that the therapeutic relationship is one of the most robust and important factors when it comes to client recovery (Cloitre *et al.*, 2004; Shirk & Karver, 2003) with studies even suggesting this

relationship is more important to the therapeutic outcome than any specific model or treatment approach (Frank, 1971; Shedler, 2010).

1.6.1 Working with People Diagnosed with BPD

Bowlby's Attachment Theory (1969; 1982) states that, in order to work in an effective and meaningful way, clinicians have to consider early patterns of attachment and how these may be played out in the patient-therapist relationship (Guidano & Liotti, 1983). As people with BPD often report abusive early attachment figures, it seems feasible that they may encounter difficulties in negotiating their therapeutic relationships (Bland & Rossen, 2005). This has unfortunately been made worse by the notorious BPD stigma interfering with clinicians' ability to think psychologically (and not reactively) about these potential relationship difficulties (Hersch, 2008; Nehls, 1999). This includes clinicians not being able to acknowledge and appropriately respond to their own negative counter-transference responses within the therapeutic relationship (Gunderson, Bateman & Kernberg, 2007).

Clients with BPD have additionally reported a chronic sense of feeling misunderstood by health professionals. This has included the use of pejorative terms such as 'manipulative' and 'attention seeking' actually interfering with their ability to receive effective NHS healthcare (Fallon, 2003; Horn *et al.*, 2007; McGrath & Dowling, 2012). A wealth of further studies in the 21st century have continued to confirm that a large proportion of mental health professionals find individuals with BPD difficult to work with (Black *et al.*, 2011; Bland, Tudor & Whitehouse, 2007; Bodner, Cohen-Fridel & Iancu, 2011; Cleary, Siegfried & Walter, 2002; Giannouli *et al.*, 2009; James & Cowman, 2007). This has unfortunately contributed to the re-enactment of a typical cycle of rejection, where mental health professionals invalidate and neglect the needs of their clients (Aviram, Brodsky & Stanley, 2006).

1.6.2 Staff Attitudes

Staff attitudes towards the BPD diagnosis were first introduced to the research literature by Lewis & Appleby (1988). They found that psychiatrists were more likely to rate those with a diagnosis of BPD (compared to those with Depression) as manipulative, attention-seeking and in control of their suicidal urges. Unfortunately, decades after this original study, psychiatric professionals still report individuals with BPD to be *manipulative nuisances*, who make them feel angry (Deans & Meocevic, 2006). In a study by Newton-Howes *et al.* (2008), it was even found that the mere mention of Personality Disorder (rather than associated

symptoms) seemed to influence who were rated by professionals as more or less difficult to work with. Liebman & Burnette (2013) more recently reported findings from a survey of 560 mental health workers. They conclude that older clinicians and Psychiatrists still appear to harbour more negative attitudes towards this client group, in comparison to their Psychologist colleagues.

Research has suggested that such negative counter-transference responses can actually enhance the client's sense of worthlessness and interfere with their ability to progress through therapy (Knight, Wykes, & Hayward, 2003). Perhaps unsurprisingly, the literature instead highlights a correlation between a strong therapeutic alliance and recovery for this client group (Bedics *et al.*, 2012; Holmqvist & Armelius, 2004; Lowings *et al.*, 2011; NIMHE, 2003b; Swift, 2009). Staff training has been shown to be crucial when it comes to addressing the therapeutic alliance, particularly targeting staff understanding and improving attitudes towards BPD (NIMHE, 2003b). It is therefore important that research continues to explore possible factors which impact on the therapeutic relationship and the client's subsequent recovery.

1.6.3 A PCT Perspective

Although PCT studies have contributed to the understanding and treatment of BPD, relatively few and recent empirical studies exist to explain the *therapeutic partnership* (Kelly, 1969). This is despite constructivist claims that "every disorder can be understood as a personal difficulty in relating with other people and therefore can be dealt with in the ambit of the client-therapist relationship" (Chiari & Nuzzo, 2005; p. 52). Kelly (1955) argued that clinicians should avoid making judgements about their clients, and instead "construe people propositionally rather than pre-emptively" (Kelly, 1955; p. 194). He explained this to be a process of acceptance, where the therapist strives to understand their client as a person (a personal construct system) while also maintaining a professional overview of their client's difficulties. Fransella (2003) further highlights that a strong therapeutic relationship requires clinicians to overcome their own ways of construing, and instead take a credulous approach by subsuming their client's reality. This involves "the ability to see the world through the client's eyes" (p. 105) – an essential component of working with complex clients.

Watson (1970) published the first article exploring the therapeutic relationship between a client and their clinician, using a repertory grid approach. The clinician was Watson himself, a Psychiatrist. He predicted the personal construct system (repertory grid ratings) of his

client in order to explore areas of understanding and misperception. Although Watson's research here was pioneering, limitations include the single case design and researcher bias (contributing to poor generalisability). Watson also does not reflect on the meaning of his findings (i.e. accurate grid predictions) in terms of the impact on the therapeutic relationship.

Rowe (1971) and Rowe & Slater (1976) similarly explored a Psychiatrist's ability to predict the construct ratings of their client. They found that the clinician's predictions of the client's grid ratings were positively correlated with the client's own ratings. However, these studies again do not attempt to operationalise the therapeutic relationship or suggest how the clinician's ability to accurately predict their client's grid may reflect the quality of this relationship. This appears particularly important, as the clinician's ability to 'subsume' their client's reality (Fransella, 2003a) surely implies an understanding of their client's world – evidenced to be extremely important to the therapeutic relationship (Castonguay *et al.*, 2006; Straussner & Phillips, 2005; Wright, 2011). Winter (1992) argues that the clinician's ability to subsume how their client is currently feeling about themselves (i.e. the 'current self') may be one of the most important indicators of this clinician understanding and the subsequent therapeutic bond.

Research has additionally suggested the therapeutic alliance and outcome of therapy to be influenced by the client's tendency to construe the world either 'tightly' or 'loosely' (Kelly, 1955). Bannister (1960; 1962) first postulated that persistent invalidation may result in an individual displaying looser construing about the world.⁸ Others went onto similarly propose that affective instability, experienced by people with BPD, is an example of loose construing and a likely consequence of childhood invalidation (Lawlor & Cochran, 1981; Winter *et al.*, 2003). Button (1990) alternatively suggested that individuals with non-psychotic psychological disorders may display construing which is more tight and rigid. Although his results did not confirm this hypothesis, he found that these individuals appeared to construe themselves more negatively than others. It is subsequently possible that individuals who construe *tightly* will be less able to think flexibly and psychologically about their difficulties. This is likely to affect the course of psychological therapy and the potential for a strong therapeutic alliance. This is particularly as potentially conflicting ways of understanding the client's difficulties may leave the individual vulnerable to perceiving construct invalidation from their own therapist (Winter, 1992; 2003).

⁸ *Loose construing* refers to a construct system which is weaker and inconsistently related.

1.8 Summary and Conclusions

In conclusion, people diagnosed with BPD present to services frequently, with a high level of clinical need and risk (NICE, 2009; 2015). In the current economic climate of the NHS there is a need to better understand what constitutes clinically and cost-effective treatment. This includes how clients' views of others, themselves and their difficulties may influence their ability to benefit from treatment. This is particularly important for the BPD diagnosis, as historical debates continue regarding its validity, aetiology and best available treatment. Such research findings may then assist clinicians in selecting the most appropriate people for psychological therapy (WHO, 2000). Additionally, there is currently no evidence with regard to how clients with BPD construe *illness* and how this affects their recovery (Korsbek, 2013).

Another important factor when treating clients diagnosed with BPD includes a strong therapeutic relationship. This needs to be further understood in terms of how able clinicians are to construe the world from the client's perspective. Proponents have asserted PCT to provide a reflexive *meta-therapeutic framework* which enables such necessary investigations of not only client but clinician construing (Winter & Procter, 2014; White, 2014). Furthermore, repertory grids offer an excellent opportunity to explore the unique construing of individuals and provide a window into the intricacies of personality (Caine & Smail, 1969). Unfortunately, grid research to date has neglected to explore client and clinician grids for more complex clients and beyond single case studies. Available BPD research instead lacks methodological diversity and neglects the impact of the personal meaning clients attribute to their mental health (Nehls, 1998).

1.9 Present Research

This research project therefore aimed to address some of the gaps in the literature regarding treating BPD. It is possible that a subset of this client group perceive themselves to be ill and therefore prefer a medicalised care pathway. PCT and constructivist models of recovery highlight the need to respect such clients' chosen care pathways and their individualistic ways of viewing difficulties (Winter, 1992). However, this poses a challenge to evidence-based, practitioner psychologists and their sense of integrity. This is particularly when it comes to psychologists' strive to help clients understand their difficulties in a psychologically meaningful and validating way, as opposed to colluding with a pathologised understanding of their experiences as an illness.

Exploring illness beliefs may therefore help NHS services to predict who might most benefit from psychological therapy, and “who may be at risk of poor outcomes and may therefore require altered treatment strategies” (Barnicot *et al.*, 2012; p. 401). This is because we can hypothesise that an illness identity, and the traditional Medical Model, may obstruct psychological thinking and engagement with a psychological practitioner (both key to a strong therapeutic alliance and outcome). As such factors driving individual differences in treatment effectiveness are still largely unknown (Barnicot *et al.*, 2012; Lenzenweger, 2010), there is more reason to further investigate the characteristics possibly effecting perceived benefits from therapy and psychological recovery.

1.9.1 Research Questions

This project is subsequently interested in the following research questions:

1. Does construing the self to be ill impact on clients’ perceptions of their possibility to recover from their BPD diagnosis?
2. Does construing the self to be ill impact on the therapeutic relationship for clients diagnosed with BPD?
3. Does the clinician’s ability to construe the world from the perspective of their client impact on the therapeutic relationship between clinicians and clients diagnosed with BPD?

1.9.2 Research Hypotheses

The above research questions can subsequently be transformed into the following major hypotheses.

1.9.2.1. Major Hypotheses

Hypothesis 1: Clients who construe themselves to be ill before psychological therapy will be less likely to construe benefits from psychological therapy.

Hypothesis 2: Clients who construe the well – ill construct to be important will be less likely to construe benefits from psychological therapy.

Hypothesis 3: Clients who construe the 'current self' and 'a person with psychological health problems' in a dissimilar way will present with more severe BPD symptoms.

Hypothesis 4: Clients who construe 'a person with psychological health problems' and 'a person with physical health problems' in a similar way will present with more severe BPD symptoms.

Hypothesis 5: Clinicians' accurate predictions of their clients' personal construct systems will be associated with a good therapeutic relationship. This will be particularly evident in clinicians' accurate perceptions of their clients' 'current self.'

Hypothesis 6: Clients' who construe themselves to be ill will experience a poorer therapeutic relationship.

Hypothesis 7: Clients who construe tightly will experience a poorer therapeutic relationship.

Furthermore, due to the limited literature available in this area, the present research will also consider the following exploratory hypotheses.

1.9.2.2. Exploratory Hypotheses

Hypothesis 8: Clients who construe the 'current self' to be ill will also present with more severe BPD symptoms.

Hypothesis 9: Clients who construe 'a person with psychological health problems' to be ill will also present with more severe BPD symptoms.

Hypothesis 10: Clients who construe themselves to be well will be more likely to construe themselves as getting better from their difficulties.

Hypothesis 11: The reporting of a poor therapeutic relationship will be associated with more severe BPD symptoms.

Hypothesis 12: Clients who construe the 'current self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms.

Hypothesis 13: Clients who construe the 'future self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms.

CHAPTER TWO: METHODOLOGY

2.1 Design

The research employed a quantitative, correlational and non-randomised design, using a cross-sectional approach. The correlational design was employed to further the repertory grid research which has traditionally utilised single case study designs (presenting limited external validity). A correlational approach to repertory grid research additionally enables the exploration of relationships between patterns of construing and other variables of interest. Previous literature has explored the correlational relationships between patterns of construing (extracted from repertory grids) and questionnaires which measure secondary trauma (Warner, 2011), symptoms of psychosis (Chadwick, 2011; Marshall, 2011; Paget & Ellett, 2013), psychological wellbeing (Mance & Edwards, 2012) and symptoms of BPD (White, 2014).

The present study was concerned with the impact of aspects of construing on the perceived benefits of psychological therapy, the therapeutic relationship and BPD symptoms. Two groups were recruited: a clinical group of clients with a BPD diagnosis ($n=20$) and a clinician group of each client's respective clinician ($n=12$) equating to 20 client-clinician participating pairs.⁹ Inclusion criteria for client participants included adults aged 18 or older who had been given a diagnosis of BPD¹⁰ and had been working with a clinician for at least three months.¹¹ Exclusion criteria for client participants included acute psychosis and forensic service involvement. There were no exclusion criteria for clinician participants.

2.2 Participants and Recruitment

Figure 1 displays how client and clinician participants were sought from five mental health services.

⁹ Note, some clinicians participated more than once (explained further in subsequent sections of this chapter).

¹⁰ As co-morbid diagnoses are often present with this client group (Jackson & Burgess, 2004; Leichsenring *et al.*, 2011), client participants were required to have a *principal* BPD diagnosis.

¹¹ Three months was considered to be an appropriate length of time for therapeutic rapport to have developed.

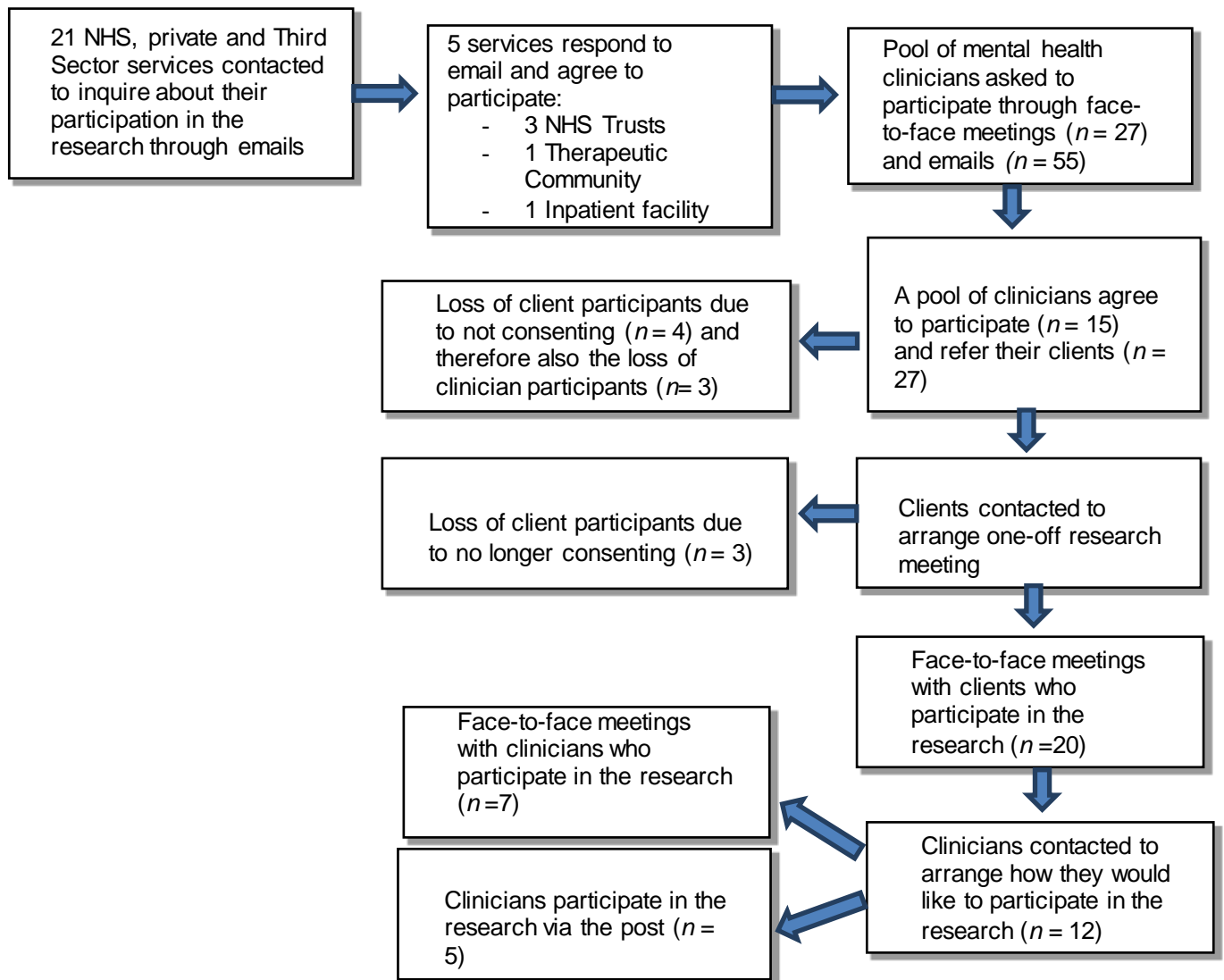


Figure 1. A conceptual map of the recruitment process.

As Figure 1 displays, emails were initially sent to people who were associated with complex mental health services. These contacts were identified through internet searches and consulting with experts in the field. This resulted in five services agreeing to take part in the present research, including: three NHS Personality Disorder services, one private Personality Disorder inpatient facility and one Third Sector therapeutic community.

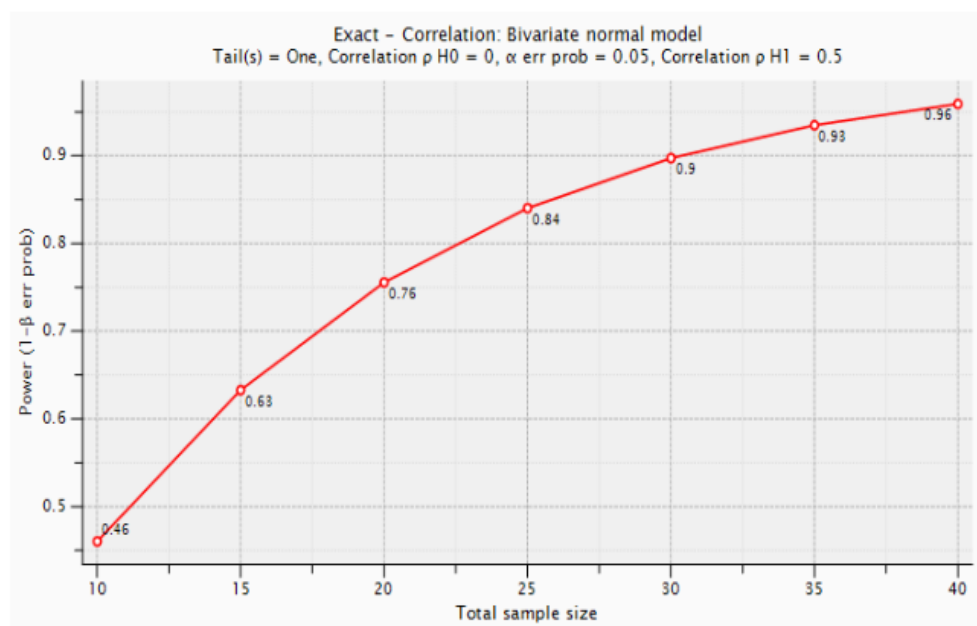
The researcher then arranged meetings with the staff teams for all five services. This was to introduce the research and request client referrals for participation. During these meetings, the Clinician Information Sheet (Appendix B) and Client Information Sheet (Appendix C)

were gone through, with clinicians, in detail. The researcher explained that clinicians would also be required to participate if they refer clients. It was therefore emphasised that *both* the client and clinician would need to consent in order for *either of them* to be able to participate in the study. Clinicians were encouraged to take copies of the Client Information Sheet to go through with appropriate clients. The researcher explained that clients and clinicians could contact them to discuss their participation and any questions further.

It is estimated that hundreds of people with BPD were under the original five mental health services. However, the researcher only received referrals from three of these services.¹² To enhance recruitment over the months, multiple reminder emails were sent to the original teams and to other contacts acquired.¹³ Unfortunately, it is not possible to accurately establish how many clients were informed about the research. It is therefore not possible to ascertain the exact number of the pool of potential participants for this research.

2.2.1 Power Calculation

Consideration was given to the effect size required for the study to demonstrate adequate power. A sample size of 20 participants (and their clinician counterparts) was initially decided upon, following the production of a power curve (see Figure 2).



¹² These included one private inpatient and two NHS community Personality Disorder services.

¹³ Participant recruitment took place between July 2014 and February 2015.

Figure 2. A power curve to determine sample size.

As the curve highlights, for the present study to produce correlational findings which are substantial (i.e. around $r = .50$) then a sample of 20 participants (and their respective clinicians for hypotheses 8-11) was required. This would provide an acceptable level of statistical power (i.e. 76%) to discover correlations of that magnitude with an alpha error of just 5% (given that statistical testing was to be one-tailed, due to the directional nature of hypotheses).

2.3 Measures

2.3.1 Previous Experience of Psychological Therapy

The researcher designed a structured questionnaire to explore client participants' previous experience of psychological therapy (see Appendix D). The questionnaire was administered to gather facts about the client's last experience of therapy (e.g. the type of therapy and length of engagement) and not the process itself. This was for the purposes of providing context when completing the repertory grid. The questionnaire included five closed questions and was very brief to administer.

2.3.2 Questionnaires

The present research also required the use of published questionnaires to operationalise relevant variables, including client participants' current psychological health (i.e. BPD symptomatology) and the therapeutic relationship between participating client and clinician pairs. A literature search was therefore conducted and experts in the field consulted. A number of factors were subsequently taken into consideration when deciding on the selection of questionnaires, including psychometric properties and length of completion time. Two questionnaires were eventually selected.

2.3.2.1. Borderline Personality Disorder (BPD)

Client participants' current psychological health was operationalised using the Borderline Symptoms List (BSL-23; Bohus *et al.*, 2009). The BSL-23 is a standardised questionnaire which assesses the extent of dysfunction associated with BPD, by asking people how they have been feeling over the past week (see Appendix E). It has been adapted from the longer

version of the questionnaire (BSL-95; Bohus *et al.*, 2007), into 23 items instead of 95. The BSL-23 (like the BSL-95) is based on the DSM-IV criteria for BPD (maintained in the DSM-V). Its development included consultation with those considered experts in BPD, along with clients diagnosed with the condition. The shortened version provides the benefits of reduced completion time, less respondent fatigue and similarly robust psychometric properties (Bohus *et al.*, 2009).

2.3.2.1.1 Psychometric Qualities of the BSL-23

The BSL-23 was developed using a sample of 380 people diagnosed with BPD. The items were selected from the BSL-95 based on those considered to be the most sensitive to change and the most unique to people with BPD. The psychometric properties of the BSL-23 were compared with the psychometric properties of the BSL-95, across five studies – amounting to a total of 659 participants. The results concluded that a high correlation between 0.958-0.963 existed between the total scores of the BSL-23 and BSL-95. The internal consistency is also found to be high for the BSL-23 (Cronbach's alpha: 0.94–0.97) and the discriminative validity of BPD (from other possible Axis I disorders) is also known to be sufficient, with a mean effect size of 1.13.

2.3.2.1.2 Scoring the BSL-23

The BSL-23 computes an overall BPD severity score out of 92. This is by adding scores associated with 23 questions on a 5-point Likert scale, from not at all (0) to very much so (4). The questionnaire is negatively marked, meaning the higher the score the more severe the current BPD symptomatology. The BSL-23 has an additional visual analogue scale which provides a measure of global wellbeing over the past week; from 0% (absolutely down) to 100% (excellent). Finally, the BSL-23 contains a 10-item scale to ascertain a measure of risky and dysfunctional behaviours over the past week (this scale is not scored).

2.3.2.2 The Therapeutic Relationship

The present research operationalised the therapeutic relationship using the Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR; McGuire-Snieckus *et al.*, 2007). The STAR has been developed to assess the relationship between multidisciplinary clinicians and clients with severe mental health difficulties in community settings (see Appendix F). It was developed in 2007 in response to no psychometric

questionnaire being available to quantify the therapeutic relationship. The STAR was therefore designed to be used in research and provide a standardised measure of therapeutic interactions. The scale is brief and easy to administer, with documented and robust psychometric properties. It requires both the client or patient (STAR-Patient; STAR-P) and clinician (STAR-Clinician; STAR-C) to answer 12 items on a five-point Likert scale.

2.3.2.2.1 Psychometric Qualities of the STAR

The STAR standardisation sample included 133 clients and 175 clinicians who were recruited across 17 community mental health teams in England and Sweden. Clients were selected with severe mental health problems, including Schizophrenia (59%) or other Mood Disorders (36%). The rigorous design process involved interviews with clients and clinicians, and the use of nine established scales to eventually amalgamate. The psychometric properties of the STAR were then established as having good test-retest reliability ($r = 0.76$ for the STAR-Patient and $r = 0.68$ for STAR-Clinician), internal consistency (Cronbach's alpha > 0.65) and the original factorial structure was confirmed as a 'good fit' (Goodness of Fit Index, $GFI = 0.91$).

2.3.2.2.2 Scoring the STAR

A total STAR-P score and three subscale scores (Positive Collaboration; Positive Clinician Input; Non-Supportive Clinician Input) can be obtained from the client's responses. A total STAR-C score and three subscale scores (Positive Collaboration; Emotional Difficulties; Positive Clinician Input) can be obtained from the clinician's responses. These total STAR and subscale scores are arrived at by summing a selection of the 12 item answers from never (a score of 0) to always (a score of 4). However, the Non-Supportive Clinician Input and Emotional Difficulties subscales are computed by reversing the individual's scores. McGuire-Snieckus *et al.* (2007) assert that the higher the client scores for the total STAR and each subscale, the more they perceive a high quality therapeutic relationship.

2.3.3 Repertory Grid

As explained in the introduction, the repertory grid is an interview designed to explore the content and structure of an individual's personal construct system (Kelly, 1955). A completed grid will contain *elements* (for example, my mother) which refer to what is being construed and bi-polar *constructs* (for example, happy – sad) which refer to the individual's personal, unique system of meaning. However, to begin with, the grid "is nothing more than a blank

matrix” (Fransella, 2003a; pp.109).The grid subsequently needs to be designed according to the research questions. It is administered by the interviewer eliciting a set of the interviewee’s bi-polar constructs through questioning (Bell, 2004). The interviewee is then instructed to rate a series of elements, according to these constructs, usually on a Likert scale.¹⁴

2.3.3.1 Psychometric Properties of Repertory Grids

As there is no standard grid template, absolute statements regarding the reliability and validity of this approach are not particularly meaningful. However, research has consistently demonstrated strong test-retest reliability across groups and points in time (Bannister & Mair, 1968; Caputi & Keynes, 2001; Fransella, Bell & Bannister, 2004). With regard to validity, Bannister (1965) originally stressed that only time will tell with regard to establishing the validity of the various forms of the grid. Bell (2005) later asserted the inherent difficulties with establishing the validity of a measure which has no consistent form. Nevertheless, there remains evidence of the validity of various grid measures, as reviewed in Fransella, Bell & Bannister (2004).

2.3.3.2 Chosen Elements

Bell (2000) asserts that the choice of elements is crucial and should be directly related to the research questions. The present research therefore utilised a grid which consisted of the following elements:

1. Current self (how I am)
2. Ideal self (how I would like to be)
3. Future self (how I will be)
4. Mother
5. Father
6. Partner/spouse/person close to me
7. A person with physical health problems
8. A person with psychological health problems
9. Self before engaging in psychological therapy (if I’ve had it)
10. Self after/ when I finish engaging in psychological therapy (if I’ve had it)

¹⁴ Likert scales are frequently used within grids, as constructs are more often understood to be *dimensional* instead of *dichotomous* (Walker & Winter, 2007).

11. My clinician/ therapist/ care worker

The elements relating to aspects of the self (i.e. current, future and ideal) were selected due to their use in previous grid studies. In addition to providing insight into self-construing, they are also thought to provide *anchors* against which other elements and constructs can be compared (Fransella, 2003). Elements were also chosen to explore client participants' construing regarding significant relationships, thought to be known to their participating clinician. Other elements were selected to explore client participants' construing regarding perceptions of therapy benefits and the construct of illness (relevant to research questions; Bell, 2004).

2.3.3.3 Supplied Constructs

The present research consisted of both elicited and supplied constructs. 11 elicited constructs were derived from the 11 elements above. The researcher supplied an additional two grid constructs:

1. Well – Ill
2. Will get better – Will never get better

Research has argued supplied constructs to be less meaningful and versatile than elicited constructs (Fransella, Bell & Bannister, 2004; Walker & Winter, 2007). However, it is equally acknowledged that providing constructs to the grid can enable researchers to explore specific areas of interest (Fransella, 2003a).

2.3.3.4 Analysis and Summary measures

The quantitative data extracted from repertory grids can be mathematically analysed using computer programs. For the present research hypotheses, completed grids were analysed using the IDIOGRID computer software package (Grice, 2002). This software can report on the array of inter-relationships between elements and constructs by providing a number of *summary measures* (Walker & Winter, 2007). The following section discusses the specific summary measures which were extracted from IDIOGRID to address the present research questions. Tables 1-4 (later presented in this chapter) display which of these summary measures were selected to address each hypothesis.

The first summary measure that was necessary to extract from the grids is known as standardised *Euclidean distances*. This summary measure provides an indication of perceived dissimilarity between elements.¹⁵ Distance scores range between 0 to approximately 2. A distance of more than 1.2 suggests that two elements are being construed differently, whereas a distance of less than 0.8 suggests that two elements are being construed similarly. A distance of 0 will highlight that two elements are being construed identically (Makhlouf-Norris & Norris, 1973; Winter, 1992).

The percentage variance accounted for by the first component from *Principal Component Analysis (PCA)* is another grid summary measure which was extracted by IDIOGRID. The higher the percentage of variance accounted for, the tighter the organisation of that individual's construct system. Ryle & Breen (1972) suggested that a percentage variance score of 70% and above constitutes tight construing. Alternatively, the lower the percentage of variance accounted for, the looser the construing. Winter (1992) has argued this summary measure highlights an individual's *cognitive complexity*, which he asserts to be the converse of tight construing.

The next summary measure that was extracted from the repertory grids was the *percentage sum of squares*. This provides a measure of the degree of saliency and superordinacy for each element or construct, with higher percentages (i.e. a maximum of 100%) indicating a greater degree of saliency, superordinacy or elaboration (Winter, 1992). For example, a lower sum of squares for an element suggests that the individual has made a high number of midpoint ratings (for example, 4 on a Likert scale of 1 to 7).

When comparing client and clinician grids, the percentage sum of squares measure was also extracted using a technique developed by Slater (1968). This technique refers to a grid analysis program (on IDIOGRID) which compares two grids to create a 'differential changes' grid. This grid then allows for the exploration of the differences between elements and constructs, with higher percentage sum of square values indicating higher differences (or disagreement) in the use of particular constructs or construing of particular elements (Winter, 1992).

A *Delta* correlation was additionally extracted to indicate the general degree of correlation between client and clinician grids. This summary measure is another one of several

¹⁵ For example, large Euclidean distances between 'current self' and 'ideal self' have been evidenced to be associated with psychological distress (Boldero *et al.*, 2005).

techniques developed by Slater for comparing repertory grids (Slater, 1968). A Delta correlation was conducted for each client and clinician participant pair. The clinician was given their client's blank grid and asked to complete it how they imagined their client would do. The IDIOGRID programme then compared these two grids (generating a single 'differential changes' grid) and produced a Delta correlation. This is a single correlation which reflects the overall similarity between two grids. The greater this correlation coefficient (0-1), the more similar the construct ratings of the elements between grids (Winter, 1992).

2.4 Methods of Analysis for Hypotheses

The following tables specify the methods of analysis necessary to address each hypothesis, including the predicted statistical outcome.

Table 1 displays the major hypotheses for the present study. These include those hypotheses which relate to the original research questions and those which require grid summary measures which explore substantial, structural aspects of the grid. Table 2 displays an additional list of exploratory hypotheses.

Table 1

Summary Measures and Predicted Outcomes: Major Hypotheses

Hypothesis	Summary measures	Prediction
1) Clients who construe themselves to be ill before psychological therapy will be less likely to construe benefits from psychological therapy.	Correlation between well – ill ratings on 'self before engaging in psychological therapy' and [standardised Euclidean distance between 'self before psychological therapy' and 'ideal self'] minus [standardised Euclidean distance between 'self after psychological therapy' and 'ideal self.']	Positive correlation.

2) Clients who perceive the well – ill construct to be important will be less likely to construe benefits from psychological therapy.	Correlation between percentage sum of squares accounted for by the well – ill construct and [standardised Euclidean distance between ‘self before psychological therapy’ and ‘ideal self’] minus [standardised Euclidean distance between ‘self after psychological therapy’ and ‘ideal self.’]	Negative correlation.
3) Clients who construe the ‘current self’ and ‘a person with psychological health problems’ in a dissimilar way, will present with more severe BPD symptoms.	Correlation between [standardised Euclidean distances between ‘current self’ and ‘a person with psychological health problems’] and BSL-23 scores.	Positive correlation.
4) Clients who construe ‘a person with psychological health problems’ and ‘a person with physical health problems’ in a similar way, will present with more severe BPD symptoms.	Correlation between [standardised Euclidean distances between ‘a person with psychological health problems’ and ‘a person with physical health problems’] and BSL-23 scores.	Negative correlation.
5) Clinicians’ accurate predictions of their clients’ personal construct systems will be associated with a good therapeutic relationship.	Correlation between STAR-P scores and Delta correlation.	Positive correlation.
	Correlation between STAR-C scores and Delta correlation.	Positive correlation.

<p>This will be particularly evident in clinicians' accurate perceptions of their clients' 'current self.'</p>	<p>Correlation between STAR-P and percentage sum of squares accounted for by 'current self' (on the differential changes grid).</p>	<p>Negative correlation.</p>
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<p>Correlation between STAR-C and percentage sum of squares accounted for by 'current self' (on the differential changes grid).</p>	<p>Negative correlation.</p>
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<p>6) Clients who construe themselves to be ill will experience a poorer therapeutic relationship.</p>	<p>Correlation between 'current self' ratings on the well – ill construct and STAR-P.</p>	<p>Positive correlation.</p>
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<p>Correlation between 'current self' ratings on the well – ill construct and STAR-C.</p>	<p>Positive correlation.</p>
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<p>Correlation between percentage sum of squares accounted for by the well – ill construct and STAR-P.</p>	<p>Negative correlation.</p>
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<p>Correlation between percentage sum of squares accounted for by the well – ill construct and STAR-C.</p>	<p>Negative correlation.</p>
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<p>7) Clients who construe tightly will experience a poorer therapeutic relationship.</p>	<p>Correlation between percentage variance accounted for by first principal component analysis and STAR-P.</p>	<p>Negative correlation.</p>
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Correlation between percentage variance accounted for by first principal component analysis and STAR-C.	Negative correlation.
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Table 2

Summary Measures and Predicted Outcomes: Exploratory Hypotheses

Hypothesis	Summary measures	Prediction
8) Clients who construe the 'current self' to be ill will also present with more severe BPD symptoms.	Correlation between 'current self' ratings on the well – ill construct and the BSL-23 scores.	Negative correlation.
9) Clients who construe 'a person with psychological health problems' to be ill will also present with more severe BPD symptoms.	Correlation between 'a person with psychological health problems' ratings on the well – ill construct and the BSL-23 scores.	Negative correlation.
10) Clients who construe themselves to be well will be more likely to construe themselves as getting better from their difficulties.	Correlation between 'current self' ratings on the well – ill and will get better – will never get better constructs.	Positive correlation.
	Correlation between 'self before engaging in psychological therapy' ratings on the well – ill and will get better – will never get better constructs.	Positive correlation.

11) The construal of a poor therapeutic relationship will be associated with more severe BPD symptoms.	Correlation between the STAR-C and BSL-23.	Negative correlation.
	Correlation between the STAR-P and BSL-23.	Negative correlation.
12) Clients who construe the 'current self' and 'ideal self' in a dissimilar way, will present with more severe BPD symptoms.	Correlation between BSL-23 and [standardised Euclidean distances between the 'current self' and 'ideal self.']	Positive correlation.
13) Clients who construe the 'future self' and 'ideal self' in a dissimilar way, will present with more severe BPD symptoms.	Correlation between BSL-23 and [standardised Euclidean distances between the 'future self' and 'ideal self.']	Positive correlation.

2.5 Procedure

The research comprised of two core parts – meeting with participating clients and then meeting or liaising with their participating clinicians.

2.5.1 Part One: Client Participants

After reading through the Clinician Information Sheet (see Appendix B), consenting clinicians were asked to hand the Client Information Sheet (see Appendix C) to suitable clients. Clinicians then informed the researcher when their clients were interested in participating. The researcher then contacted clients to arrange a one-off research participation meeting at their local healthcare setting. These meetings took between one to one and a half hours. Upon meeting, client participants were firstly asked to read and sign a Consent Form (see

Appendix G). Participants were then asked about their last experience of psychological therapy (see Appendix D). This took approximately 10 minutes.

Client participants then spent approximately 45 minutes completing the repertory grid with the researcher (see Appendix H). Their constructs were elicited using the 'triadic method,' where participants were asked to consider groups of three elements and asked in what way two of them were similar (Kelly, 1955; 1991). When a construct pole was identified (the 'emergent pole' e.g. happy) the client participant would then be asked for its opposite (the 'implicit pole' e.g. sad). This process continued until 11 constructs had been identified, which were combined with the two supplied constructs. Participants were then asked to rate all 11 elements, according to each bi-polar construct, on a Likert scale from 1 to 7. Participants were informed that they could rate elements as 4 if they were unsure or perceived the element as belonging to both ends of the bi-polar construct.¹⁶

After completing the repertory grid, participants completed the BSL-23 (see Appendix E) and the STAR-P (see Appendix F). Participants were finally asked some questions relating to their demographic information, handed the Client Debrief Sheet (see Appendix I) and thanked for their time.

2.5.2 Part Two: Clinician Participants

After the researcher had met with each client participant, their respective clinician (who was also participating in the research) was informed. They were subsequently given the option of whether they would like to participate face-to-face or via post. All those clinician participants who opted to meet face-to-face were met with for a one-off session at their place of work. These meetings took no more than an hour. Those who opted to participate via post were sent the relevant materials by recorded delivery. Clinicians were required to participate in the study each time one of their client's participated. Therefore, clinicians who referred more than one client were met with, or contacted via the post, more than once (i.e. corresponding to each client participant they were working with).

Clinician participants were asked to firstly read and sign the Consent Form (see Appendix G). They were then given a copy of their client's repertory grid, which included all elicited (and supplied) bi-polar constructs, but blank construct ratings. Clinician participants were

¹⁶ Rating elements (as opposed to ranking) was decided in order to allow for increased flexibility when defining the elements listed.

instructed to predict their client's construct ratings, for each element, using a 1-7 Likert scale. This took approximately 15-20 minutes. Finally, clinician participants were asked to complete the STAR-C (see Appendix F). They were then asked questions relating to their demographic information, handed or sent a Clinician Debrief Sheet (see Appendix J) and thanked for their time.

2.6 Feedback

The researcher informed participants that they would be unable to provide individual feedback regarding the repertory grid and questionnaires. However, all participants were asked if they would like to receive a report giving a short summary of the research and its results (after research completion).

2.7 Ethical Considerations

2.7.1 Official Documents

The University of Hertfordshire provided ethical approval, sponsorship and indemnity insurance (see Appendix K). The NHS Integrated Research Application System (IRAS) subsequently provided ethical approval for the research. This was after a meeting with a Research Ethics Committee (REC) and requested amendments (see Appendix L). Liaison was also required with each of the research site's Research & Development (R&D) departments. R&D documentation is available for two sites, as the third was a non-NHS private inpatient facility (see Appendix M).

2.7.2 Standard Ethical Procedures

Prior to the recruitment process, service user involvement was sought. Two adult, female clients (associated with NHS mental health services) agreed to read through the present study's original protocol and materials.¹⁷ A brief meeting was then arranged to discuss their impressions. Generally positive feedback was reported, although they suggested some additional information to explain the repertory grid technique to potential participants. The Client Information Sheet was therefore adjusted accordingly (see Appendix B). A former NHS male clinician (with extensive BPD experience) additionally read through the clinician participant materials and offered verbal feedback.

¹⁷ Note, one of these clients confirmed to the researcher that she had received a diagnosis of BPD.

To adhere to ethics during the recruitment stage, each participant was advised of their right to withdraw from the research, at any point, with no questions asked. Participants were also informed that no identifiable information about them would be published. They were additionally informed of their right to withdraw at a later date (up to June 2015) by contacting the researcher.¹⁸ These ethical rights were also reiterated in the research study's Information Sheets (Appendix B and C) and in the Consent Form (Appendix G).

With regard to confidentiality and anonymity, each participant was informed that the information they give during the research will be kept confidential (as long as the researcher did not become concerned about their safety; see the Risk Management section below). The Clinician and Client Information Sheets (see Appendix B and C) and Clinician and Client Debrief Sheets (see Appendix I and J) additionally explicitly stated that clients and clinicians would not be informed of the accuracy of clinician grid predictions and that the accuracy would even remain anonymous to the researcher.

2.7.3. Risk Management Issues

As discussed throughout this research project, people diagnosed with BPD can present with high risk behaviours due to their struggles to cope with intense emotions and their tendency to act on impulse. In addition to the day to day difficulties people with BPD face, the researcher was also aware that asking client participants to consider their relationships with themselves and others (through the repertory grid) may result in a certain amount of discomfort.

A number of key safeguarding procedures were consequently utilised throughout the conduct of this research study. These included the following:

1. Client participants were made aware of the kinds of questions the repertory grid would ask, prior to participating (Appendix C).
2. Client participants were given the opportunity to ask the researcher questions about the nature of the project, prior to participating.

¹⁸ Note, each participant was assigned a unique identification number for this purpose.

3. Client participants were informed of the limits of confidentiality (Appendix C). This explained the clinical responsibility of the researcher to pass on information to the relevant professionals, should the participant suggest that their or someone else's safety may be at risk.
4. The BSL-23 provided a measure of risk assessment, as 11 supplemental questions asked client participants about their engagement in risky behaviours over the past week (Appendix E).¹⁹
5. The researcher encouraged client participants to make contact with their responsible clinician for support and psychological skills coaching, should they feel they needed it.
6. The researcher was prepared to suggest DBT coping skills to client participants (NICE, 2009; 2015) if they presented in crisis and this was considered absolutely necessary.
7. Client participants were given a list of local NHS and charitable organisations within the Debrief Sheet (Appendix I). This was in case they wanted to discuss any distress potentially encountered as a result of taking part in the research study.

2.8 Data Collation and Analysis

During data collection, all data was kept secure in a locked filing cabinet or on a password protected computer.²⁰ Questionnaires were then hand-scored, checked and electronically stored on excel spread sheets. The repertory grids were inputted and electronically stored on IDIOGRID (Grice, 2002).

The Statistical Package for the Social Sciences (SPSS; Version 16.0, 2008) was used to conduct statistical analyses, once data was inputted from the questionnaires and extracted

¹⁹ During face-to-face meetings, the researcher informed client participants that risky responses would need to be fed back to their responsible clinician (as stated in the Client Information Sheet; Appendix C).

²⁰ All raw data will be destroyed after a period of five years i.e. February 2020.

from the repertory grids. Non-parametric tests were used, as descriptive statistics revealed the data to not meet parametric assumptions i.e. homogeneity of variance, linearity or a normal distribution of data. These included the Spearman rank order correlation coefficient for correlations and the Mann-Whitney U test or Wilcoxon Signed Rank test for group comparisons.

Findings revealed a number of medium effect size correlations which were limited in statistical power, due to the study's sample size (refer back to Figure 1). A post-hoc power calculation was therefore conducted for one of the medium effect correlations that did not yield statistical significance (i.e. Hypothesis 8). This indicated that a medium correlation of $r = .40$ produced a power of only 55% (at an alpha level of 5%). The decision to consider *borderline significant* results (i.e. $p < .10$) was therefore taken in addition to inspecting *statistically significant* results (i.e. $p < .05$).

CHAPTER THREE: RESULTS

In this chapter, the study findings will be presented for the client and clinician participants, concluding with whether or not each of the 13 hypotheses can be confirmed or not. As stated in Chapter Two, numbers have been assigned to each participant for the purposes of confidentiality and will be referred to throughout this chapter. The chapter is divided into four main sections. The first section will present the demographic information and characteristics of those who participated in the research. The second section will present questionnaire and grid descriptive statistics. The third section will then present the subsequent analyses of these statistics (under a sub-title for each of the major and exploratory hypotheses). Finally, the fourth section of this chapter will discuss two case examples.

3.1 Demographic Information

The study's clinician participant sample comprised of 12 clinicians (five females and seven males). The maximum number of clients who were referred by any clinician was two.²¹ All clinicians were from a White British ethnic background, with ages ranging from 29 to 60 years old. The Mean age (*M*) for the sample was 43.92 with a Standard Deviation (*SD*) of 10.59. Clinician participants additionally reported a number of different mental health professions, compiling a sample of four Psychologists, three Senior Practitioner Therapists, two Psychiatric Nurses and one Support Worker, Social Worker and Psychiatrist.

The study's client participant sample comprised of 18 females and two males, with the majority coming from a White British ethnic background (one person identified as Asian British). Ages ranged from 18 to 50 years, *M* = 35.70, *SD*= 8.91. All of the clients had received a primary diagnosis of Borderline Personality Disorder by a mental health service. The researcher was informed that some of the client participants had comorbid diagnoses, including other Axis I disorders (such as Anxiety).

3.2 Descriptive Statistics

²¹ Note: Although 12 clinicians participated in the study, Chapter Three and subsequent appendices will present tables which refer to data for 20 clinicians. This is because eight clinicians participated more than once, due to referring two clients. Data is therefore presented which corresponds to each of the 20 client participants.

The following section presents the findings from the Past Experiences of Psychological Therapy Questionnaire, BSL-23 and STAR. This section then goes on to report the relevant measures (as previously described) which have been extracted from the client and clinician repertory grids to address the present hypotheses.

3.2.1 Past Experiences of Psychological Therapy Questionnaire

All client participants had received or were currently receiving psychological therapy. Further details about this treatment were gathered by the Previous Experiences of Psychological Therapy Questionnaire (Appendix D).²²

Figures 3 and 4 display the length of time and specific type of psychological therapy client participants last engaged in.

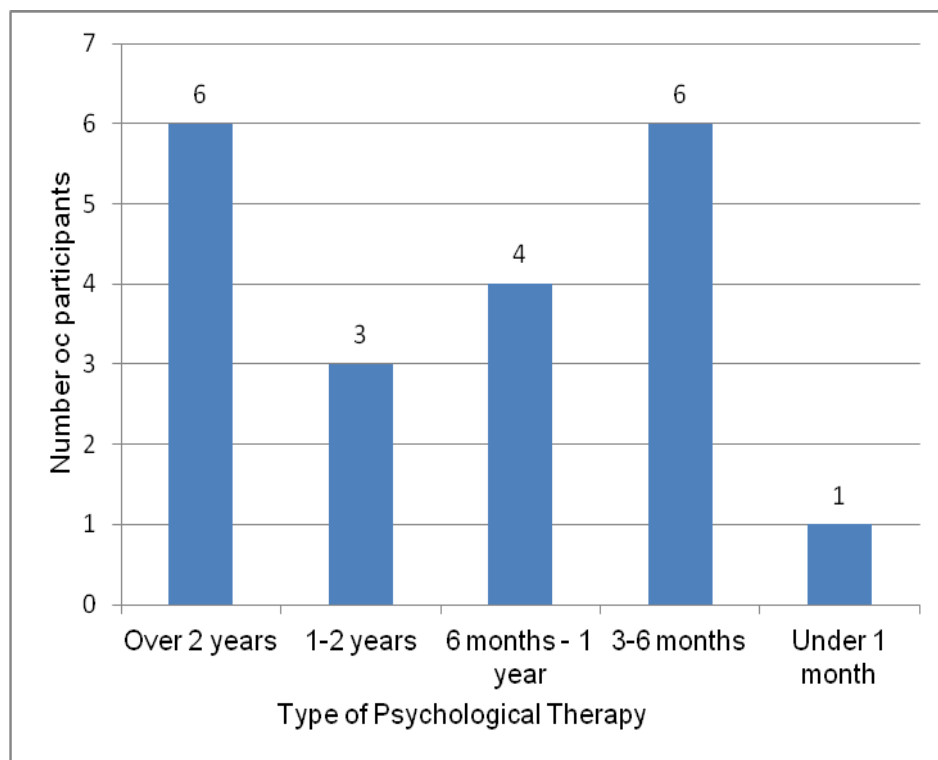


Figure 3. Length of time participants spent engaging in their most recent psychological therapy ($n = 20$).

²² Although this questionnaire originally provided a space for further comments, no significant qualitative information was obtained.

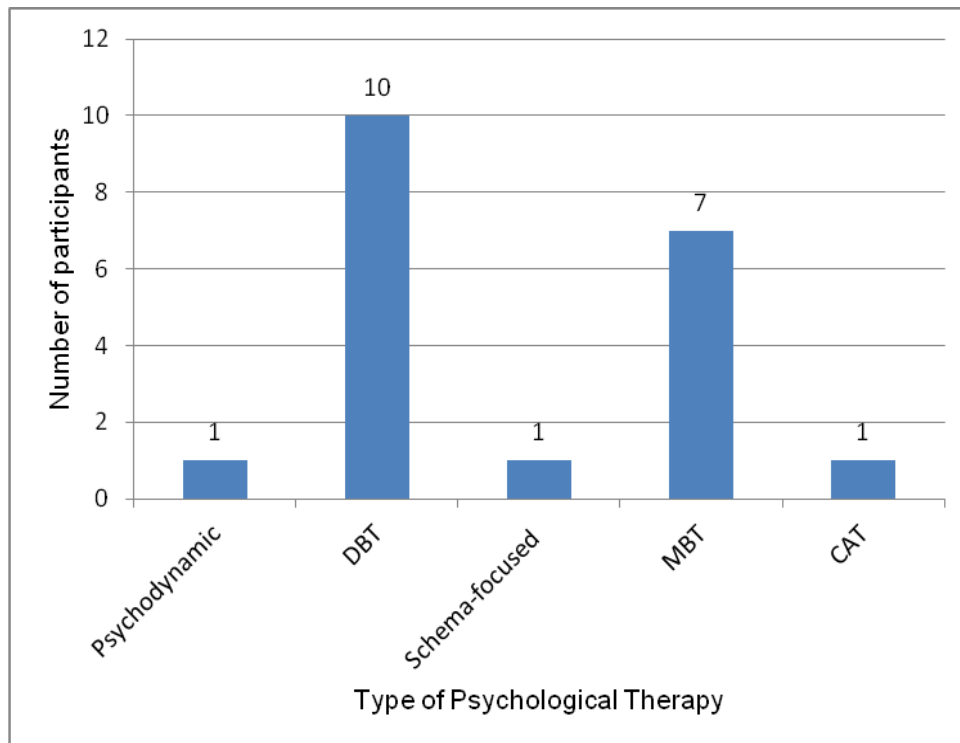


Figure 4. Type of psychological therapy participants are or have most recently engaged in ($n = 20$).

A total of 16 client participants were still receiving psychological therapy at the time of this project and four were not (reporting their last experience of psychological therapy ended three months to five years ago). A total of 14 client participants (out of 20) were currently receiving psychological therapy from the clinician participants who referred them for the present research. As Figure 3 displays, the length of time that these participants had been in therapy ranged from under one month to over two years. All participants reported seeing their therapists once a week, except one who saw their therapist once a fortnight. Out of the six clients remaining, four were currently not receiving formal psychological therapy from their clinician participants and two were receiving formal psychological therapy from another clinician (not taking part in the present research).

3.2.2 Borderline Symptoms List Questionnaire (BSL-23)

Hypotheses 3, 4, 8, 9, 11, 12 and 13 require BSL-23 data to correlate with other questionnaire or repertory grid measures. Table 3 displays the individual BSL-23 scores for each client participant. According to the scoring criteria, the higher an individual scores (out of 92) the more likely they are to display clinically significant Borderline Personality Disorder

traits (note, as previously mentioned, all client participants had a formal BPD diagnosis). The BSL-23 also requests the individual to report a global wellbeing score, from 0% (absolutely down) to 100% (excellent).

Table 3

Borderline Symptoms List (BSL-23) Scores for Client Participants

Participant	BSL-23	'Overall personal state' (0-100%)	Participant	BSL-23	'Overall personal state' (0-100%)
1	92	40%	11	32	50%
2	39	50%	12	51	30%
3	45	30%	13	44	40%
4	47	40%	14	72	30%
5	46	50%	15	72	30%
6	84	0%	16	68	60%
7	37	40%	17	33	60%
8	53	30%	18	62	30%
9	61	30%	19	50	70%
10	4	90%	20	57	30%

Although the BSL-23 does not suggest a cut-off score for a diagnosis of BPD, it is worth noting that seven participants scored less than half of the total global factor score (i.e. less than 46). Table 4 below displays the measures of central tendency for client participants' BSL-23 scores. The client sample were found to have a mean BSL-23 score of 52.45 ($SD = 19.90$) with a range of 4-92.

Table 4

Measures of Central Tendency for Client Participants' BSL-23 Scores

	BSL-23
<i>N</i>	20
<i>M</i>	52.45
Median	50.50
Mode	72.00
Minimum	4.00
Maximum	92.00

<i>SD</i>	19.90
Skewness	-.18

It is worth noting that the BSL-23 is a measure of the individual's past week and is therefore not a purely diagnostic tool (as it does not account for the individual's developmental history). The client sample were also found to have reported a mean 'global wellbeing' BSL-23 score of 42% ($SD = 0.19\%$) with a range of 0-90%.

Table 5 displays the BSL-23 mean item score (the total mean score of 52.45 divided by 23) in comparison to the same normative data supplied by the clinical standardisation sample (note, no normative mean data is available for global wellbeing percentage scores). The clinical standardisation sample consisted of BSL-95 data, taken from 380 clients with a diagnosis of BPD (Bohus *et al.*, 2007). Of these, 76% were inpatients and 24% were in outpatient treatment. Bohus *et al.* (2009) asserts that one can apply this normative data with the BSL-23. Table 5 suggests that the client sample is presenting with very similar BPD symptoms as Bohus *et al.* (2007) would expect for this client group.

Table 5
BSL-23 Normative Data and Client Participant Mean Scores

Total BSL-23 Mean score and Standard Deviation	
Standardisation sample ($n = 380$)	$M = 2.0, SD = 0.76$
Client sample ($n = 20$)	$M = 2.3, SD = 0.87$

3.2.3 Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR)

Hypotheses 5, 6, 7 and 11 require STAR data to correlate with other questionnaire or repertory grid measures.²³ Figure 5 displays a scatterplot for the total STAR-P and STAR-C participant scores for each client and clinician pair. According to the scoring criteria, the

²³ Appendices N and O display the individual total and sub-scale STAR scores for each client and clinician participant.

higher an individual scores (out of 48) the higher they perceive the quality of the therapeutic relationship.

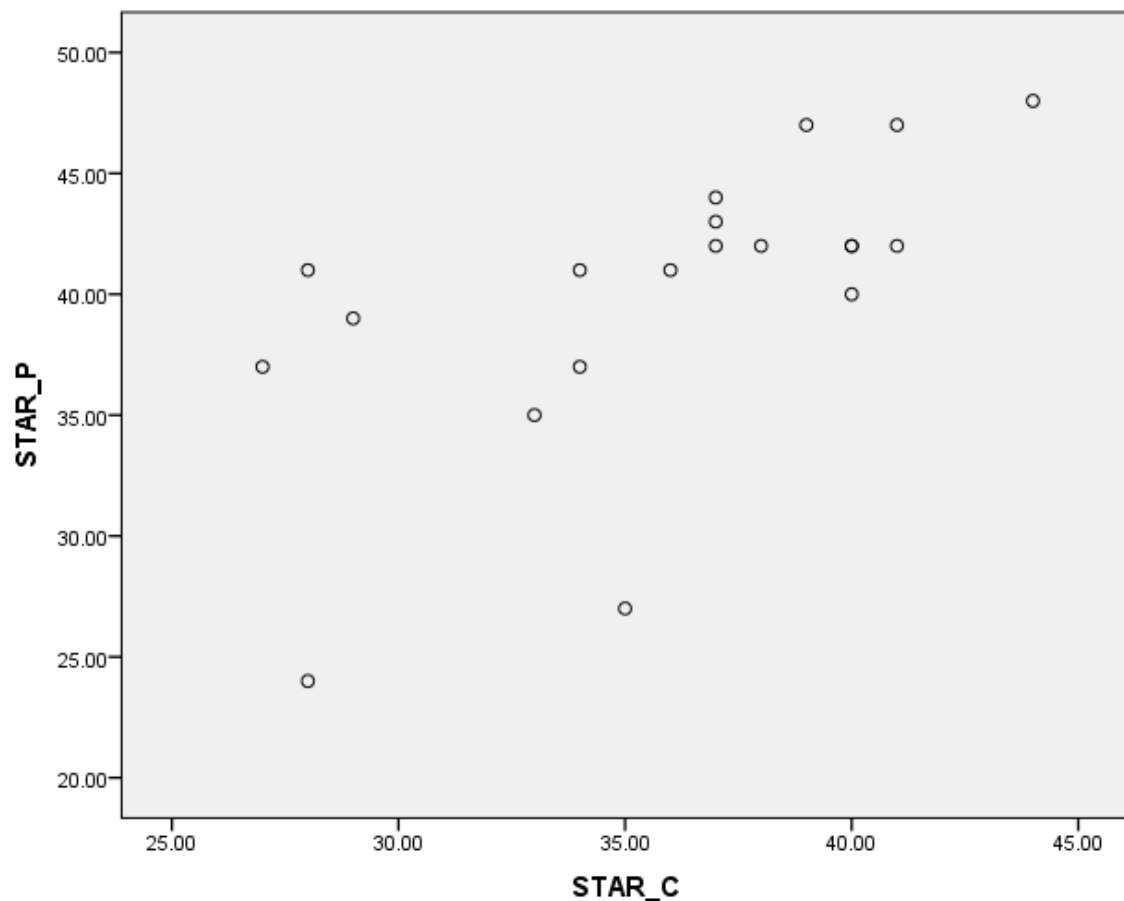


Figure 5. STAR scores for participating client and clinician pairs ($n = 20$).

Upon inspecting Figure 5, it appears that participating clients (STAR-P) and clinicians (STAR-C) are generally reporting a similar perception of the therapeutic relationship. A Spearman's rho correlation revealed this relationship to be statistically significant, with a large effect size²⁴ ($r_s(18) = 0.75$ $p < .001$, two-tailed). Figure 5 additionally depicts the majority of scores within the top-right quarter of the scatterplot, highlighting that most participants rated the therapeutic relationship to be of a good quality. A cluster of three scores on the left of the scatterplot reveals three participating pairs where the clinician reported the relationship to be of a markedly poorer quality than reported by the client.

²⁴ Note, interpretations of the magnitude of effect sizes are based on Cohen's (1988) assertion that .10 equates to a "small" effect size, .30 equates to a "medium" effect size and .50 equates to a "large" effect size.

Tables 6 displays the measures of central tendency for client and clinician participants' STAR scores.²⁵

Table 6

Measures of Central Tendency for Client and Clinician Participants' STAR Scores

	STAR-P	STAR-C
<i>N</i>	20	12
<i>M</i>	40.05	35.90
Median	41.50	37.00
Mode	42.00	37.00 ^a
Minimum	24.00	27.00
Maximum	48.00	44.00
<i>SD</i>	5.98	4.89
Skewness	-1.44	-.51

a. Multiple modes exist. The smallest value is shown

The clinical standardisation sample for the STAR-P consisted of 266 clients engaging in community outpatient treatment. They all had longstanding mental health difficulties and were mostly diagnosed with either Schizophrenia (67%) or Mood Disorder (13%). The clinical standardisation sample for the STAR-C consisted of 120 clinicians, who were psychiatric nurses (68%) social workers (17%), occupational therapists (8%) psychologists (3%) and psychiatrists (1%). Unfortunately, mean scores are not available from the STAR-P and STAR-C standardisation samples (as confirmed by the measure's authors, upon contacting them). It is therefore not possible to compare the present research study's STAR means with normative data from the clinical standardisation samples.

Figure 6 displays two box plots for participants' total STAR scores (i.e. STAR-P and STAR-C).²⁶ The boxes highlight the interquartile range of that particular variable (i.e. the 25th to 75th percentile), the median score (displayed by a horizontal line) and the 'whiskers' which extend from the ends of the box to depict the lowest and highest scores on that variable (excluding outliers, i.e. scores much lower or higher than others, marked by a circle or asterisk).

²⁵ Appendices P and Q display the measures of central tendency for each client and clinician STAR subscale score.

²⁶ Appendices R and S displays box plots for client and clinician STAR sub-scale scores.

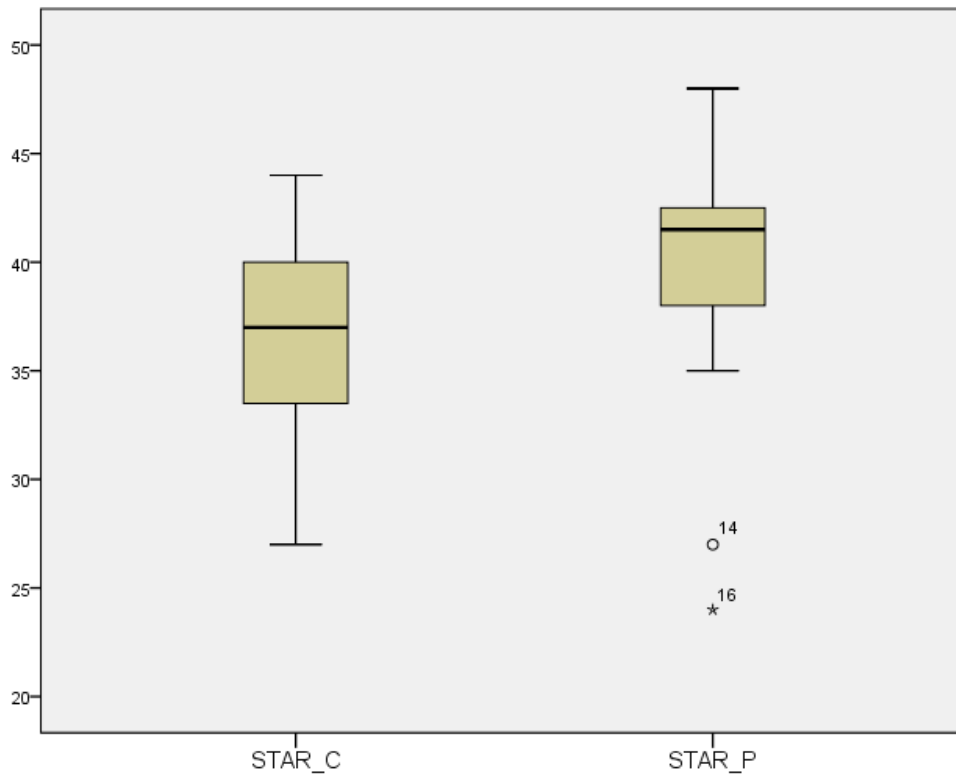


Figure 6. Box plots to display the dispersion of scores across total scores for the STAR-P and STAR-C variables.

As Figure 6 and Table 6 displays, the median STAR value is higher for clients than it is for clinicians. This suggests clients are reporting a generally higher quality therapeutic relationship than their clinicians. The clinician box plot (STAR-C) shows a slight negative skew and the client box plot (STAR-P) shows a slight positive skew. However, the client box plot is situated further up Figure 6 than the clinician box. This highlights that clients generally reported higher scores (i.e. higher quality therapeutic relationships) than clinicians. Clients additionally appear to report similar perceptions of the therapeutic relationship (depicted by a shorter box and interquartile range), except for a few outliers – highlighting two clients who viewed their relationships considerably more poorly.

A Mann-Whitney U test was also conducted to investigate the statistical significance between client (STAR-P) and clinician (STAR-C) reports of the therapeutic relationship (at an alpha level of .05). The results show that the difference in STAR scores between clients ($n = 20$, *Mean Rank* = 25.78) and clinicians ($n = 20$, *Mean Rank* = 15.23) was statistically significant, $U = 94.50$ ($z = -2.86$, $n = 20$, $p = .004$, two-tailed). A measure of effect size additionally shows the difference between the median values is moderate ($r = -.45$). A

significant and moderate difference was therefore revealed between client and clinician perceptions of the therapeutic relationship, with clients reporting this relationship more favourably.

3.2.4 Repertory Grids

The following section displays the descriptive statistics yielded from the repertory grids which are relevant to the present research hypotheses (as reported in Tables 1-4).²⁷ These descriptive statistics have been extracted from the 20 client participant repertory grids and from comparing the 20 client and 20 clinician repertory grid pairs.

Table 7 and 8 firstly display descriptive statistics for client participants' ratings, across all elements, on each of the two supplied constructs. The supplied constructs were rated on a Likert scale from 1-7. All 20 client participants completed all aspects of the repertory grid.

With regard to Table 7, clients rated each person in their life (element) according to how ill or well they construed them to be on this particular construct (note, the higher the score the more well that person is construed to be). The table displays that clients, on average, construe themselves before engaging in psychological therapy to be the most ill (i.e. 2.10 is the lowest mean value; $SD = 1.25$). Interesting, clients, on average, construe both a person with psychological health problems and a person with physical health problems more towards the ill construct pole, construing those with psychological health problems to be more ill than those with physical health problems. Perhaps unsurprisingly, clients construed their ideal self to be the most well although, interestingly, some do not aspire to be the most well they could possibly be (i.e. a score of 7). Clients also construed their clinicians very positively, as Table 7 displays an average well rating of 6.35 ($SD = 0.99$). The skewness statistics reflect this further, displaying negatively skewed data distributions for the elements ideal self, my clinician and future self, respectively. Client ratings of their mother appear to be the most normally distributed.

Although 'current self' ratings range from 1-6, the mean value of 3.80 and SD value of 1.28 suggest that client participants generally construe their current selves similarly when it comes to the well-ill construct i.e. somewhat in the middle as neither ill nor well. The higher

²⁷ Appendix T displays the supplied construct repertory grid ratings for each client participant.

mean value for the 'future self' element additionally suggests clients are relatively hopeful about their recovery in the future.

A Wilcoxon Signed Rank test was carried out (at an alpha level of .05) concluding that there is a statistically significant difference between how ill clients construe themselves before psychological therapy ($n = 20$, $Mdn = 2$) and after psychological therapy ($n = 20$, $Mdn = 5$; $Z = -3.75$, $p < .001$, two-tailed). A measure of effect size additionally shows the difference between the median values is large ($r = -.59$). The direction of this relationship suggests that clients reported a significant and large improvement with regard to construing themselves to be less ill following psychological therapy.

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Table 7

Descriptive Statistics for Client Ratings on the well – ill Construct

	Current self	Ideal self	Future self	Mother	Father	Partner/ person close	A person with physical health problems	A person with psychological health problems	Self before therapy	Self after therapy	Clinician
<i>N</i>	20	20	20	20	20	20	20	20	20	20	20
<i>M</i>	3.80	6.85	5.25	4.85	4.65	5.50	3.65	3.00	2.10	5.15	6.35
Median	4.00	7.00	5.00	4.50	5.00	6.00	4.00	3.00	2.00	5.00	7.00
Mode	5.00	7.00	5.00	4.00	5.00	6.00	4.00	3.00	1.00	6.00	7.00
<i>SD</i>	1.28	.37	1.37	1.73	1.90	1.36	1.63	1.30	1.25	1.04	.99
Skewness	-.42	-2.12	-1.45	-.22	-.57	-.63	-.26	.64	.87	-1.26	-1.50
Minimum	1.00	6.00	1.00	2.00	1.00	3.00	1.00	1.00	1.00	3.00	4.00
Maximum	6.00	7.00	7.00	7.00	7.00	7.00	6.00	6.00	5.00	6.00	7.00

With regard to Table 8, clients rated each person in their life (element) according to how likely they believed they were to get better (note, the higher the score the more the client participant construes this person as likely to get better). The table displays that clients, on average, again construe their ideal selves and clinicians most favourably and thus likely to continue to get better (whatever this means to them). Client participants interestingly again, on average, rated their current self a 4 and therefore neither likely nor unlikely to get better at this point in time (possibly reflecting mixed feelings). There is little difference with regard to how clients, on average, construe people with physical and psychological health problems with regard to getting better and recovery (the distributions show a large rating range of 1-7). The largest negatively skewed data distributions are for the elements ideal self, my clinician and future self, respectively. This is similar to the skewed data distributions displayed in Table 7.

Client ratings of their 'current self' and (again, like in Table 7) their 'mother' appear to be the most normally distributed elements. The table finally highlights similarities between the two supplied constructs, as similar patterns emerge again where clients are, on average, construing 'a person close to me' as more likely to get better than their parents. The higher average 'future self' rating additionally suggests clients are relatively hopeful about their recovery in the future.

A Wilcoxon Signed Rank test was also carried out (at an alpha level of .05) concluding that there is a statistically significant difference between how clients construe themselves as likely to 'get better' before psychological therapy ($n = 20$, $Mdn = 1$) and after psychological therapy ($n = 20$, $Mdn = 5$; $Z = -3.57$, $p < .001$, two-tailed). A measure of effect size additionally shows the difference between the median values is large ($r = -.56$). The direction of this relationship suggests that clients reported a significant and large improvement with regard to construing themselves to be more likely to 'get better' following psychological therapy.

Table 8

Descriptive Statistics for Client Ratings on the will get better - will never get better Construct

	Current self	Ideal self	Future self	Mother	Father	Partner/ person close	A person with physical health problems	A person with psychological health problems	Self before therapy	Self after therapy	Clinician
<i>N</i>	20	20	20	20	20	20	20	20	20	20	20
<i>M</i>	4.00	6.70	5.00	4.10	3.50	5.50	3.45	3.85	1.85	4.95	5.80
Median	4.00	7.00	5.00	4.00	3.50	6.00	3.50	4.00	1.00	5.00	6.50
Mode	4.00	7.00	6.00	4.00 ^a	1.00 ^a	4.00 ^a	4.00	4.00 ^a	1.00	5.00 ^a	7.00
<i>SD</i>	1.62	.57	1.62	1.86	1.99	1.36	1.67	1.76	1.18	1.39	1.54
Skewness	-.16	-1.85	-.99	-.16	.29	-.35	.25	-.27	1.38	-.55	-1.16
Minimum	1.00	5.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	2.00	2.00
Maximum	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	5.00	7.00	7.00

a. Multiple modes exist. The smallest value is shown

Table 9 displays the key measures of central tendency for the standardised Euclidean distances (between 0-2). These Euclidean distances address client participants' construing of particular pairs of elements (as relevant to address the present research hypotheses).²⁸

Table 9

Measures of Central Tendency for Standardised Euclidean Distances between Elements

	'Current self and 'A person with psychological health problems'	'A person with psychological health problems' and 'A person with physical health problems'	'Self before psychological therapy' and 'Ideal self'	'Self after psychological therapy' and 'Ideal self'	'Current self' and 'Ideal self'	'Future self' and 'Ideal self'
<i>N</i>	20	20	20	20	20	20
<i>M</i>	0.86	0.78	1.63	0.68	1.09	0.65
Minimum	0.45	0.19	1.23	0.21	0.39	0.24
Maximum	1.21	1.48	1.98	1.16	1.69	1.40
<i>SD</i>	0.23	0.31	0.24	0.30	0.31	0.29

Table 10 displays the standardised Euclidean distance between 'self before psychological therapy' and 'ideal self' minus the standardised Euclidean distance between 'self after psychological therapy' and 'ideal self' (pertaining to Hypotheses 1 and 2).

²⁸ Appendix U displays the Euclidean distance summary measures which have been extracted from each client participant.

Table 10

Standardised Euclidean Distances between Elements: The Construal of Benefits Following Psychological Therapy

Participant	Euclidean distance between 'Self before psychological therapy' and 'Ideal self' <i>minus</i> Euclidean distance between 'Self after psychological therapy' and 'Ideal self'
1	0.11
2	0.92
3	0.79
4	0.71
5	1.29
6	0.26
7	1.02
8	0.80
9	1.52
10	1.62
11	0.57
12	0.72
13	1.03
14	0.82
15	1.14
16	0.88
17	0.72
18	1.45
19	1.26
20	1.45

Table 9 is important with regard to Hypotheses 1, 2, 3, 4, 12 and 13 as they are each addressed by extracting and collating the 'Euclidean distance' grid measure. Table 10 is important with regard to Hypotheses 6 and 7 as the difference between Euclidean distances addresses clients' ability to construe benefits from psychological therapy.

Norris & Makhoul-Norris (1976) argued 'cut-off' values of 0.8 and below (small distances) suggest very similar construing of elements and 1.2 and above (big distances) suggest very dissimilar construing of elements. With regard to Hypothesis 3, Table 9 displays the mean

standardised Euclidean distance between 'current self' and 'a person with psychological health problems' is 0.86 ($SD = 0.23$). This suggests that participants appear to be construing their current self as similar to a person with psychological health problems. The analysis section later in this chapter will correlate these findings with the BSL-23 scores to conclude whether Hypothesis 3 can be confirmed or not.

When addressing Hypothesis 4, Table 9 displays the mean standardised Euclidean distance between 'a person with psychological health problems' and 'a person with physical health problems' is 0.78 ($SD = 0.31$). This indicates that, on average, participants tend to construe people with psychological and physical health problems similarly. The analysis section later in this chapter will correlate these findings with the BSL-23 scores to conclude whether Hypothesis 4 can be confirmed or not.

Hypotheses 1 and 2 concern Euclidean distances to address client participants' perceived benefits from psychological therapy. Table 9 displays the mean standardised Euclidean distance between 'self before engaging in psychological therapy' and 'ideal self' is 1.63 ($SD = 0.24$) and the mean standardised Euclidean distance between 'self after engaging in psychological therapy' and 'ideal self' is 0.68 ($SD = 0.30$). A Wilcoxon Signed Rank test (at an alpha level of .05) concludes that there is a statistically significant difference between clients construing of themselves as similar to their 'ideal self' before psychological therapy ($n = 20$, $Mdn = 1.68$) and after psychological therapy ($n = 20$, $Mdn = 0.63$); $Z = -3.92$, $p < .001$, two-tailed). A measure of effect size additionally shows the difference between the median values is large ($r = -.62$). The direction of this relationship suggests that clients reported a significant and large improvement with regard to benefiting from psychological therapy.

Table 10 displays the difference between these Euclidean distances as a measure of clients' construal of benefits from psychological therapy. A mean score of 0.95 ($SD = 0.40$) suggests an expected measure of change following psychological therapy (as Euclidean distance range from 0-2). The analysis section later in this chapter will explore whether such benefits are associated with the well – ill construct. This will be addressed by correlating therapy benefit findings with well – ill construct ratings on the 'self before engaging in psychological therapy' element (Hypothesis 1) and with the percentage sum of squares accounted for by the well – ill construct (Hypothesis 2).

Table 9 displays the mean standardised Euclidean distances between 'current self' and 'ideal self' (Hypothesis 12) and between 'future self' and 'ideal self' (Hypothesis 13) are 1.09 ($SD = 0.31$) and 0.65 ($SD = 0.29$), respectively. This indicates that, on average, participants

tend to see their future self as more similar to their ideal self than their current self. The analysis section later in this chapter will correlate these findings with the BSL-23 scores to conclude whether Hypotheses 12 and 13 can be confirmed or not.

Table 11 displays the key measures of central tendency for the percentage sum of squares data extracted from the 20 client participant repertory grids (between 0-100%).²⁹ This refers to the superordinacy of the well – ill construct for client participants (Hypotheses 2 and 6) and the accuracy of clinician participants' prediction of their clients' 'current self' ratings (Hypothesis 5).

Table 11

Measures of Central Tendency for Percentage Sum of Squares Measure (%)

	Percentage sum of squares accounted for by the well – ill construct	Percentage sum of squares accounted for by the 'current self' (on the differential changes grid)
<i>N</i>	20	20
<i>M</i>	7.20	7.67
Minimum	1.80	2.47
Maximum	10.23	14.92
<i>SD</i>	2.04	3.91

Table 11 shows that the mean percentage sum of squares accounted for by the well – ill construct is 7.20% (*SD* = 2.04%), suggesting that this is not a particularly superordinate construct for client participants. The table further displays a range where the maximum value is still relatively low. This chapter will later address whether or not we can confirm Hypothesis 2 (in the Analysis section) by correlating this construct's percentage sum of squares with the distance between standardised Euclidean distances. The percentage sum of squares accounted for by the well – ill construct will also be correlated with STAR-P and STAR-C scores, to address whether or not Hypothesis 6 can be confirmed.

Table 11 additionally displays the percentage sum of squares accounted for by clinicians' predictions of their clients' system of constructs for the element 'current self.' The mean score of 7.67% is below what would be expected if the percentages were evenly spread

²⁹ Appendix V displays the percentage sum of squares (%) summary measures which have been extracted from each client participant.

across all 11 elements (i.e. 9.09%). This suggests that, on average, clinicians were able to predict their client’s system of construct ratings for ‘current self.’ This finding will later be correlated with STAR-P and STAR-C scores to address whether or not Hypothesis 5 can be confirmed.

Table 12 displays the key measures of central tendency with regard to the Delta summary measure. This summary measure (ranging from a value of 0-1) refers to the general degree of correlation between client and clinician grids (pertaining to Hypothesis 5).³⁰

Table 12
Measures of Central Tendency for Delta Correlations

	Delta
<i>N</i>	20
<i>M</i>	0.57
Minimum	0.24
Maximum	0.80
<i>SD</i>	0.16

As a higher Delta score (between 0 and 1) indicates increased similarity between grids, the mean score of 0.57 (*SD* = 0.16, displayed in Table 12), although suggesting a trend towards accuracy, also suggests a mixed picture with regard to clinicians’ ability to accurately construe the world from their client’s point of view. A wide range of 0.24-0.80 suggests that some clinicians are much more able to do this than others.

Finally, Table 13 displays the key measures of central tendency for the percentage variance accounted for by the first Principal Component Analysis (PCA) for client participants’ grids.³¹ This refers to how tightly clients construe (Hypothesis 7).

³⁰ Appendix W displays the Delta summary measures which have been extracted from each client and clinician pair.

³¹ Appendix X displays the percentage variance accounted for by the first PCA extracted from each client participant’s repertory grid.

Table 13

Measures of Central Tendency for Percentage Variance Accounted for by the First PCA (%)

Percentage variance accounted for by first PCA	
N	20
Mean	66.02
Minimum	38.27
Maximum	88.06
SD	14.34

With regard to Table 13, the higher the percentage variance accounted for by the first PCA, the tighter the individual is thought to construe. The mean variance accounted for by the first principal component ($M = 66.02\%$, $SD = 14.34\%$) provides some evidence that client participants diagnosed with BPD may be more likely to construe the world tightly (normative data reports the mean percentage variance in a non-clinical population to be 39.4%; Ryle & Breen, 1972).

However, it is important to note that such normative data is based on a slightly larger 16 (as opposed to 13) construct grid, and that the smaller the grid, the higher the percentage variance expected (Winter, 1992). It is also possible that the mean percentage variance has been affected by some client participants construing more tightly and others more loosely (as suggested by the minimum and maximum first PCA values). This supports literature which suggests individuals with psychological difficulties tend to construe in more extreme styles (Dalton & Dunnet, 1992). The next section will address whether or not Hypothesis 7 can be confirmed, following correlating this variable with STAR-P and STAR-C scores.

3.3 Analysis

The following section presents the relevant statistical analyses for each major and exploratory hypothesis, including the figurative representation of correlations (note, some graphs contain duplicate values). As the data collected for the present research contains outliers and skewed distributions (as displayed in the earlier descriptive statistics tables), Spearman rank order non-parametric correlations were used due to their robustness and lack of assumed linearity. As all of the study hypotheses predicted a direction for the results,

one-tailed tests were employed. However, if results were opposite to what had been originally predicted, a two tailed test was used.

3.3.1 Major Hypotheses

Hypothesis 1: Clients who construe themselves to be ill before engaging in psychological therapy will be less likely to construe benefits from psychological therapy.

It was hypothesised that clients who construe themselves to be ill before engaging in psychological therapy (as rated on the self before engaging in psychological therapy well – ill construct) will be less likely to construe benefits from psychological therapy (as measured by the Euclidean distances between ‘self before engaging in psychological therapy’ and ‘ideal self’ minus ‘self after engaging in psychological therapy’ and ‘ideal self’).

A positive correlation was predicted between ‘self before engaging in psychological therapy’ ratings on the well – ill construct (the higher the rating, the more well) and the difference between Euclidean distances (the greater the difference, the more change clients construe with regard to being similar to their ‘ideal self’ following psychological therapy). These two variables were plotted against each other on a scatterplot (Figure 7) to see if a relationship exists. Although the scatterplot highlights the fact that a number of client participants considered themselves to be ill before therapy, a relationship does not appear visible with regard to the effect of this on perceived therapeutic benefits.

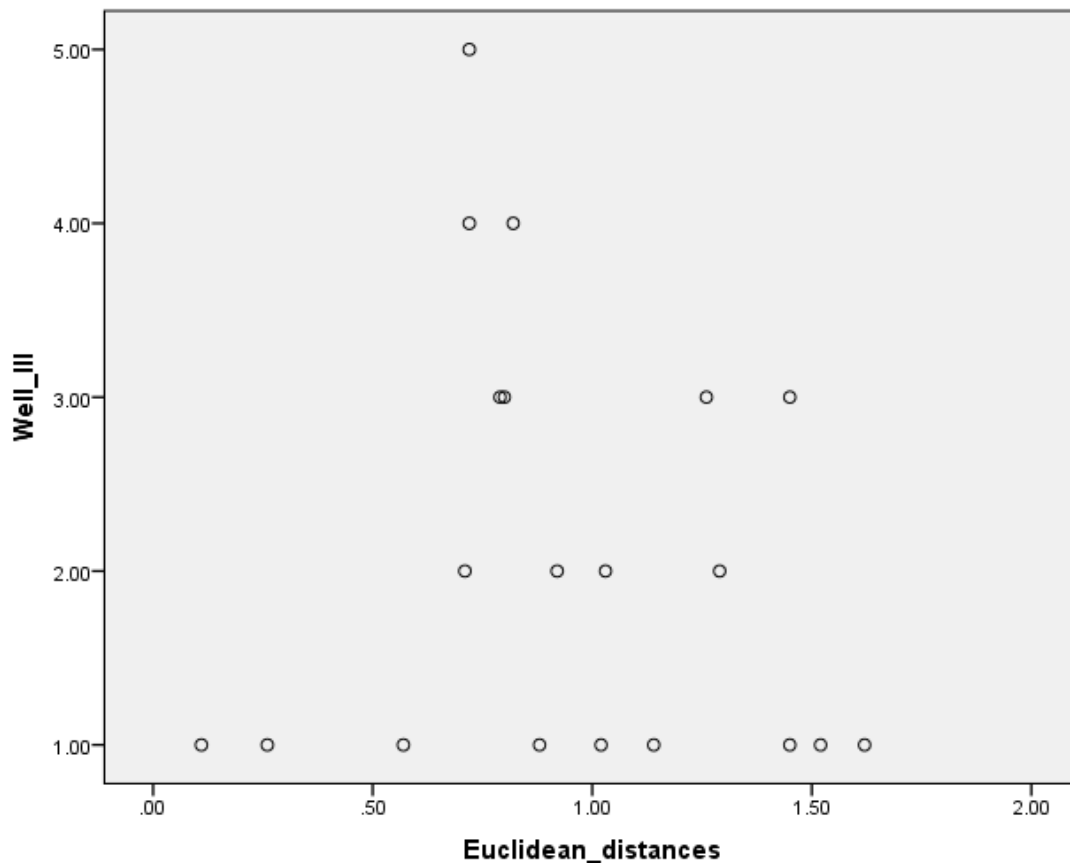


Figure 7. Scatterplot showing the relationship between 'self before psychological therapy' ratings on the well – ill construct and the difference between 'self before psychological therapy,' 'self after psychological therapy' and 'ideal self' Euclidean distances.

The correlation between 'self before engaging in psychological therapy' ratings on the well – ill construct and the Euclidean distances between 'self before engaging in psychological therapy' and 'ideal self' minus the Euclidean distances between 'self after engaging in psychological therapy' and 'ideal self' produced a small effect size and was not found to be statistically significant ($r_s(18) = -0.15$ $p = .538$, two-tailed). These results indicate that Hypothesis 1 cannot be confirmed.

Hypothesis 2: Clients who construe the well – ill construct to be important will be less likely to construe benefits from psychological therapy.

It was hypothesised that clients who perceive the well – ill construct to be important (as measured by the percentage sum of squares summary measure), will be less likely to construe benefits from psychological therapy (as measured by the Euclidean distances between 'self before engaging in psychological therapy' and 'ideal self' minus 'self after

engaging in psychological therapy' and 'ideal self'). A negative correlation was predicted between percentage sum of squares accounted for by the well – ill construct (the lower the percentage, the less superordinate the construct) and the difference between Euclidean distances (the greater the difference, the more change clients construe with regard to being similar to their 'ideal self' following psychological therapy). These two variables were plotted against each other on a scatterplot (Figure 8) to see if a relationship exists. Upon inspection of the plot, there appears to be a weak negative correlation. However, a cluster of three scores on the lower half of the scatterplot highlight how the well-ill construct does not appear to be particularly important nor does it influence some clients' perception of therapeutic change.

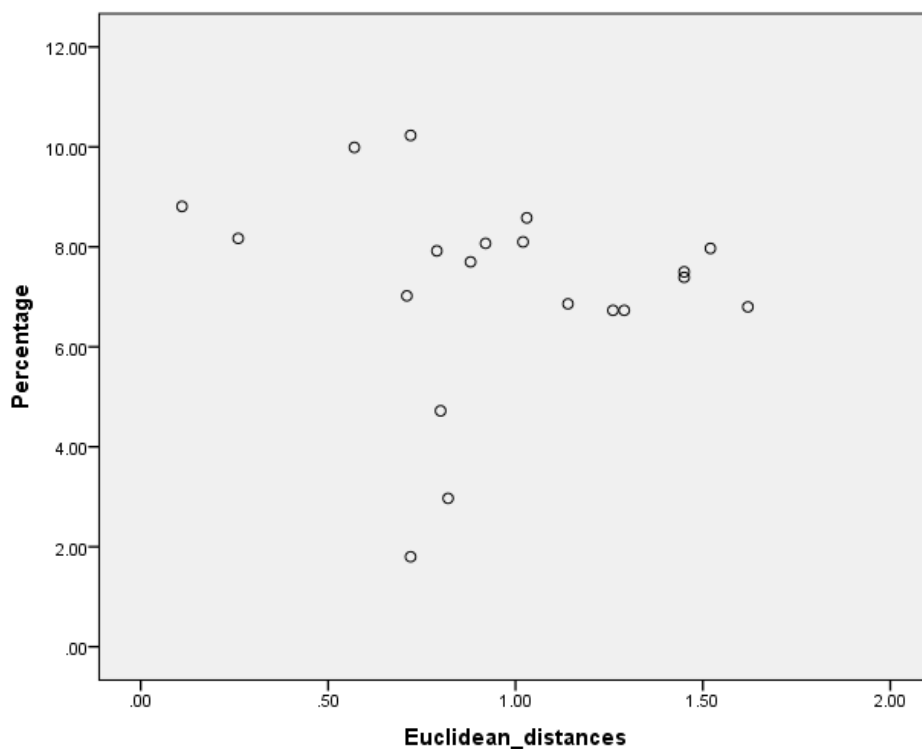


Figure 8. Scatterplot showing the relationship between Percentage sum of squares accounted for by the well – ill construct and the difference between 'self before psychological therapy,' 'self after psychological therapy' and 'ideal self' Euclidean distances.

The correlation between percentage sum of squares accounted for by the well – ill construct and [Euclidean distances between 'self before engaging in psychological therapy' and 'ideal self'] minus [Euclidean distances between 'self after engaging in psychological therapy' and 'ideal self'] was found to be borderline significant, with a medium effect size, ($r_s(18) = -0.34$, $p = .074$, one-tailed). This research project therefore provides some evidence for the

relationship between the well-ill construct and the perception of therapy benefits for clients with BPD. These results indicate that Hypothesis 2 can be tentatively confirmed.

Hypothesis 3: Clients who construe the 'current self' and 'a person with psychological health problems' in a dissimilar way, will present with more severe BPD symptoms.

It was hypothesised that clients who construe the 'current self' and 'a person with psychological health problems' in a dissimilar way (as measured by Euclidean distances on the repertory grid) will be more likely to present with more severe BPD symptoms (as measured by the BSL-23). A positive correlation was predicted between Euclidean distances (the greater the distance, the more different the client construes their 'current self' and 'a person with psychological health problems') and BSL-23 scores (the higher the score, the more severe the BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 9) to see if a relationship exists. A very weak positive correlation appears possible at first glance, as participants who see themselves dissimilarly from those with psychological health problems appear to be reporting more BPD symptoms. One outlier is clearly visible, as the participant has reported seeing themselves as different from a person with psychological health problems but has also scored low on BPD symptomatology.

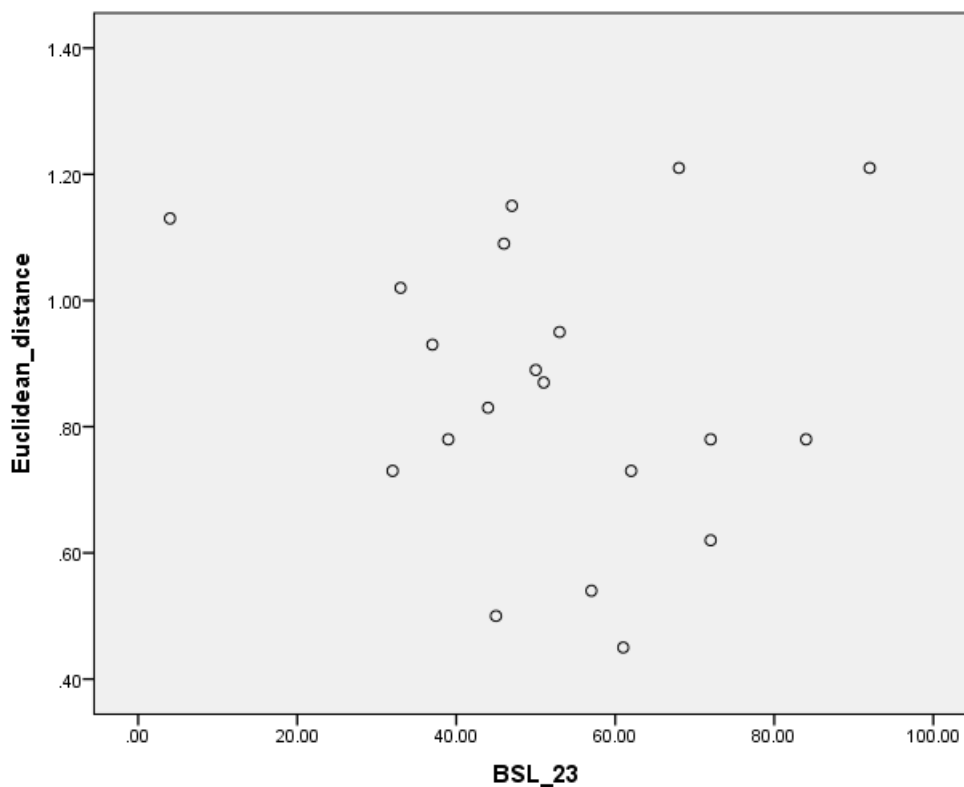


Figure 9. Scatterplot showing the relationship between Euclidean distances ('current self' - 'a person with psychological health problems') and BSL-23 scores.

The correlation between Euclidean distances ('current self' - 'a person with psychological health problems') and BSL-23 scores produced a small effect size and was not statistically significant ($r_s(18) = -0.10$ $p = .670$, two-tailed). These results indicate that Hypothesis 3 cannot be confirmed.

Hypothesis 4: Clients who construe 'a person with psychological health problems' and 'a person with physical health problems' in a similar way will present with more severe BPD symptoms.

It was hypothesised that clients who construe 'a person with psychological health problems' and a 'person with physical health problems' in a similar way (as measured by Euclidean distances on the repertory grid) will be more likely to present with more severe BPD symptoms (as measured by the BSL-23). A negative correlation was predicted between Euclidean distances (the lower the score, the more similar the client construes 'a person with psychological health problems' and 'a person with physical health problems') and BSL-23 scores (the higher the score, the more severe the BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 10) to see if a relationship exists. The scatterplot shows some participants construed people with psychological and physical health problems similarly, while others construed them dissimilarly, which appears to be associated with a variety of different BSL scores. A small cluster of people show no strong relationships between the variables either way, as they score in the middle range for both.

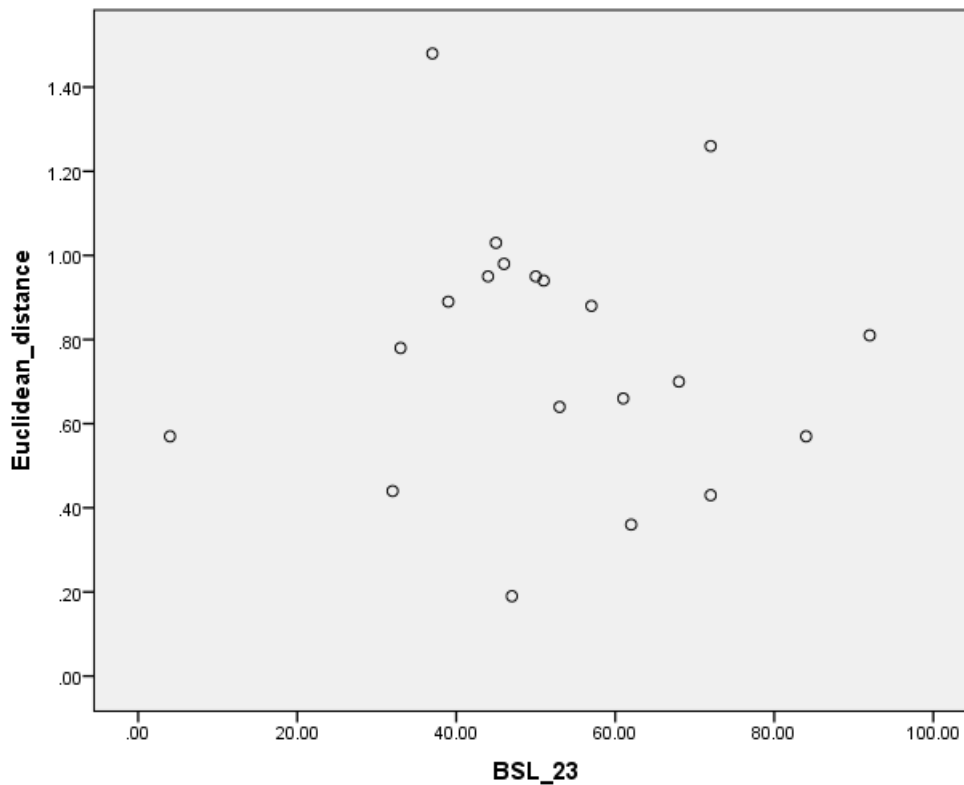


Figure 10. Scatterplot showing the relationship between Euclidean distances ('a person with psychological health problems' - 'a person with physical health problems') and BSL-23 scores.

The correlation between Euclidean distances ('a person with psychological health problems' - 'a person with physical health problems') and BSL-23 scores produced a small effect size and was not statistically significant ($r_s(18) = -0.16$ $p = .247$, one-tailed). These results indicate that Hypothesis 4 cannot be confirmed.

Hypothesis 5: Clinicians' accurate predictions of their clients' personal construct systems will be associated with a good therapeutic relationship. This will be particularly evident in clinicians' accurate perceptions of their clients' 'current self.'

It was hypothesised that clinicians' accurate predictions of their clients' personal construct systems (measured by the Delta summary measure) will be associated with a good therapeutic relationship (measured by the STAR). A number of correlation predictions were made with regard to this hypothesis.

A positive correlation was firstly predicted between client STAR-P scores (the higher the score, the higher the perceived quality of the therapeutic relationship) and the Delta

correlation (the higher the correlation, the more similar the two grids and the more accurate the clinician's predictions of their client's grid ratings). These two variables were plotted against each other on a scatterplot (Figure 11) to see if a relationship exists. In addition to two outliers which suggest the client's perception of the relationship is not affected by the clinician's ability to accurately predict their grids (to the left of the plot), there appears to be a cluster of scores suggesting varying degrees of clinician accuracy which fall within a similar range with regard to STAR-P scores.

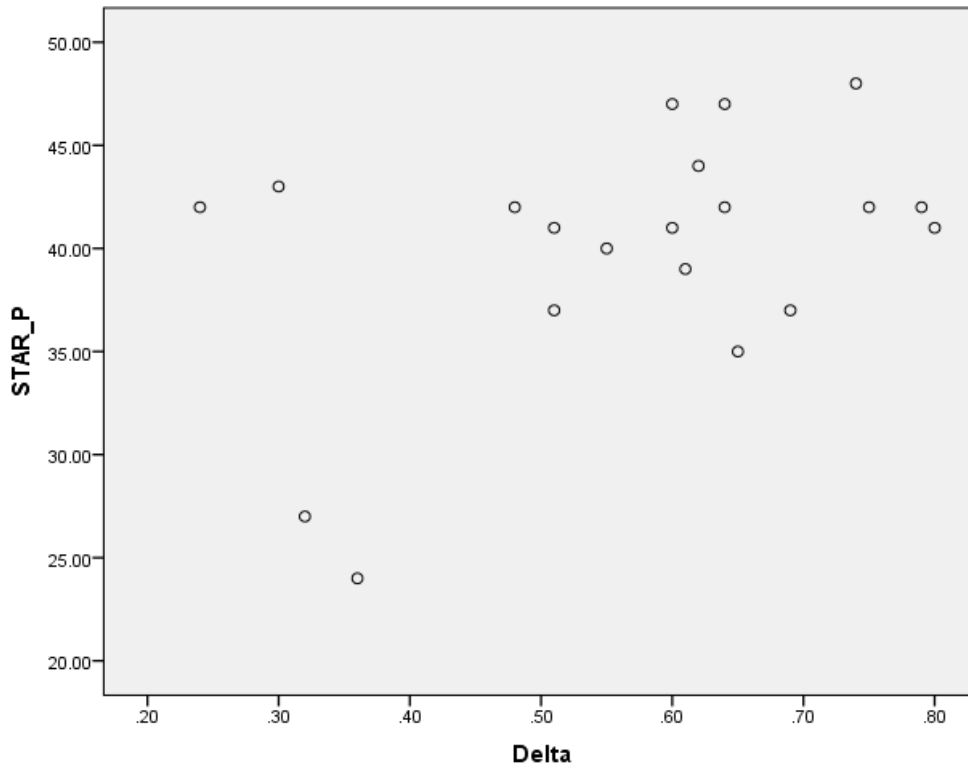


Figure 11. Scatterplot showing the relationship between STAR-P and Delta scores.

The correlation between STAR-P and Delta scores produced a small effect size and was not found to be statistically significant ($r_s(18) = 0.20$ $p = .196$, one-tailed).

A positive correlation was also predicted between clinician STAR-C scores and the Delta correlation. These two variables were plotted against each other on a scatterplot (Figure 12) to see if a relationship exists. It appears as though clinicians' perception of the therapeutic relationship as positive is generally correlated with their ability to accurately predict their grid ratings. This relationship appears to be stronger when the relationship is rated more positively or the clinician has been more accurate in their predictions. Three outliers are present as individuals appear to have rated a positive relationship in spite of their reduced ability to accurately predict their clients' grid ratings.

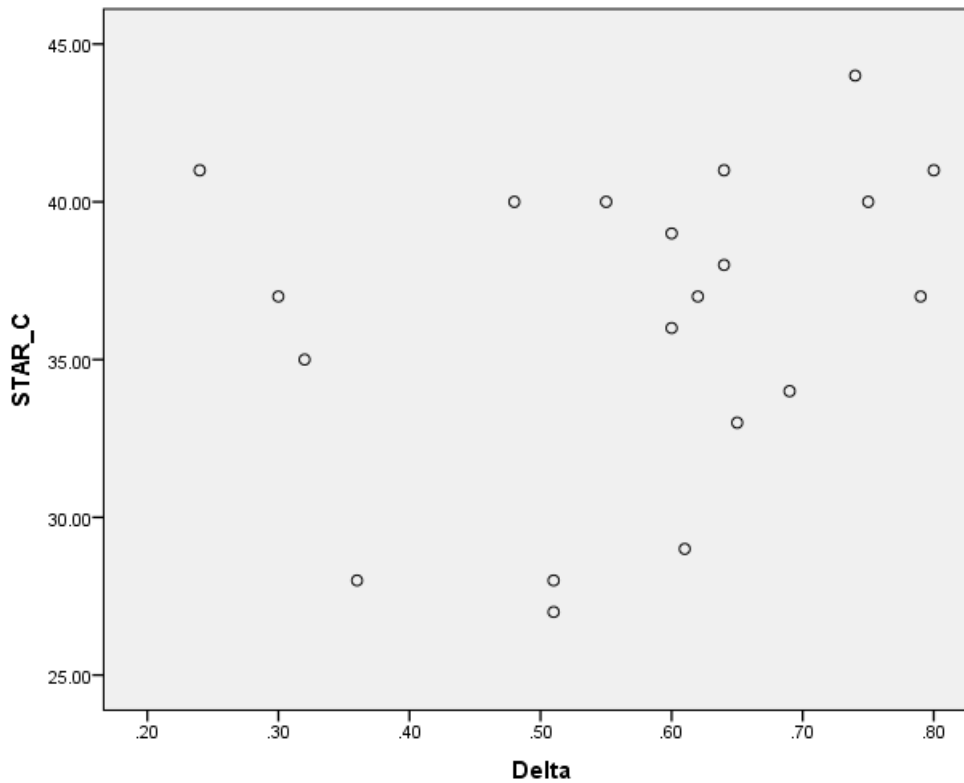


Figure 12. Scatterplot showing the relationship between STAR-C and Delta scores.

The correlation between STAR-C and Delta scores produced a medium effect size and was not found to be statistically significant ($r_s(18) = 0.27$ $p = 0.121$, one-tailed).

A negative correlation was also predicted between clinician STAR-P scores and percentage sum of squares accounted for by 'current self.' These two variables were plotted against each other on a scatterplot (Figure 13) to see if a relationship exists. On inspection of the scatterplot, we can see that clinician participants generally varied with regard to their ability to accurately predict their client's 'current self' ratings – and this does not appear to be associated with clients' perception of the therapeutic relationship (depicted in the horizontal scatter of scores). Two outliers are visible, one of which displays how one clinician's ability to most accurately predict 'current self' ratings is not associated with a better therapeutic relationship (as Hypothesis 5 predicted).

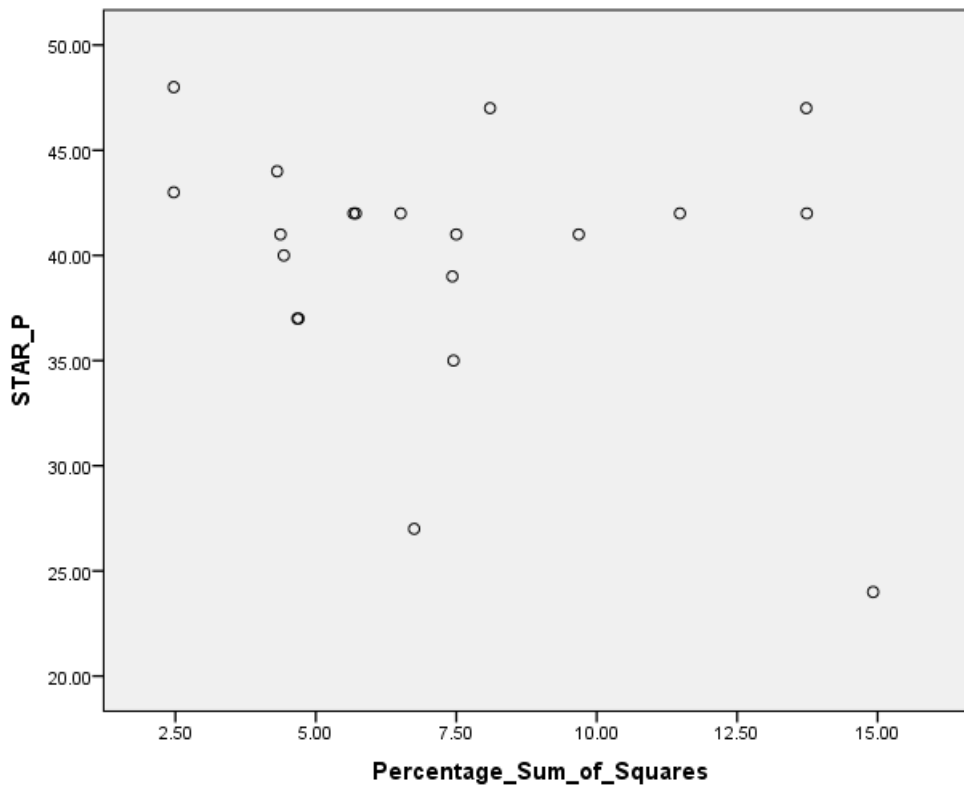


Figure 13. Scatterplot showing the relationship between STAR-P and Percentage sum of squares accounted for by 'current self.'

The correlation between STAR-P and Percentage sum of squares accounted for by 'current self' produced a small effect size and was not found to be statistically significant ($r_s(18) = -0.18$ $p = .225$, one-tailed).

Finally, a negative correlation was also predicted between clinician STAR-C scores and percentage sum of squares accounted for by 'current self.' These two variables were plotted against each other on a scatterplot (Figure 14) to see if a relationship exists. The scatterplot shows a similar picture as in Figure 13, except for a weaker spread of scores – suggesting clinicians report less positive relationships, which may explain why they are less able to accurately predict how their clients see themselves (i.e. 'current self' ratings).

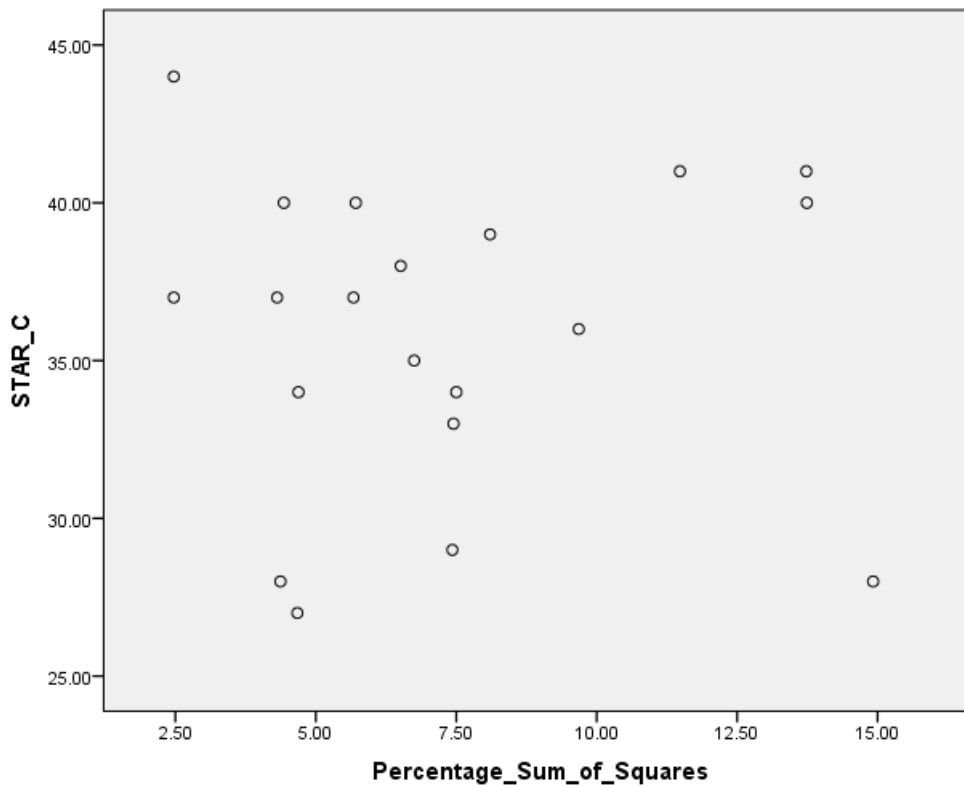


Figure 14. Scatterplot showing the relationship between STAR-C and Percentage sum of squares accounted for by 'current self.'

The correlation between STAR-C and Percentage sum of squares accounted for by 'current self' produced a small effect size and was found not to be statistically significant ($r_s(18) = 0.04$ $p = .872$, two-tailed). The lack of significant correlations suggests that Hypothesis 5 cannot be confirmed.

Hypothesis 6: Clients who construe themselves to be ill will experience a poorer therapeutic relationship.

It was hypothesised that clients who construe themselves to be ill (measured on the repertory grid) will be less likely to think psychologically about their difficulties and will therefore report a poorer therapeutic relationship (measured by the STAR). A number of correlation predictions were made with regard to this hypothesis.

A positive correlation was firstly predicted between clients' 'current self' rating on the well – ill construct (the higher the score, the more well) and STAR-P scores (the higher the score, the higher the perceived quality of the therapeutic relationship). These two variables were plotted against each other on a scatterplot (Figure 15) to see if a relationship exists. As

Figure 15 demonstrates, the scatterplot does not depict any clear relationships between the two variables.

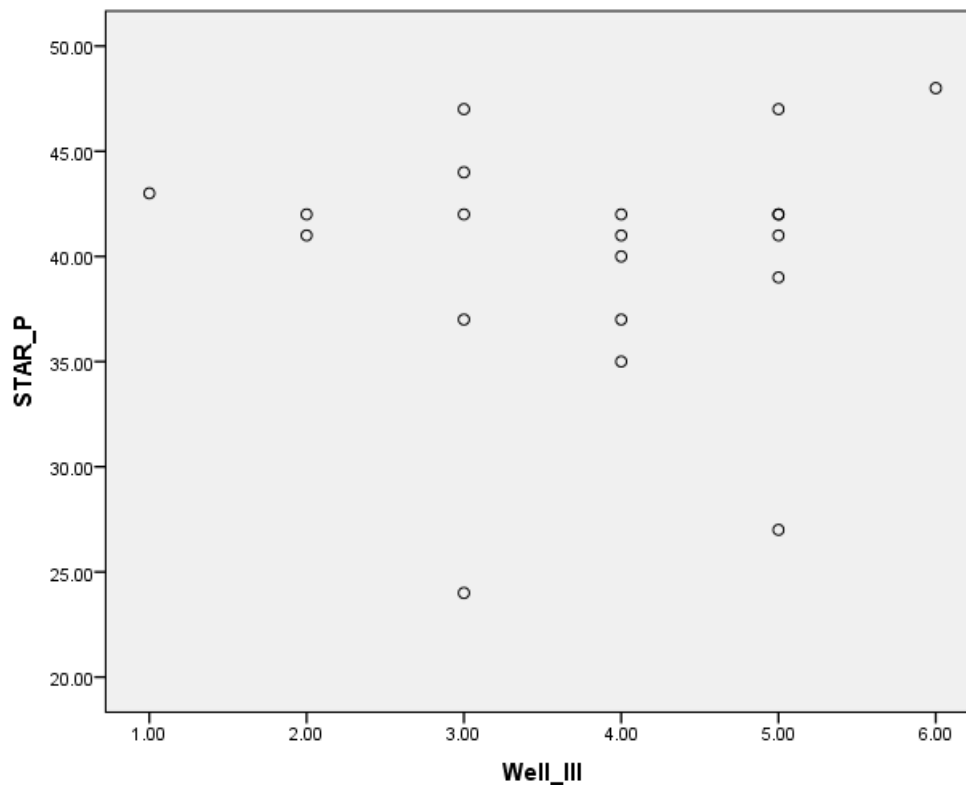


Figure 15. Scatterplot showing the relationship between STAR-P and 'current self' ratings on the well – ill construct.

The correlation between STAR-P and 'current self' ratings on the well – ill construct produced a small effect size and was not found to be statistically significant ($r_s(18) = 0.01$ $p = .484$, one-tailed).

A positive correlation was also predicted between clients' 'current self' rating on the well – ill construct and STAR-C scores. These two variables were plotted against each other on a scatterplot (Figure 16) to see if a relationship exists. The scatterplot generally depicts clinicians report stronger therapeutic relationships with their BPD clients who perceive themselves as more well (however, one outlier suggests this to definitely not be the case as the client has rated themselves as 1 on the well – ill construct).

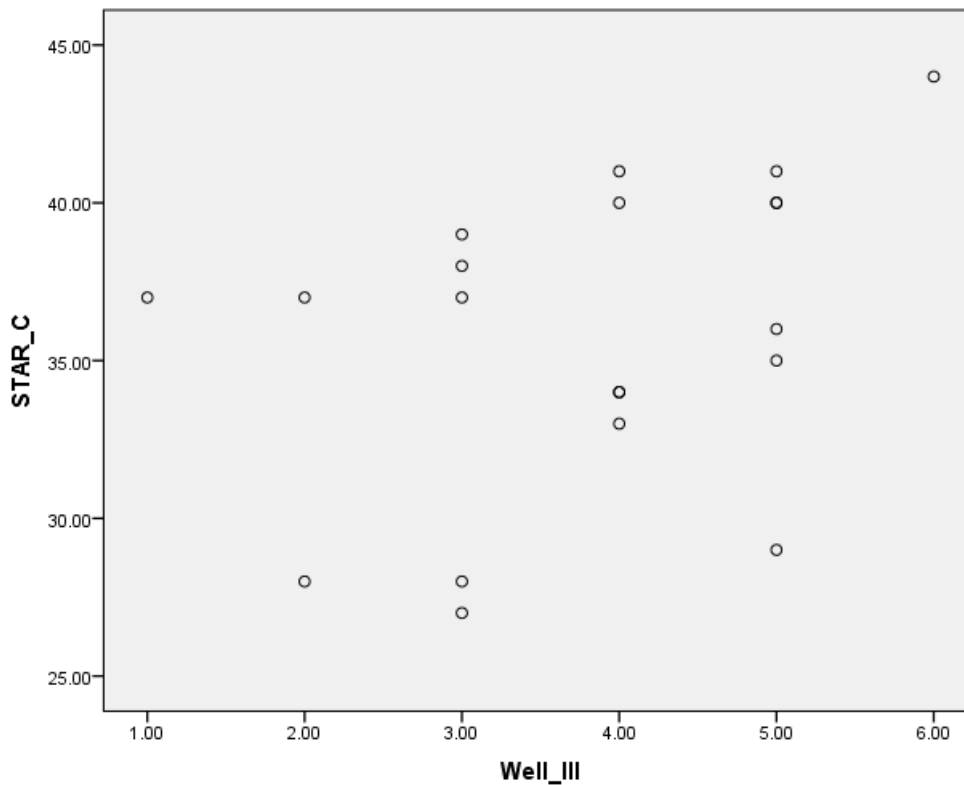


Figure 16. Scatterplot showing the relationship between STAR-C and 'current self' ratings on the well – ill construct.

The correlation between STAR-C and 'current self' ratings on the well – ill construct was found to be statistically significant, with a medium effect size ($r_s(18) = 0.38$ $p = 0.048$, one-tailed). This suggests that clients who construe themselves to be ill are more likely to be working with clinicians who perceive the therapeutic relationship poorly.

A negative correlation was also predicted between how important clients perceive the well – ill construct to be (measured by the percentage sum of squares accounted for by the well – ill construct) and the therapeutic relationship (measured by the STAR). The percentage sum of squares and STAR-P were firstly plotted against each other on a scatterplot (Figure 17) to see if a relationship exists. Although the scatterplot suggests a spread of scores, a small cluster of scores exist and appear to suggest the more important clients perceive the well – ill construct, the more positively they perceive the therapeutic relationship (contradicting the negative correlation, as predicted by Hypothesis 6).

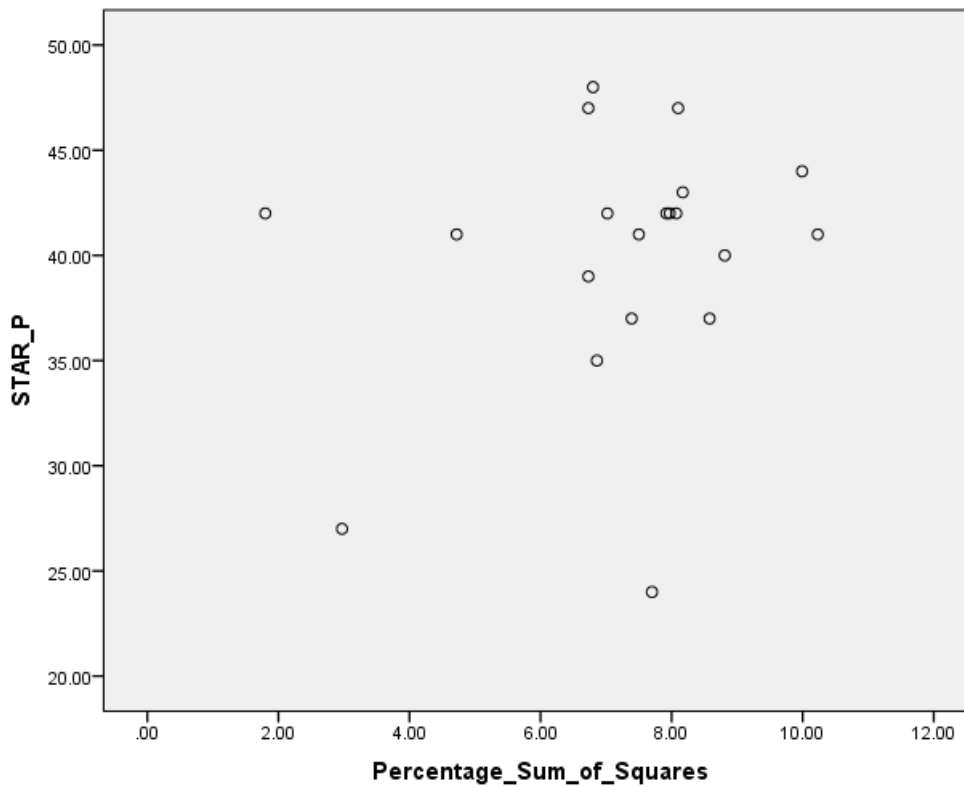


Figure 17. Scatterplot showing the relationship between STAR-P and Percentage sum of squares accounted for by clients for the well – ill construct.

The correlation between STAR-P and percentage sum of squares accounted for by clients for the well – ill construct produced a small effect size and was found not to be statistically significant ($r_s(18) = 0.12$ $p = .602$, two-tailed).

Finally, a negative correlation was predicted between the percentage sum of squares accounted for by clients for the well – ill construct and STAR-C scores. These variables were plotted against each other on a scatterplot (Figure 18) to see if a relationship exists. As we can see, there appears to be a weak, vertical spread of scores – suggesting poor to strong therapeutic relationships are perceived by clinicians, regardless of how important the well – ill construct for their clients.

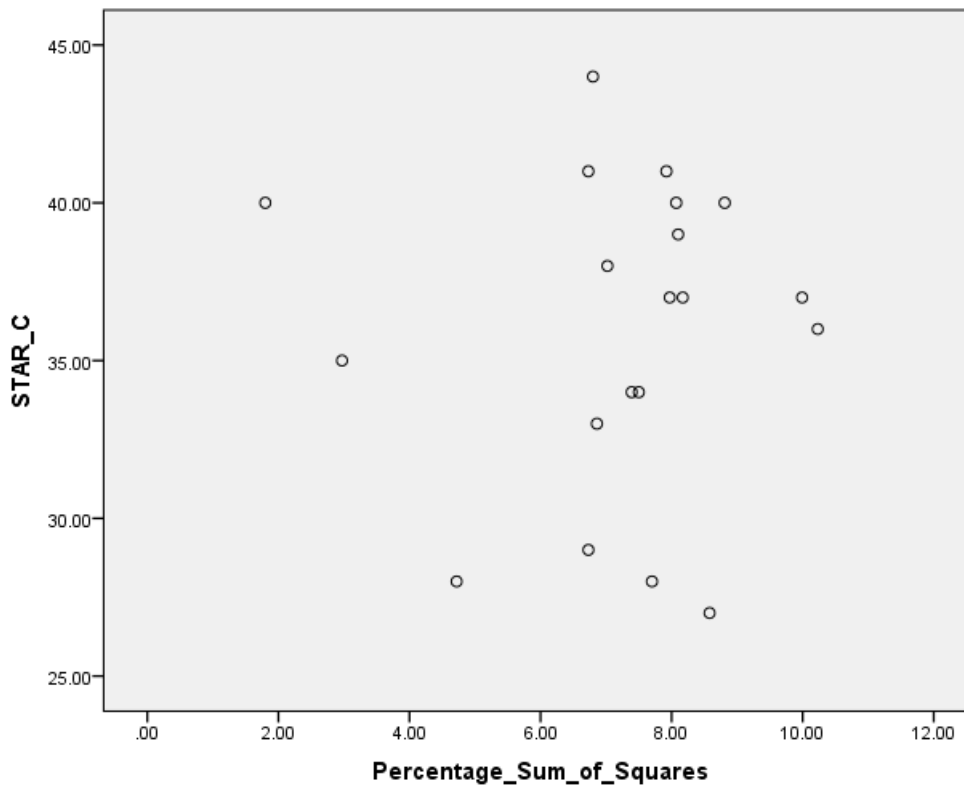


Figure 18. Scatterplot showing the relationship between STAR-C and Percentage sum of squares accounted for by clients for the well – ill construct.

The correlation between STAR-C and percentage sum of squares accounted for by clients for the well – ill construct produced a small effect size and was found not to be statistically significant ($r_s(18) = 0.02$ $p = .926$, two-tailed).

One relationship was found to have a medium effect size and be statistically significant. This was between clients who construe themselves to be ill and their clinicians' perception of a poor therapeutic relationship ($r_s(18) = 0.383$ $p = .048$, one-tailed). However, three other correlations corresponding to this hypothesis did not produce significant results. Hypothesis 6 can therefore not be confirmed.

Hypothesis 7: Clients who construe tightly will experience a poorer therapeutic relationship.

It was hypothesised that clients who construe tightly (as measured by the percentage variance accounted for by the first principal component) will report a poorer therapeutic relationship (as measured by the STAR). A negative correlation was firstly predicted between percentage variance accounted for by the first principal component (the higher the percentage, the tighter the construing) and clients' STAR-P scores (the lower the score, the

poorer the quality of the therapeutic relationship). These two variables were plotted against each other on a scatterplot (Figure 19) to see if a relationship exists. With the exception of a few outliers, the scatterplot appears to be showing a slight positive relationship, suggesting the tighter participants construe the world the more positively they regard the therapeutic relationship (despite the Hypothesis 7 prediction of a negative relationship).

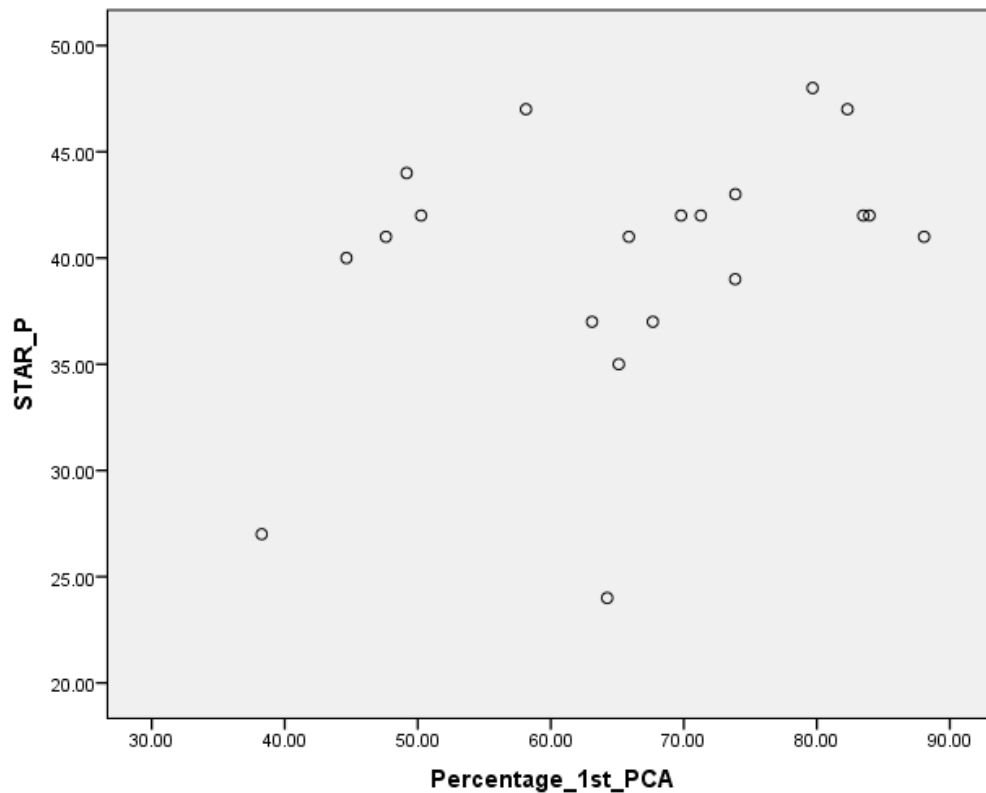


Figure 19. Scatterplot showing the relationship between STAR-P and Percentage variance accounted for by the first PCA.

The correlation between STAR-P and percentage variance accounted for by the first principal component produced a medium effect size and was found not to be statistically significant ($r_s(18) = 0.35$ $p = .126$, two-tailed).

A negative correlation was also predicted between percentage variance accounted for by the first principal component (the higher the percentage, the tighter the construing) and clinicians' STAR-C scores (the lower the score, the poorer the quality of the therapeutic relationship). These two variables were plotted against each other on a scatterplot (Figure 20) to see if a relationship exists. As we can see from the scatterplot, there appears to be no clear relationship between the two variables.

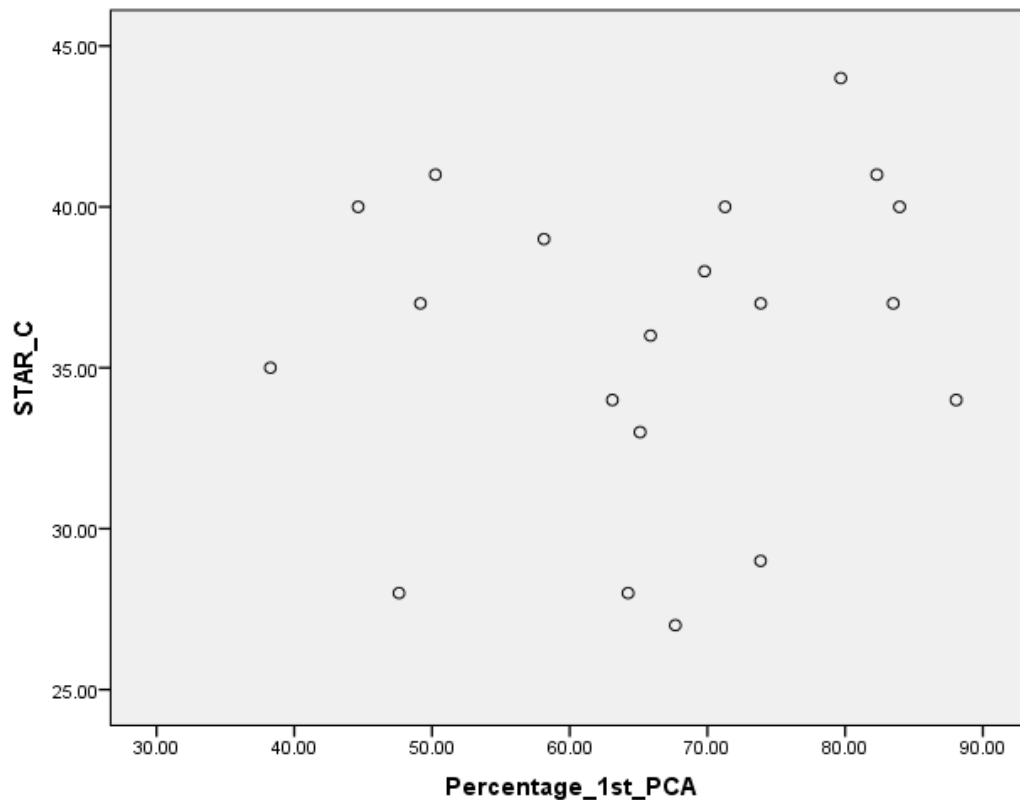


Figure 20. Scatterplot showing the relationship between STAR-C and Percentage variance accounted for by the first PCA.

The correlation between STAR-C and percentage variance accounted for by the first principal component produced a small effect size and was found not to be statistically significant ($r_s(18) = 0.19$ $p = .422$, two-tailed).

These results suggest that Hypothesis 7 cannot be confirmed.

3.3.2 Exploratory Hypotheses

Hypothesis 8: Clients who construe the ‘current self’ to be ill will also present with more severe BPD symptoms.

It was hypothesised that clients who construe their ‘current self’ as ill (as measured by the repertory grid) will be more likely to present with more severe BPD symptoms (as measured by the BSL-23). A negative correlation was predicted between construct ratings (the lower the score, the more ill the client construes their current self) and BSL-23 scores (the higher the score, the more severe the BPD symptoms). These two variables were plotted against

each other on a scatterplot (Figure 21) to see if a relationship exists. A cluster of people can be seen to score somewhere in the middle for both variables. Two visible outliers depict the negative correlation predicted i.e. one participant who has scored very low for BPD symptoms and highly in terms of rating themselves to be well, and another who has scored very high for BPD symptoms and low in terms of rating themselves to be ill.

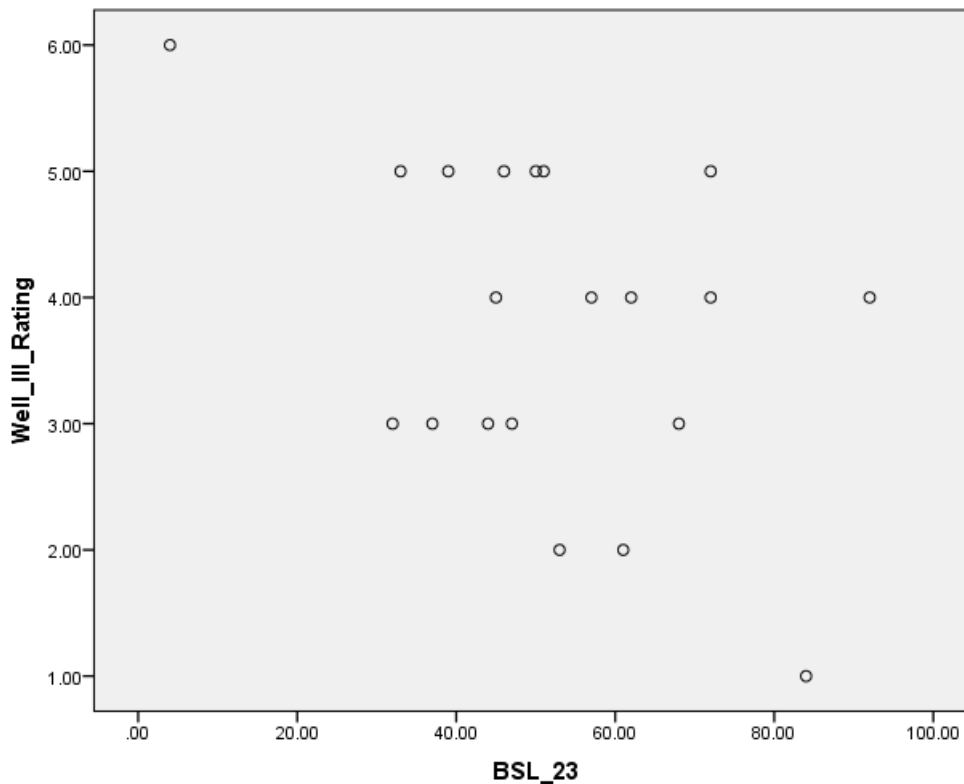


Figure 21. Scatterplot showing the relationship between well – ill construct ratings (for the ‘current self’ element) and BSL-23 scores.

The correlation between well – ill construct ratings (for the ‘current self’ element) and BSL-23 scores produced a medium effect size and was not statistically significant ($r_s (18) = -0.28$ $p = .114$, one-tailed). These results indicate that Hypothesis 8 cannot be confirmed (though there appears to be a trend in the hypothesised direction).

Hypothesis 9: Clients who construe ‘a person with psychological health problems’ to be ill will also present with more severe BPD symptoms.

It was hypothesised that clients who construe ‘a person with psychological health problems’ as ill (as measured by the repertory grid) will be more likely to present with more severe BPD symptoms (as measured by the BSL-23). A negative correlation was predicted between

construct ratings (the lower the score, the more ill the client construes ‘a person with psychological health problems’ to be) and BSL-23 scores (the higher the score, the more severe the BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 22) to see if a relationship exists. As before, the two outliers can be seen, i.e. those individuals who scored particularly low and high on the BSL-23. Overall, we can see that most people appeared to rate people with psychological health difficulties as somewhere between the middle to higher end of the scale, suggesting client participants were more inclined to view this population as well.

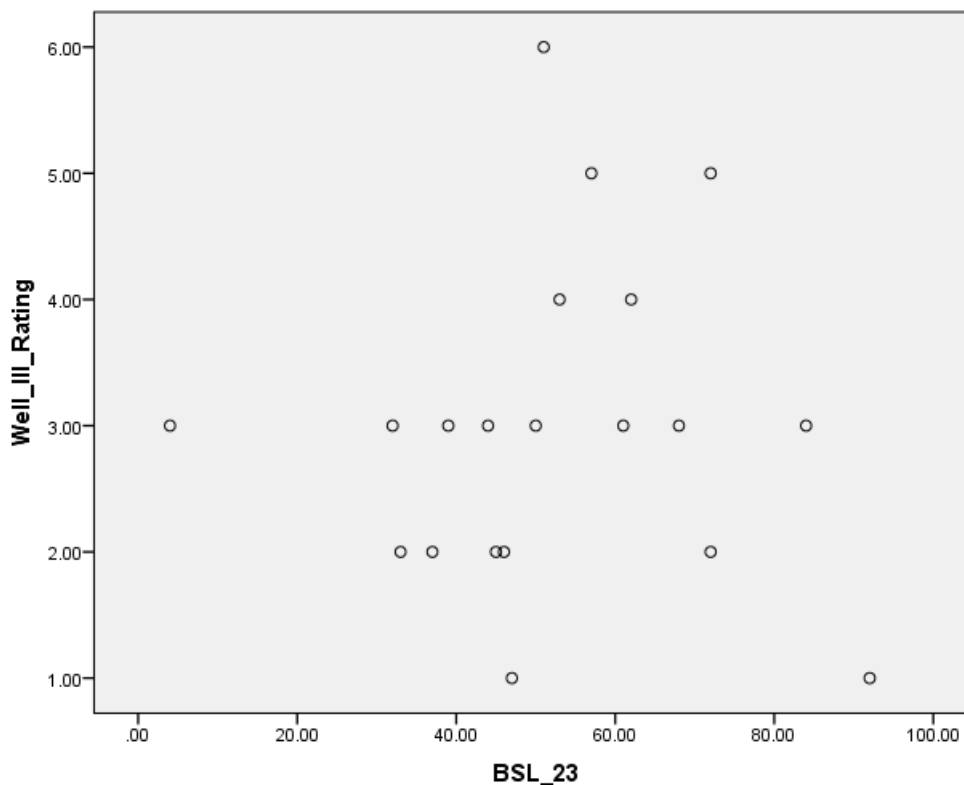


Figure 22. Scatterplot showing the relationship between well – ill construct ratings (for the ‘a person with psychological health problems’ element) and BSL-23 scores.

The correlation between well – ill construct ratings (for ‘a person with psychological health problems’ element) and BSL-23 scores produced a small effect size and was not statistically significant ($r_s(18) = 0.17$, $p = .486$, two-tailed). These results indicate that Hypothesis 9 cannot be confirmed.

Hypothesis 10: Clients who construe themselves to be well will be more likely to construe themselves as getting better from their difficulties.

It was hypothesised that clients who construe themselves to be well (and therefore not medically ill) will be more likely to construe themselves as getting better. A positive correlation was predicted between 'current self' ratings on the well – ill construct and will get better – will never get better construct (with the higher the rating, the more well and likely to get better the person construes themselves to be). These two variables were plotted against each other on a scatterplot (Figure 23) to see if a relationship exists. A clear positive relationship is visible, with one outlier. This may be due to this participant expressing themselves to be less likely to get better – perhaps due to interpreting there to be less of a need, as they already view themselves as well.

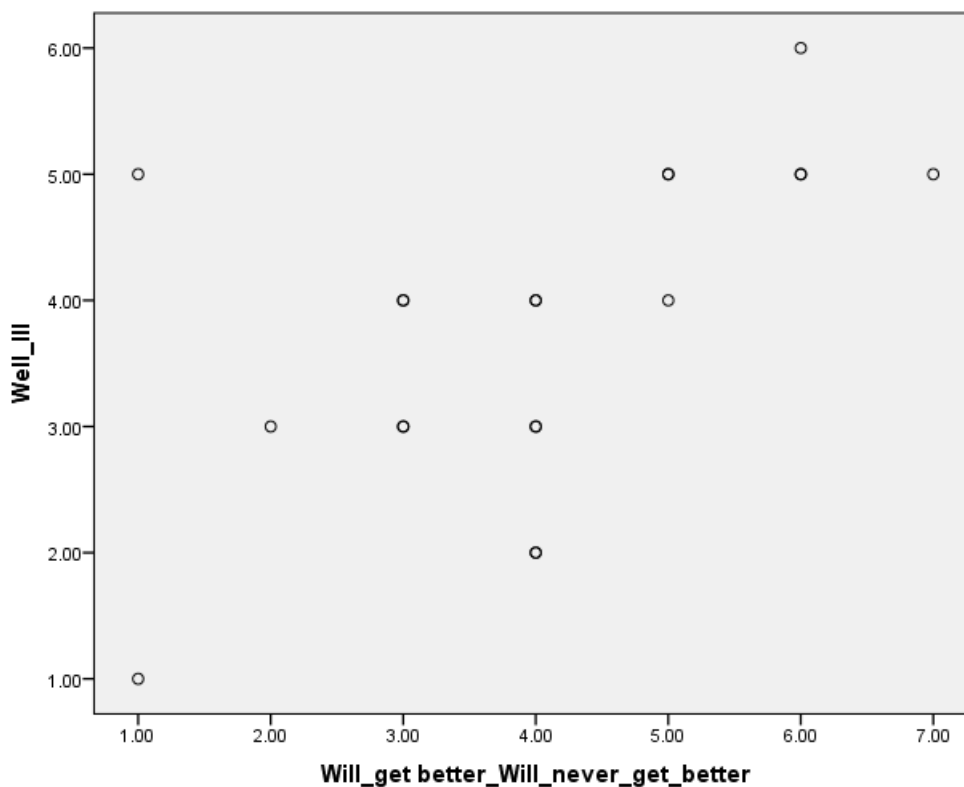


Figure 23. Scatterplot showing the relationship between 'current self' ratings on the well – ill construct and will get better - will never get better construct.

The correlation between 'current self' ratings on the well – ill construct and will get better - will never get better construct was found to be statistically significant, with a large effect size ($r_s(18) = 0.60$, $p < .001$, one-tailed). These results therefore highlight the relationship between construing the self to be well and likely to get better (as opposed to construing the self to be ill and less likely to get better).

A positive correlation was also predicted for this hypothesis between 'self before engaging in psychological therapy' ratings on the well – ill construct and will get better – will never get better construct. These two variables were plotted against each other on a scatterplot (Figure 24) to see if a relationship exists. A positive correlation is visible, although a number of participants appear to have also rated themselves before therapy as ill and less likely to get better (one outlier particularly depicts this in the top left corner).

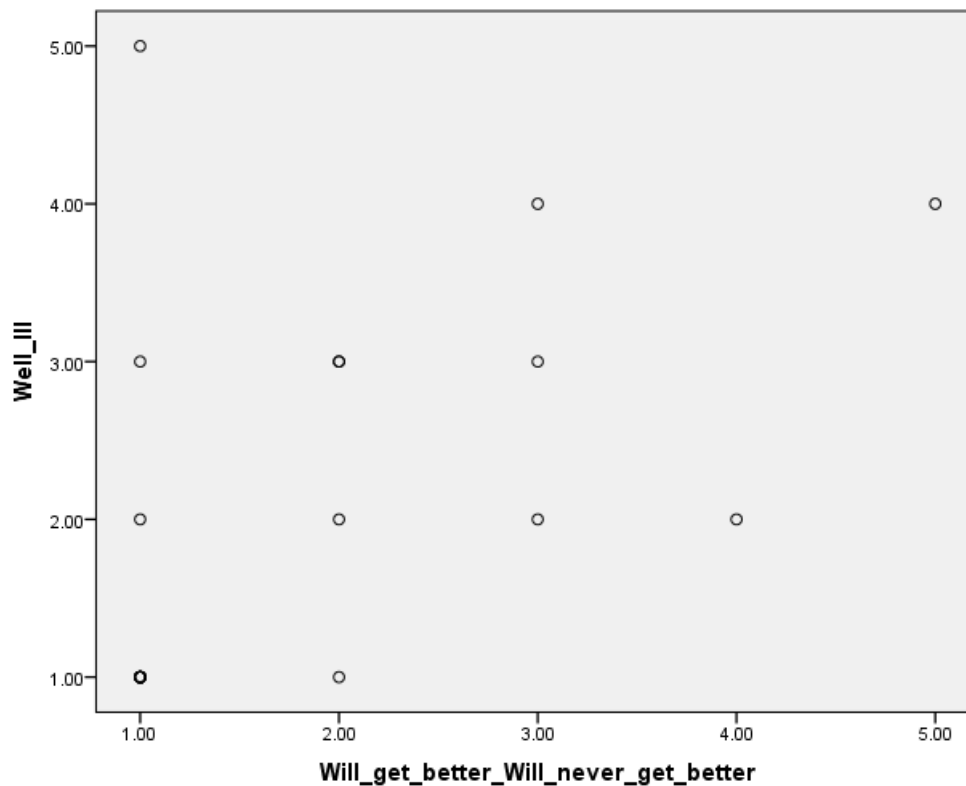


Figure 24. Scatterplot showing the relationship between 'self before engaging in psychological therapy' ratings on the well – ill construct and will get better - will never get better construct.

The correlation between 'self before engaging in psychological therapy' ratings on the well – ill construct and will get better - will never get better construct was also found to be statistically significant, with a large effect size ($r_s(18) = 0.56$, $p = .005$, one-tailed). These results again highlight the relationship between construing the self to be well and likely to get better, but this time before starting therapy. This suggests that construing the self to be well is important with regard to maintaining an optimistic attitude about recovery.

Both significant correlations suggest that Hypothesis 10 can be confirmed.

Hypothesis 11: The reporting of a poor therapeutic relationship will be associated with more severe BPD symptoms.

It was hypothesised that clients who construe the therapeutic relationship poorly (measured by the STAR-C) will report more severe BPD symptoms. A negative correlation was firstly predicted between the clinicians' STAR-C scores (the lower the score, the poorer the quality of the therapeutic relationship) and BSL-23 scores (the higher the score, the more severe BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 25) to see if a relationship exists. We can see that the majority of scores fall within the middle of the scatterplot, with a small cluster of four scores suggesting generally poorer therapeutic relationships (as perceived by clinicians) and two outliers suggesting an alternative to Hypothesis 11, i.e. clinicians appear to be reporting stronger therapeutic relationships than predicted with clients who have high BPD symptomatology.

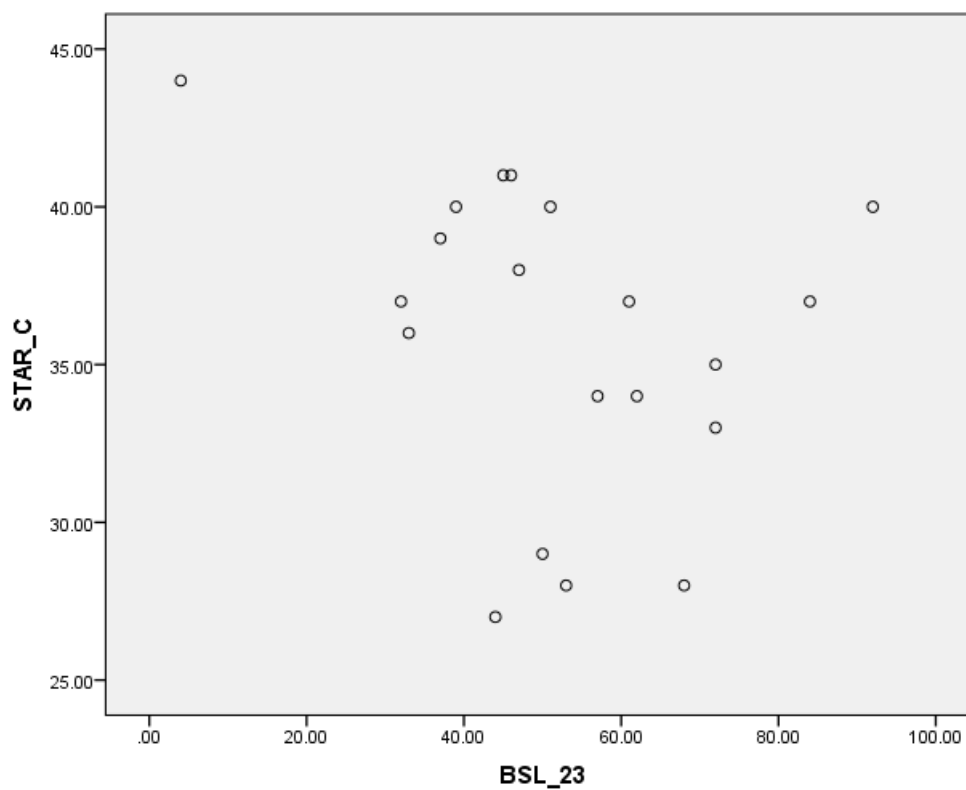


Figure 25. Scatterplot showing the relationship between STAR-C and BSL-23 scores.

The correlation between STAR-C and BSL-23 was found to be borderline significant with a medium effect size ($r_s(18) = -0.33$ $p = .075$, one-tailed).

It was hypothesised that clients who construe the therapeutic relationship poorly (measured by the STAR-P) will report more severe BPD symptoms. A negative correlation was also predicted between the clients' STAR-P scores (the lower the score, the poorer the quality of the therapeutic relationship) and BSL-23 scores (the higher the score, the more severe BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 26) to see if a relationship exists. The scatter of scores suggests that higher BSL-23 scores are associated with lower STAR-P scores.

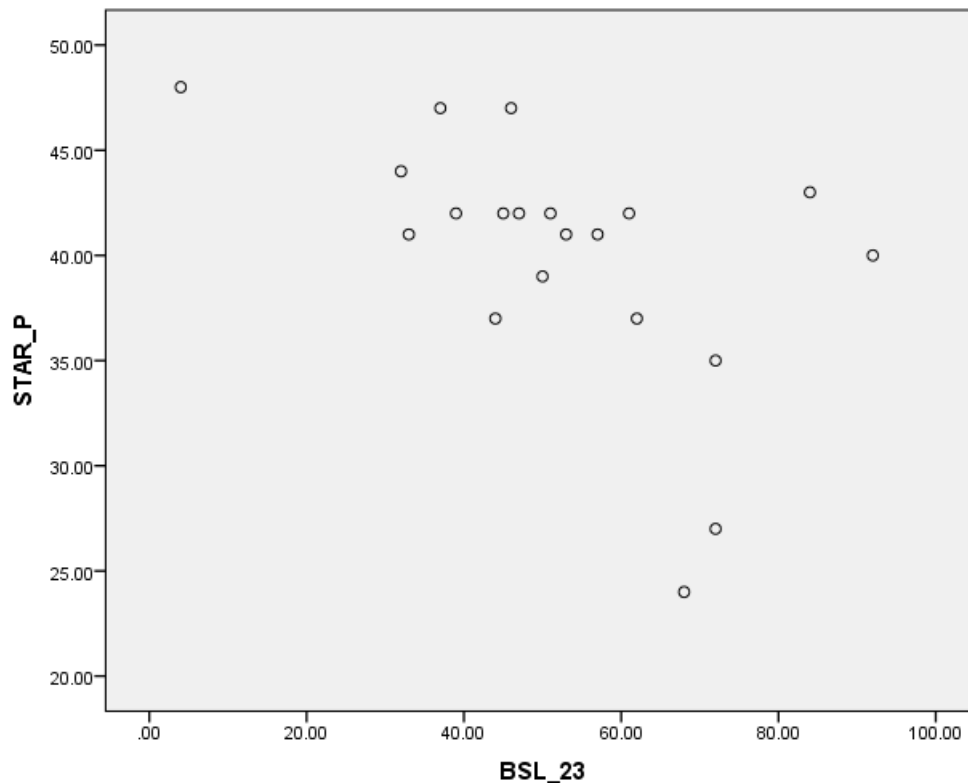


Figure 26. Scatterplot showing the relationship between STAR-P and BSL-23 scores.

The correlation between STAR-P and BSL-23 was found to be statistically significant, with a large effect size ($r_s(18) = -0.57$ $p = .004$, one-tailed).

The correlational findings for Hypothesis 11 suggest that the experience of a poor therapeutic relationship appears to be associated (to some degree) with more severe BPD symptoms. Hypothesis 11 can therefore be confirmed with regard to the client perception of the therapeutic relationship. Hypothesis 11 can only be tentatively confirmed with regard to the clinician perception of the therapeutic relationship.

Hypothesis 12: Clients who construe the 'current self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms.

It was hypothesised that clients who construe the 'current self' and 'ideal self' in a dissimilar way (measured by Euclidean distances) will present with more severe BPD symptoms (measured by the BSL-23). A positive correlation was predicted between the distance between 'current self' and 'ideal self' (the greater the distance, the more different the client construes their current and ideal self) and BSL-23 scores (the higher the score, the more severe the BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 27) to see if a relationship exists. The scatterplot shows that large differences between 'current self' and 'ideal self' are not necessarily associated with high BPD symptomatology (depicted in a cluster of scores towards the top of the scatterplot).

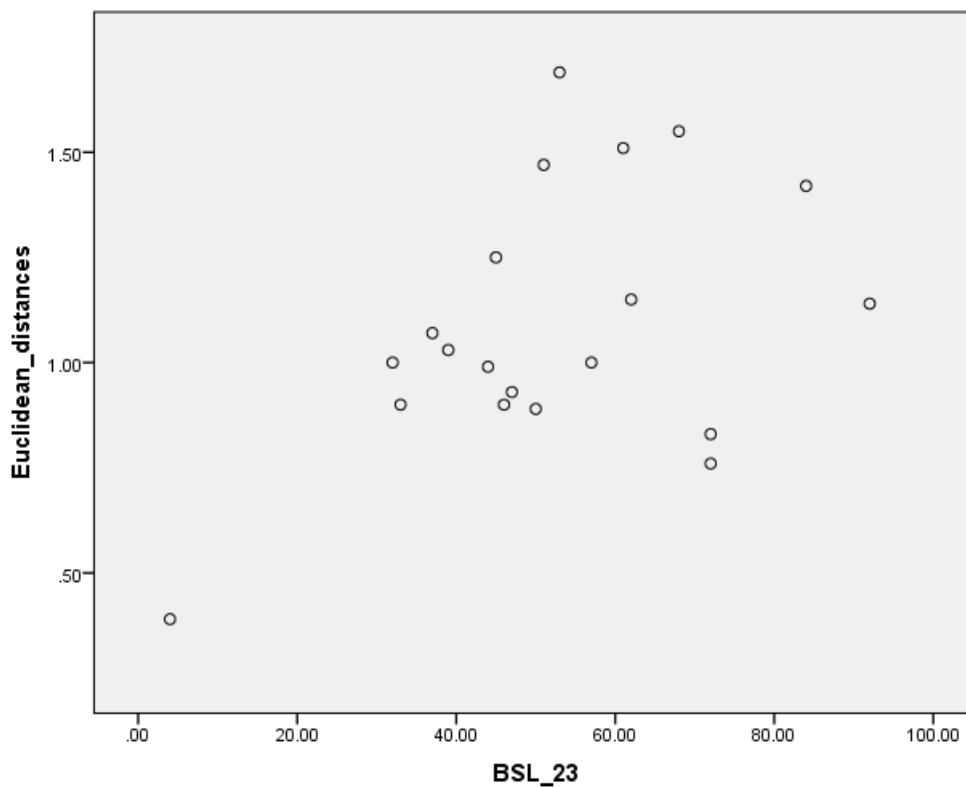


Figure 27. Scatterplot showing the relationship between Euclidean distances (between 'current self' and 'ideal self') and BSL-23 scores.

The correlation between Euclidean distances (between 'current self' and 'ideal self') and BSL-23 scores, was found to be borderline significant with a medium effect size ($r_s(18) = 0.31$, $p = .096$, one-tailed). This finding provides evidence for the presence of more severe

BPD symptomatology when the client is unable to construe their 'current self' as similar to how they would like to be. Hypothesis 12 can therefore be tentatively confirmed.

Hypothesis 13: Clients who construe the 'future self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms.

It was hypothesised that clients who construe the 'future self' and 'ideal self' in a dissimilar way (measured by Euclidean distances) will present with more severe BPD symptoms (measured by the BSL-23). A positive correlation was predicted between the distance between 'future self' and 'ideal self' (the greater the distance, the more different the client construes their current and ideal self) and BSL-23 scores (the higher the score, the more severe the BPD symptoms). These two variables were plotted against each other on a scatterplot (Figure 28) to see if a relationship exists. The scatterplot shows a strong positive relationship between variables, which is depicted in the lower part of the scatterplot due to the generally similar Euclidean distances.

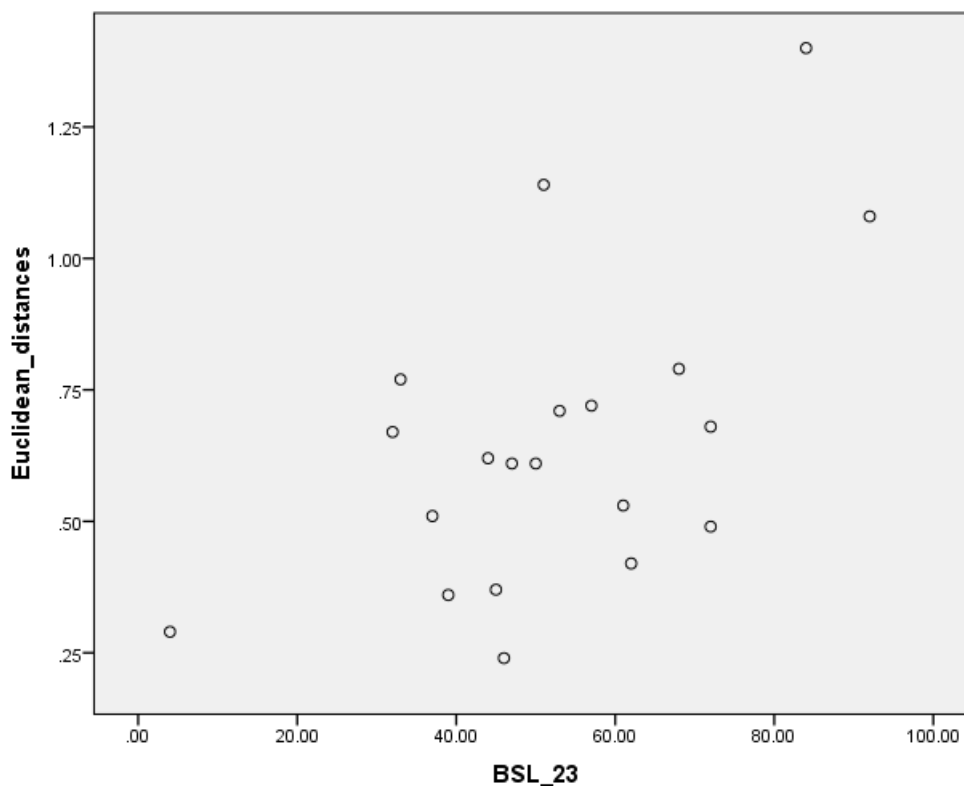


Figure 28. Scatterplot showing the relationship between Euclidean distances (between 'future self' and 'ideal self') and BSL-23 scores.

The correlation between Euclidean distances (between 'future self' and 'ideal self') and BSL-23 scores was found to be statistically significant, with a large effect size ($r_s(18) = 0.45$ $p = .024$, one-tailed). This suggests that clients are likely to be presenting with severe BPD symptoms if they construe their selves in the future as being dissimilar from how they would ideally like to be. These results suggest that Hypothesis 13 can be confirmed.

3.4 Case Studies

Two case examples will now be presented. These are the clients who rated their therapeutic relationship most positively (Client 10) and most poorly (Client 16).

3.4.1 Client 10: A Positive Therapeutic Relationship.

Client 10 was a 40 year-old White-British woman, who had been engaging in DBT for over two years (currently seeing her therapist once a week). She rated a total BSL-23 score of four (out of 92) and an overall personal state rating of her last week as 90% - the lowest total score and highest personal state rating recorded from all 20 client participants. She also rated the therapeutic relationship most positively, in comparison to all other client participants. She scored the highest possible score of 48 (for the total STAR-P score) and rated positive collaboration at 24, positive clinician input at 12 and non-supportive clinician input at 12 (the highest possible scores across each sub-category).

The following 11 constructs were elicited from Client 10's repertory grid:

Wise-minded - Emotionally-minded

Vulnerable – Strong

Focused – Unfocused

Stubborn – Relaxed

Determined – Unmotivated

Challenging – Easy-going

Lost – Grounded

Scared – Safe

Consistent – Chaotic

Committed – Has no direction

Helping – Ignoring

Table 14 displays the descriptive statistics for her repertory grid.

Table 14

Descriptive Statistics for Client 10's Repertory Grid

Supplied construct ratings on well – ill (supplied construct)

Current self: 6

Ideal self: 7

Future self: 6

Mother: 4

Father: 4

Partner: 3

A person with physical health problems: 4

A person with psychological health problems: 3

Self before therapy: 1

Self after therapy: 6

My clinician: 7

(note, the higher the score, the more *well* that person is construed)

Supplied construct ratings on will get better-will never get better (supplied construct)

Current self: 6

Ideal self: 7

Future self: 6

Mother: 4

Father: 4

Partner: 5

A person with physical health problems: 4

A person with psychological health problems: 4

Self before therapy: 1

Self after therapy: 6

My clinician: 7

(note, the higher the score, the more *likely to get better* that person is construed)

Standardised Euclidean distances

'Current self' and 'A person with psychological health problems': 1.13 (neither similar nor dissimilar)

'A person with psychological health problems' and 'A person with physical health problems':
0.57 (similar)

'Self before therapy' and 'Ideal self': 1.97 (dissimilar)

'Self after therapy' and 'Ideal self': 0.35 (similar)

'Self before therapy' and 'Ideal self' *minus* 'Self after therapy' and 'Ideal self': 1.62 (dissimilar)

'Current self' and 'Ideal self': 0.39 (similar)

'Future self' and 'ideal self': 0.29 (similar)

Percentage sum of squares accounted for

Well – Ill construct: 6.80%

'Current Self' (on differential changes grid): 2.47%

Percentage variance accounted for

First PCA: 79.68%

Delta correlations

Between Client 10 and Clinician 10: 0.74

Implicative dilemmas

Total number: 0

Table 14 suggests that Client 10 construes her current self as well (and not ill) and therefore also likely to get better, and construed herself before therapy as ill and therefore also likely to never get better (supporting Hypothesis 10). However, her construal of herself as *ill* before therapy has not made a difference with regard to how she has been able to perceive benefits from psychological therapy (not confirming Hypothesis 1). We can also see that Client 10 construes her current self in a similar way to her future and ideal selves, supporting Hypotheses 12 and 13. Client 10 additionally appears to construe people with psychological and physical health difficulties similarly (not confirming Hypothesis 4) and does not rate the well – ill construct as a particularly important construct (Hypothesis 2).

With regard to the therapeutic relationship, Client 10's tight construing (79.68%) does not appear to be impacting on her perception of the therapeutic relationship (not confirming Hypothesis 7). The Delta correlation of 0.74 was additionally found to be the third highest out of all 20 participant pairs. This support Hypothesis 5 and previous research (Winter, 2013),

as the Clinician 10's ability to subsume Client 10's construing appears to be associated with a strong therapeutic relationship.

Repertory grid summary measures were additionally extracted using IDIOGRID (Grice, 2002) in order to analyse Client 10's repertory grid for the presence of implicative dilemmas. 'Implicative dilemmas' refer to the implicit cost associated with embracing one's ideal self (Feixas, Saul & Sanchez, 2000; Feixas & Saul, 2004; Winter, 2013). For Client 10, no implicative dilemmas were identified. As she had a very low BSL-23 score, this supports previous research connecting symptom severity and implicative dilemmas (Badzinski & Anderson, 2012; Feixas, Saul & Avila-Espada, 2009).

A Principal Component Analysis was next carried out to arrive at the visual representation of Client 10's repertory grid (see Figure 29). The horizontal axis represents the first principal component and the vertical axis represents the second principal component. Client 10's elements and constructs are all plotted on the graph according to their loadings on both principal components.

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Slater Analyses for Client 10

Axis Range: -13.30 to 13.30

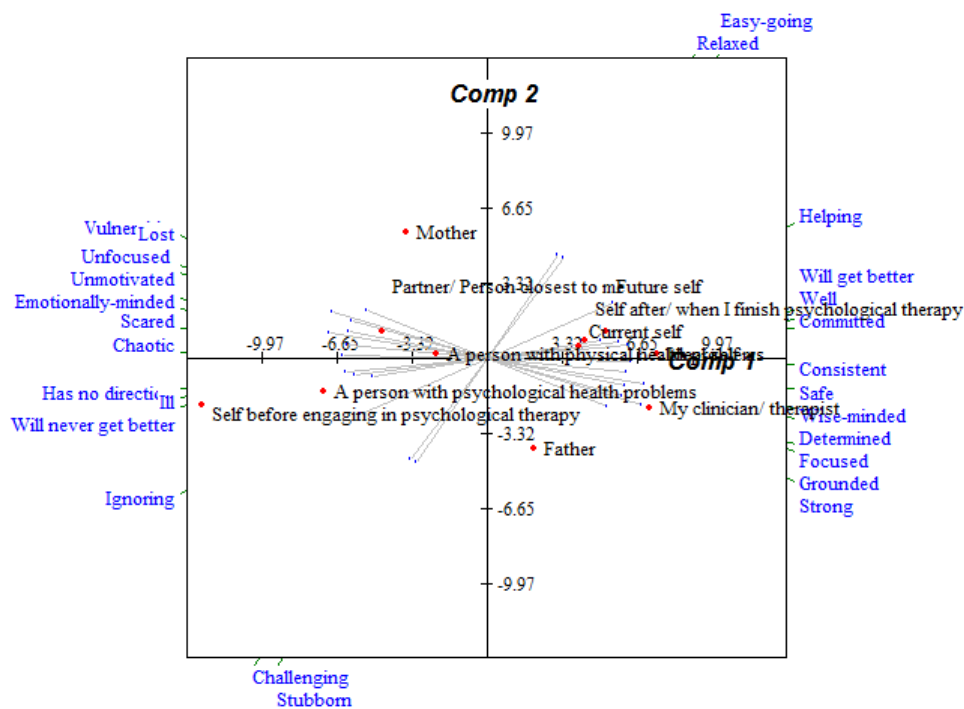


Figure 29. A plot representing Client 10's repertory grid.

On inspection of Figure 29, Client 10 associates their clinician with more positive construct poles, such as: consistent, safe, wise-minded, determined, focused, grounded and strong. We can, alternatively, see that they construe themselves before therapy as being scared, chaotic, having no direction, being ill and never getting better. Client 10 now construes their 'current self' more closely with their 'ideal self' and 'self after psychological therapy.' We can also see that they have a less elaborated perception of people with physical health problems (located closer to the origin of the plot). They also have more extreme constructions of people with psychological health problems who, like Client 10 before therapy, are more likely to have less direction, be ill and unlikely to get better. This suggests Client 10 may associate being ill more with 'mental health' rather than 'physical health' difficulties.

3.4.2 Client 16: A Poor Therapeutic Relationship.

Client 16 was a 36 year-old White-British woman, who had been engaging in MBT for 1-2 years (currently seeing her therapist once a week). She rated her overall personal state rating of her last week as 60% and reported a total BSL-23 score of 68 (out of 92) – higher (and therefore more Borderline traits) than the client participants sample mean of 52.45 ($SD = 19.89$). She rated the therapeutic relationship most poorly in comparison to all other client participants. She scored 24 (for the total STAR-P score) and rated positive collaboration at 13 (out of 24), positive clinician input at six (out of 12) and non-supportive clinician input at five (out of 12).

The following 11 constructs were elicited from Client 16's repertory grid:

Anxious – Not anxious

Happy – Unhappy

Hard working – Lazy

Good parent – Not being there

Coping on your own – Asking for help

Strong – Weak

Pretending you're fine – Understanding your difficulties

Depressed – Accepting

Stubborn – Being easy

Hopeful – Pessimistic

Courageous – Scared

Table 15 displays her descriptive statistics for her repertory grid.

Table 15

Descriptive Statistics for Client 16's Repertory Grid

Supplied construct ratings on well – ill (supplied construct)

Current self: 3

Ideal self: 7

Future self: 4

Mother: 3

Father: 3

Partner: 3

A person with physical health problems: 4

A person with psychological health problems: 3

Self before therapy: 1

Self after therapy: 5

My clinician: 7

(note, the higher the score, the more *well* that person is construed)

Supplied construct ratings on will get better-will never get better (supplied construct)

Current self: 3

Ideal self: 7

Future self: 4

Mother: 7

Father: 7

Partner: 7

A person with physical health problems: 4

A person with psychological health problems: 5

Self before therapy: 1

Self after therapy: 4

My clinician: 7

(note, the higher the score, the more *likely to get better* that person is construed)

Standardised Euclidean distances

'Current self' and 'A person with psychological health problems': 1.21 (dissimilar)
'A person with psychological health problems' and 'A person with physical health problems':
0.70 (similar)
'Self before therapy' and 'Ideal self': 1.69 (dissimilar)
'Self after therapy' and 'Ideal self': 0.81 (similar – but just on benchmark guidelines of 0.8
and under)
'Self before therapy' and 'Ideal self' *minus* 'Self after therapy' and 'Ideal self': 0.88 (neither
similar nor dissimilar)
'Current self' and 'Ideal self': 1.55 (dissimilar)
'Future self' and 'Ideal self': 0.79 (similar)

Percentage sum of squares accounted for

Well – Ill construct: 7.70%

'Current self' (on differential changes grid): 14.92%

Percentage variance accounted for

First PCA: 64.24%

Delta correlations

Between Client 16 and Clinician 16: 0.36

Implicative dilemmas

Total number: 0

Table 15 suggests that Client 16 construes her current self and self before therapy as more ill than well, and therefore less likely to get better (confirming Hypothesis 10). Her perception of therapy suggests fewer benefits than Client 10. This potentially offers support for Hypothesis 1, as her self-construal as *ill* may have influenced her ability to perceive benefits. We can also see that Client 16 construes her current self in a dissimilar way to her ideal self (confirming Hypotheses 12.) However, she sees her future self and ideal self as similar (not confirming Hypothesis 13). Client 16 additionally appears to construe people with psychological and physical health difficulties similarly (possible evidence for Hypothesis 4).

With regard to the therapeutic relationship, Client 16 appears to less tightly construe (64.24%) than Client 10 (79.68%), not providing evidence in support of Hypothesis 7. However, Client 16's clinician has been less successful at predicting their client's 'current

self ratings (14.92%) and overall grid ratings (Delta correlation of 0.36). These findings provide some evidence in support of previous research (Winter, 2013) and Hypothesis 5.

Client 16's grid additionally revealed no implicative dilemmas on IDIOGRID, contradicting previous research regarding high symptom severity. However, both Client 10 and 16 had been receiving psychological therapy for over a year, which may account for the absence of implicative dilemmas within their grids (Feixas *et al.*, 2013; Winter, 2003).

An additional Principal Component Analysis was carried out to arrive at the visual representation of Client 16's repertory grid (see Figure 30).

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Slater Analyses for Client 16

Axis Range: -1.76 to 1.76

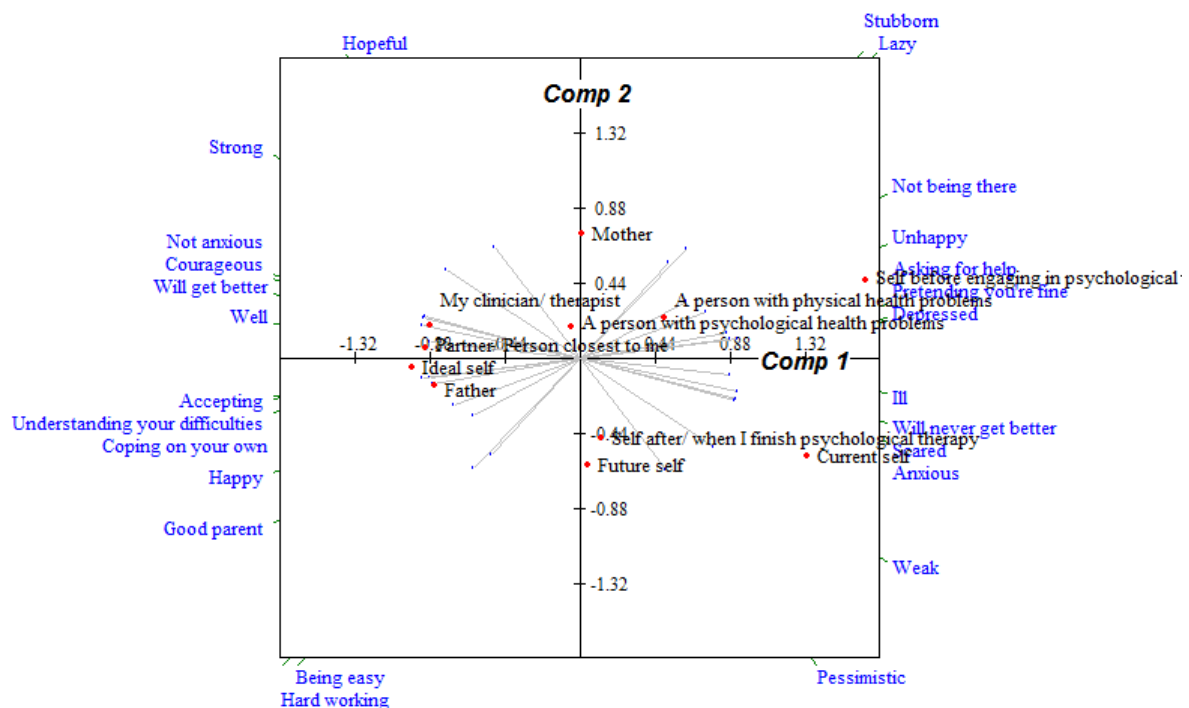


Figure 30. A plot representing Client 16's repertory grid.

On inspection of Figure 30, we can see that Client 16 associates their clinician with being courageous, well, likely to get better, accepting and understanding their difficulties. This is despite a poorer rating of the therapeutic relationship, suggesting Client 16 is able to recognise some positive qualities in their clinician (particularly as they are also, interestingly, construed in a similar way to Client 16's ideal self). Client 16 unfortunately construes her

current self, future self and self after therapy as pessimistic, weak, anxious, scared, ill and less likely to get better. The plot also suggests that Client 16 does not have particularly strong views about how people with psychological health problems may be, although construes people with physical health problems as unhappy, pretending they're fine and having to ask for help. Upon comparing Client 16's plot with Client 10's plot, it is clear that Client 16 construes more distance between how they are now and how they would ideally wish to be (Hypothesis 12).

3.5 Summary of Results

Appendix Y provides two summary tables conveying the final results and conclusions for each of the major and exploratory hypotheses.

3.5.1 Major Hypotheses

One major hypothesis can be *tentatively* confirmed based on a borderline significant correlation coefficient. This is the following:

1. Clients who construe the well – ill construct to be important will be less likely to construe benefits from psychological therapy (Hypothesis 2).

Findings further revealed medium effect size correlations which were neither borderline nor statistically significant. Therefore, although these hypotheses cannot be confirmed, findings highlight some evidence for the following major hypotheses:

1. Clinicians' accurate predictions of their clients' personal construct systems will be associated with a good therapeutic relationship (Hypothesis 5, but only with regard to clinicians' perception of the relationship).
2. Clients who construe more tightly will report a poorer therapeutic relationship (Hypothesis 7, but only with regard to clients' perception of the relationship). However, this was revealed to be in the opposite direction than originally hypothesised (discussed further in Chapter Four).

3.5.2 Exploratory Hypotheses

Three exploratory hypotheses can be confirmed based on statistically significant correlation coefficients. These are the following:

1. Clients who construe themselves to be *well* will be more likely to construe themselves as *getting better* from their difficulties (Hypothesis 10).
2. The reporting of a poor therapeutic relationship will be associated with more severe BPD symptoms (Hypothesis 11).
3. Clients who construe the 'future self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms (Hypothesis 13).

One exploratory hypothesis can be *tentatively* confirmed based on a borderline significant correlation coefficient. This is the following:

1. Clients who construe the 'current self' and 'ideal self' in a dissimilar way, will present with more severe BPD symptoms (Hypothesis 12).

Finally, findings revealed a medium effect size correlation which was neither borderline nor statistically significant. Therefore, although this hypothesis cannot be confirmed, findings highlight some evidence for the following exploratory hypotheses:

1. Clients who construe the 'current self' to be ill will also present with more severe BPD symptoms (Hypothesis 8).

CHAPTER FOUR: DISCUSSION

This chapter will initially provide an overview of the research questions and findings. It will then contextualise these findings by examining each of the major and exploratory hypotheses and the wider literature. These findings will then be considered by reflecting on relevant features of the research, including the study's methodological strengths and weaknesses. The clinical relevance and implications of the main findings will then be discussed. The chapter will finish with suggestions for future research and will offer final conclusions.

4.1 Overview of Research Questions and Findings

1. Does construing the self to be ill impact on clients' perceptions of their possibility to recover from their BPD diagnosis?

A number of hypotheses explored the impact of the well – ill construct with regard to client participants' perceptions of their possibility to recover. Recovery was operationalised by exploring BPD symptomatology, perceived benefits from psychological therapy and hopefulness regarding getting better.

This study's findings firstly produced some evidence in support of Hypothesis 8, as a medium effect size was found between construing the self to be ill and more BPD symptomatology. Similar findings were not revealed when construing 'a person with psychological health problems' to be ill (Hypotheses 9). Furthermore, no evidence was found to suggest BPD symptomatology is linked to how people construe themselves differently from others with psychological health problems (Hypothesis 3) or how similarly they construe people with psychological and physical health problems (Hypothesis 4).

Findings additionally did not produce evidence which suggests client participants who construe themselves to be ill before therapy will also perceive fewer benefits (Hypothesis 1). However, some evidence was revealed which suggests that participants with BPD, who consider the well – ill construct to be *more important*, will perceive fewer benefits from psychological therapy (Hypothesis 2). Client participants were also found to be more likely to construe themselves as getting better from their difficulties when they believed themselves to be well (Hypothesis 10).

2. Does construing the self to be ill impact on the therapeutic relationship for clients diagnosed with BPD?

The present study explored four correlations between self-reports of the therapeutic relationship and the well – ill construct. There was not enough evidence to confirm Hypothesis 6, and conclude that construing the self to be ill impacts on the therapeutic relationship. However, one medium effect size and statistically significant correlation was discovered between clients' ratings on the well – ill construct and clinicians' ratings of the therapeutic relationship. This interestingly suggests that the therapeutic relationship may be more challenging for clinicians if the client construes themselves to be ill. Furthermore, the study found no evidence to suggest that people with BPD, who construe tightly, will experience a poor therapeutic relationship (Hypothesis 7). In fact, a medium effect size revealed tight client construing is associated with clinicians' perception of a better quality therapeutic alliance.

3. Does the clinician's ability to construe the world from the perspective of their client impact on the therapeutic relationship between clinicians and clients diagnosed with BPD?

This study found no evidence that a clinician's ability to predict their client's construing is associated with the client's perception a strong therapeutic relationship. However, a medium effect size proposes some evidence for this to be important when it comes to clinicians' perception of the therapeutic relationship (Hypothesis 5). A poor therapeutic relationship was additionally found to be associated with more BPD symptomatology (Hypothesis 11). Although this finding was only statistically significant for client perceptions of the therapeutic relationship, a borderline significant finding also provides some evidence for clinician perceptions. BPD symptoms were also found to be associated with clients' difficulties construing their ideal self as similar to their current self (Hypothesis 12) and their future self (Hypothesis 13).

4.2 Hypotheses

This section will now discuss the research findings, for each hypothesis, in the context of the available literature.

4.2.1 Major Hypotheses

Hypothesis 1: Clients who construe themselves to be ill before engaging in psychological therapy will be less likely to construe benefits from psychological therapy.

This research study did not find that client participants who construed themselves to be ill were less likely to perceive benefits from psychological therapy. Findings here fail to support the rationale that construing the self to be *ill* reflects a reduced capacity to exhibit Psychological Mindedness and benefit from therapy (McCallum *et al.*, 2003; Piper *et al.*, 1994; Piper *et al.*, 2001). Alternatively, it is possible that client participants were able to perceive benefits from psychological therapy, even in the face of an adherence to the Medical Model. This supports Rogers & Acton (2012) who found that a selection of people with BPD appear to report a preference for both psychological and medical treatments.

Hypothesis 2: Clients who construe the well – ill construct to be important will be less likely to construe benefits from psychological therapy.

Interestingly, a medium effect size and borderline significant finding suggests that clients who perceive the well – ill construct to be more *important* or *superordinate* will be less likely to construe benefits from psychological therapy.³² The PCT literature highlights that the more *superordinate* a construct is, the more resistant the person will be to changing their position on that particular construct (Hinkle, 1965). It is therefore possible that client participants were less able to construe benefits from therapy, as this would mean that they would have to also change their positions i.e. construe the self to be less *ill*. One can therefore anticipate that the need to maintain a position on a more superordinate construct (such as illness) may be even more important to an individual's identity and construct system than perceiving recovery through therapy (Fransella, 2003b; Winter, 1992; 2003).

Hypothesis 3: Clients who construe the 'current self' and 'a person with psychological health problems' in a dissimilar way, will present with more severe BPD symptoms.

Findings did not suggest that clients who construe themselves differently from people with psychological health problems will present with more BPD symptoms. These findings do not support those reported by Nyklicek, Majoor & Schalken (2010) who found that clients who identify with the psychological nature of their difficulties report reduced symptoms. Alternatively, client participants who view themselves differently from other clients may be

³² A measure of construct importance (or 'superordinancy') is arrived at by extracting the Percentage Sum of Squares summary measure. This indicates the extent of an individual's extreme construct ratings e.g. frequency of 1 or 7 ratings on a 7-point Likert scale.

reflecting a distinct point in their recovery where they are more inclined to identify with other, healthier aspects of themselves (Pettie & Triolo, 1999; Slade, 2009).

Hypothesis 4: Clients who construe 'a person with psychological health problems' and 'a person with physical health problems' in a similar way will present with more severe BPD symptoms

Research findings found no evidence for Hypothesis 4. These findings do not support the rationale that construing psychological problems to be similar to physical health problems (i.e. an illness) will impede recovery. Findings therefore fail to support Large (1985) who reported physical illness construing coincided with a reduced ability to construe the emotional components of health and recover. It is possible that construing people with physical and psychological health problems in a similar way may instead reflect holistic and flexible thinking. This supports Vater *et al.* (2015), who suggested psychological health is reflected in one's ability to integrate supposedly conflicting constructions.

Hypothesis 5: Clinicians' accurate predictions of their clients' personal construct systems will be associated with a good therapeutic relationship. This will be particularly evident in clinicians' accurate perceptions of their clients' 'current self.'

Clinician participants' accurate predictions of their clients' construing (including the 'current self') were not found to be associated with a good therapeutic relationship. It is possible that such findings suggest other aspects of this relationship may be more important than clinician understanding. This is particularly as the therapeutic relationship has been evidenced to comprise a number of factors (Martin, Gaske & David, 2000). Factors such as *warmth*, *empathy* and *unconditional positive regard* may make up these more important 'non-specific factors' (Strupp, 2001).

The present research did, however, find one medium effect size which highlights a trend between accurate predictions of the clients' personal construct systems and a good therapeutic relationship – but only as perceived by clinicians. This evidence supports literature which highlights the importance of clinicians being able to subsume their clients' reality (Castonguay *et al.*, 2006; Fransella, 2003b; Straussner & Phillips, 2005; Wright, 2011). It is possible that this effect was not revealed among clients, as other 'non-specific factors' of the therapeutic alliance (e.g. *warmth*) may be more important among a client group that is often sensitive to rejection and abandonment (APA, 2013; Gunderson, 1996).

Hypothesis 6: Clients who construe themselves to be ill will report a poorer therapeutic relationship.

The present research revealed one medium effect and statistically significant correlation suggesting clients' construal of themselves to be *ill* is associated with the *clinician's* (and not client's) perception of a *poorer therapeutic relationship*. As hypothesised, it is possible that different aetiological understandings of BPD may have resulted in clinicians experiencing construct invalidation and therefore a more challenging therapeutic alliance (Winter, 1992; 2003). It is also possible that clinicians are reporting a poor therapeutic relationship because their clients who are more attached to an *illness identity* are particularly complex to work with e.g. present with increased hopelessness (Korsbek, 2013).

However, the majority of findings suggest the therapeutic relationship to not be dependent on the client's perception of themselves as ill. Martin, Gaske & David (2000), in their meta-analytic review, highlight this relationship to depend on a number of additional factors; including collaboration, agreement on treatment goals and a general affective bond between client and therapist. It is also possible that construing oneself to be *ill* does not imply a reduced capacity to think psychologically or engage in psychological therapy. Viney (1983) points out that the *image* one construes about ill-health will impact on that individual's experience. For example, some may construe being ill to include isolation, whereas others may construe being ill to bring family closer (cited in Winter, 1992).

Hypothesis 7: Clients who construe tightly will experience a poorer therapeutic relationship.

There were no significant findings that clients who construe tightly will experience a poor therapeutic relationship. This fails to support Winter (2003) who asserts that tight construing may lead to construct invalidation from others (i.e. the clinician participants). It is therefore possible that the bond between client and therapist is more influenced by other factors, such as mutually agreed upon goals (Martin, Gaske & David, 2000).

However, one medium effect size correlation was revealed between tight client construing and a *better* quality therapeutic relationship. Although in the opposite hypothesised direction, this finding provides evidence for Kelly's (1955) suggestion that the tightness or looseness of a client's construing impacts on the therapeutic bond. Additionally, it further supports

Winter's (1992) proposal that tight construing may strengthen this bond when the therapy is well structured.³³

4.2.2 Exploratory Hypotheses

Hypothesis 8: Clients who construe the 'current self' to be ill will also present with more severe BPD symptoms.

It was hypothesised that clients who consider themselves to be *ill* will present with more psychological symptoms. A medium effect size in the hypothesised direction follow the findings of St Claire & He (2009), St Claire, Clift & Dumbleton (2008) and the model proposed by Yanos, Roe & Lysaker (2010; cited in Korsbek, 2013) which highlight a positive correlation between identifying as ill and symptoms of poor health. This additionally appears to correspond with the Self-fulfilling Prophecy (Merton, 1948), which reports individuals to be more likely to display signs of a label they are given and identify with. Aviram, Brodsky & Stanley (2006) also suggest a self-fulfilling tendency for people with BPD, although they associate symptomatology with the BPD diagnosis and not the concept of illness (although, arguably, synonymous concepts).

It is possible that current findings did not reveal a larger effect because the participant sample (and client group) varies with regard to how individuals construe *illness*. Self-Regulation Theory asserts that an individual's subjective experience of their health condition is directly influenced by how one attributes meaning to their symptoms (Leventhal & Nerenz, 1985; Leventhal, Nerenz, & Steele, 1984). Subsequently, it is then possible that some client participants identified themselves to be *ill* and then developed a helpful and internal Locus of Control with regard to how they manage their BPD symptoms (Norman & Bennett, 1996; Rotter, 1954). Construing the self to be *ill* may therefore be, for some, synonymous with insight and the acceptance of mental health difficulties, ultimately beneficial for one's treatment motivation and recovery (Slade, 2009).

Hypothesis 9: Clients who construe 'a person with psychological health problems' to be ill will also present with more severe BPD symptoms.

It was hypothesised that clients who construe an average 'person with psychological health problems' to be ill will present with more BPD symptoms. This hypothesis was found not to

³³ Note: MBT and DBT, reported by the majority of client participants, are regarded to be structured therapeutic approaches.

be confirmed by the results. Construing psychological health problems to be *an illness* does therefore not appear to be associated with a lack of Psychological Mindedness (Applebaum, 1973) and one's restricted recovery (Carey *et al.*, 2007; Higginson & Mansell, 2008). It is instead possible that the construct of *illness* is associated with clinically helpful constructs, such as *acceptance* or *insight* (Slade, 2009).

Hypothesis 10: Clients who construe themselves to be well will be more likely to construe themselves as getting better from their difficulties.

Correlational findings additionally highlighted that those client participants who construed themselves to be *well* also believed that they were likely to *get better*. These findings suggest that construing the self to be *well* is important with regard to anticipating future recovery (White, 2014). This finding also supports the relationship between construing the self to be ill and hopelessness (i.e. not getting better), suggested by Yanos, Roe & Lysaker (2010) in their illness identity model (Korsbek, 2013). It is possible that the BPD stigma was also a mediating factor, as client participants may have believed themselves to be ill and unlikely to recover due to self-stigmatising beliefs (Corrigan & Watson, 2002).

Hypothesis 11: The reporting of a poor therapeutic relationship will be associated with more severe BPD symptoms.

A relationship was found between the perception of a poor therapeutic relationship and BPD symptomatology. These results support literature which highlights the importance of a strong therapeutic relationship when it comes to recovery for people diagnosed with BPD (Bedics *et al.*, 2012; Holmqvist & Armelius, 2004; Lowings *et al.*, 2011; NIMHE, 2003a; Swift, 2009). Although a significant correlation was only revealed for clients, a borderline significant correlation also provides support for this finding among clinicians. This is consistent with the evidence that client perceptions of the therapeutic alliance are most strongly correlated with therapeutic outcome (Horvath & Symonds, 1991; Lambert & Barley, 2001; Norcross & Wampold, 2011).

Hypothesis 12: Clients who construe the 'current self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms.

Despite the lack of a statistically significant correlation, findings revealed a borderline significant finding in support of Hypothesis 12. This supports literature which suggests a link between distress and a perception of being unlike one's ideal self (Boldero *et al.*, 2005;

Ribeiro, *et al.*, 2012). Findings here also support wider PCT literature which highlights an increased likelihood of self and ideal-self similarities following cognitive (Neimeyer, Heath & Strauss, 1985) and Personal Construct Psychotherapy groups (Winter, Gournay, & Metcalfe, 1999).

Hypothesis 13: Clients who construe the 'future self' and 'ideal self' in a dissimilar way will present with more severe BPD symptoms.

Client participants who construed the 'future self' and 'ideal self' in a dissimilar way presented with more BPD symptoms. This supports previous findings which highlight a link between distress and a perception that one will not reach their future ideal self (Boldero *et al.*, 2005; Freshwater, Leach & Aldridge, 2001). Findings additionally support Winter *et al.* (2000), who reported individuals who self-harm (a symptom of BPD) will be less able to construe desirable possibilities in their future. Finally, it appears intuitive that features of BPD may interfere with an individual's ability to see themselves positively in the future e.g. an unstable sense of self (APA, 2013).

It is possible that being less able to perceive the self as one would like to be in the *future* is more distressing than believing this to be true in the *present*. This may explain the borderline significant correlational finding for Hypothesis 12, as client participants may still be hopeful about being more similar to their 'ideal self' in the future. This supports findings which highlight the importance of optimism and hopefulness with regard to one's experience of mental health (Leamy *et al.*, 2011) and particularly for this client group (Fonagy & Bateman, 2005; White, 2014).

4.3 Features of the Research

This section will now seek to understand the present research findings further by considering some specific features of the study's design and implementation.

4.3.1 Limitations of the Research

Design

One of the key limitations of the present research project is that the study employs a correlational design and therefore lacks internal validity. This means that cause and effect relationships cannot be inferred (Mann, 2003). This is particularly regarding how perceptions

of illness and the therapeutic relationship may *cause* things to happen during the recovery of people with BPD. Longitudinal, prospective, studies will instead be necessary to ascertain such cause and effect relationships (Hole, 2012). Due to the time constraints of the present research, it was not possible to utilise a quasi-experimental research design where two groups of client participants (i.e. those who considered themselves *ill* and those who didn't) would complete a repertory grid before and after psychological therapy.³⁴

It is also important to consider the implications of how concepts have been operationalised. This particularly concerns an adherence to the Medical Model, which was operationalised through the exploration of the supplied well – ill construct. This immediately presents limitations as Kelly (1955) asserts, in his notion of 'constructive alternativism,' that people have an unlimited number of ways of construing the same thing. It is therefore possible that client participants construed the construct pole *ill* to mean a number of things in addition to, or instead of, medicalised thinking about psychological difficulties. This would suggest that medical and psychological thinking does not have to be mutually exclusive, and instead highlights the personal meaning individuals can bring to seemingly generic constructions (Kelly, 1955).

Sample

There are a number of further study limitations with regard to the client and clinician samples. Firstly, it is possible that findings are limited due to self-selection bias. This is because the research required clinicians to initially consent to take part, before approaching their clients for consent. It is therefore possible that clinicians who chose to take part were more willing because they perceived a strong therapeutic relationship. Clinicians who were likely to be experiencing more relational difficulties with their clients may have shied away from the research, due to concerns about judgements regarding their clinical competence. This partially explains why clinician participants tended to report a positive therapeutic relationship, which was somewhat unexpected given the complex nature of the therapeutic relationship with this client group (Linehan, 2014; NICE, 2009; 2015).

Furthermore, it is important to be mindful of the large number of clinicians and clients who decided not to participate (reflecting the recruitment difficulties with this client group; White, 2014). Possible reasons for this may include the current pressured climate of the NHS, leaving staff believing research to be an added, time-consuming commitment. The present

³⁴ This was first pioneered by Ryle & Lunghi (1969) in grid research.

research could have therefore benefited from a larger client and clinician sample. This would have increased the study's statistical power and allowed for greater sensitivity when evaluating the significance of research findings. The interpretations of the present study's findings and evidence for hypotheses must therefore be treated with caution.

Measures

Repertory grid

Limitations also present themselves with regard to the use of repertory grids. In particular, it is possible that some grid elements and elicited constructs were more ambiguous or had not yet been explored within the therapeutic relationship. This may have interfered with clinicians' ability to predict their clients' construing (Hypothesis 5). The researcher attempted to attend to such limitations by providing clarity to clinicians regarding some of the elements i.e. who their client was construing for the 'partner or someone close to me' element.³⁵ Clinician participants were also informed that their client's construct ratings for the elements 'a person with psychological health problems' and 'a person with physical health problems' did not refer to specific people. Finally, if in doubt, clinicians were encouraged to predict mid-point Likert ratings (i.e. 4 out of 7).

The operationalisation of certain concepts also needs to be considered. Firstly, the notion of Psychological Mindedness was operationalised by Euclidean distances relating to the 'current self', 'a person with psychological health problems' and 'a person with physical health problems' (Hypotheses 3 and 4). It is possible that the construct validity of measuring Psychological Mindedness is limited. This is particularly as client participants may not see psychological and physical conceptualisations of health as mutually exclusive. They may also not see themselves as similar to others with psychological problems, not because they lack insight, but because they are further along their journey of recovery. Finally, Euclidean distances were also used to operationalise perceived benefits from psychological therapy (Hypotheses 1 and 2). This also raises queries over the content validity of *perceived benefits* which, particularly when considering the recovery approach, may be more complex and idiosyncratic than quantitative changes in construct ratings (Anthony, 1993). The problem of *recall bias* may have also influenced some of the participants' ability to accurately and retrospectively recall benefits from psychological therapy (Belli, 1998).

³⁵ Note, additional clarity was provided when one client participant decided to construe their adopted, and not biological, mother.

Previous Experience of Psychological Therapy Questionnaire

Another study limitation, with regard to measuring the impact of psychological therapy, refers to the Previous Experience of Psychological Therapy Questionnaire. This questionnaire revealed that client participants were all at varying stages along their experience of therapy.³⁶ Furthermore, it is unclear how much psychological therapy client participants had engaged in prior to their most recent experience. Although the majority of client participants were engaging in long-term DBT or MBT, the lack of homogeneous experiences of therapy compromises this study's external validity. Additionally, a small number of client and clinician participants were not currently or had not engaged in psychological therapy together. This meant that the researcher was not able to explore the direct relationship between the therapeutic alliance and perceived benefits from psychological therapy.

Scale To Access Therapeutic Relationships (STAR)

Finally, the study also presents measure limitations when it comes to the STAR (McGuire-Snieckus *et al.*, 2007). This is because, although demonstrated to show adequate psychometric properties, the questionnaire only asks 12 questions. Although this was initially thought to result in less respondent fatigue, it appears that such a short questionnaire has resulted in reduced questionnaire sensitivity and a subsequent ceiling effect (Russo, 2003). This is because the majority of participants reported higher and therefore generally good quality therapeutic relationships. This may have contributed towards the lack of many statistically significant findings for Hypotheses 8 and 9. Furthermore, the STAR fails to detail normative data to sufficiently contextualise the study's findings. Finally, it is worth noting that this study's attempt to quantify a unique relational process (such as the therapeutic alliance) can be interpreted as reductionist and therefore not a true reflection of the quality of this complex relationship (Ardito & Rabellino, 2011).

Borderline Symptoms List (BSL-23)

The BSL-23 (Bohus *et al.*, 2009) finally presents some research issues to be considered. Firstly, the BSL-23 similarly lacks normative data, restricting the ability to contextualise the study's findings with other clinical groups. Future research may wish to utilise the BSL-93 (Bohus *et al.*, 2007), as it presents normative data and the potential to break down scores into further sub-scales. The BSL-23/95 additionally requires respondents to answer

³⁶ As highlighted by the 'Descriptive Statistics' section in Chapter Three.

questions with reference to the past week. Although this seems reasonable, it is plausible the client participants may have been having a particularly bad or good week, consequently affecting the reliability of their responses. A measure of BPD may have alternatively been more reliable if it had inquired about long-standing and chronic symptoms of psychological functioning. Other BPD inventories, indeed, take this into consideration e.g. Millon's (2006) Clinical Multi-axial Inventory (MCMI-III). The MCMI-III also takes into account other comorbid clinical syndromes known to be associated with the BPD diagnosis. As details on client participants' comorbid diagnoses were not gathered, it is possible that results may have been confounded by the presence of additional difficulties.

Procedure

The present study's procedure also needs to be inspected for research limitations. Firstly, it is possible that order effects may have influenced the way client participants completed the STAR and BSL-23, due to fatigue. These measures were left to last, due to the time required to complete the repertory grid. Future research may wish to consider spreading measures over two meetings. Clinician participants were additionally given the option to complete the research materials, on their own, and send them back via a stamp-addressed envelope. It is possible that this influenced clinicians' responses, as they did not have the opportunity to ask the researcher questions face-to-face. As the repertory grid is a rather novel interview technique for most, standardised instructions may have been useful to orientate participants to the research and increase the reliability of findings.

Another important consideration concerns the research settings. 13 clients participated in NHS community services and seven participated in an inpatient setting. Although the inpatient setting was not for acute mental health crises (instead considered a long-term, intensive psychological therapy service) such differences between settings may have impacted on the present findings. In particular, the STAR has only been documented for use in community settings (McGuire-Snieckus *et al.*, 2007) suggesting administration in an inpatient environment may invalidate scores. However, it was considered acceptable to utilise this measure as all seven client participants were not in an acute mental health crisis.³⁷

4.3.2 Strengths of the Research

³⁷ In fact, all seven client participants had been voluntarily engaging in the service for over a year. One client participant was also a day patient, residing in the local community.

The research study presents a number of strengths. It has firstly contributed towards developing an understanding of what may help or hinder people with BPD when it comes to perceiving benefits from psychological therapy. It has particularly achieved this by exploring the impact of perceiving oneself to be ill, including how this affects identity and the therapeutic relationship. This research is therefore likely to raise discussions about different aetiological understandings of BPD and subsequent treatment implications. The research has also contributed to an understanding of what constitutes the complex and critical therapeutic relationship.

A number of strengths additionally come from the use of repertory grids. This includes the researcher being able to investigate client participants' construing, in their own unique terms. Changes following psychological therapy were therefore considered from a client-centred and holistic perspective (Ryle & Lunghi, 1969), as opposed to research which has traditionally focused on a more reductionist decline in self-harm and suicide attempts. The use of grids also enabled the exploration of client participants' construing without them having to go into too much detail (which may have been difficult for them in a research context).

Grids additionally, for participants, present with low face validity and are therefore unlikely to produce results confounded by demand characteristics or social desirability (Rowe, 1971; Jankowicz, 2004). With regard to clinicians and the therapeutic relationship, the repertory grid provided a unique opportunity to explore clinicians' ability to subsume their client's reality (Kelly, 1955). It is also worth noting that all client participants appeared intrigued by the knowledge that their clinicians were going to be asked to predict their construing. They therefore all expressed an interest in the study's findings, with two client and clinician pairs requesting a copy of the grid to discuss in subsequent therapy sessions.

4.4 Relevance of Findings

The present research is one of only one other repertory grid study which has sought to take a PCT perspective and exclusively explore the construing of people diagnosed with BPD. As far as the author is aware, this research is the only study that has sought to compare client and clinician repertory grids for BPD and outside of single case studies. Although this means that research findings reported are innovative to the development of research in this area, previous literature does not exist to enable these findings to be compared with other samples.

The present study produced some evidence to highlight that BPD clients who identify as *ill* also present with more BPD symptoms and a poorer therapeutic relationship (as reported by their clinician). Findings additionally suggest evidence for a possible relationship between perceiving the well – ill construct to be important and a reduced ability to perceive benefits from therapy. Well-ill findings finally demonstrate that BPD clients who construe themselves to be *well* also report to be more hopeful about their future recovery.

With regard to the therapeutic relationship, present findings report some evidence to suggest this relationship is affected by the client's style of construing and the clinician's ability to see the world from their client's perspective. Results highlight a poorer therapeutic relationship to be significantly correlated with more BPD symptoms. Finally, additional analyses revealed that increased BPD symptoms were associated with clients' inability to see themselves now, and in the future, as they would like to be.

4.5 Implications of Findings

The implications of the key research findings will now be considered.

4.5.1 Major Finding: The Importance of the Well-Ill Construct

In particular, the relevance of the well – ill construct should be explored by mental health services when considering whether or not an individual with BPD is ready for psychological therapy (including possible secondary gains of identifying as *ill*). This is in line with the WHO (2000) notion of ensuring that candidates for therapy are indeed appropriate. As suggested by present findings, it is possible that some individuals consider the well – ill construct to be more important to their identity and construct system (Kelly, 1955). This may be experienced by clients as being particularly preoccupied with themselves, and others, as 'patients' and a strong inclination to exhibit and maintain an 'illness identity.'

It may therefore be helpful for such clients to be offered psychoeducation before engaging in therapy, particularly regarding the psychological nature of BPD (i.e. not a purely medical illness). It will also be helpful for clinicians to spend considerable time developing individual, psychological formulations for their clients diagnosed with BPD. It will be important for such formulations to highlight that mental health difficulties, however complex, can make sense and therefore be treated. Such thoughtful and comprehensive psychological formulations should also emphasise, to both clients and commissioners, the importance of seeking psychological therapy for complex, psychological problems. Mental health services may

wish to additionally seek appropriate consultation and training, ensuring staff feel competent and supported with regard to their formulation skills. Finally, such psychological formulations should help to reduce the hopelessness associated with an ‘illness identity.’ Clinicians would do well to be mindful of the importance of hopefulness during any intervention – reminding clients of times when they’ve felt differently and even, at times, having to ‘carry’ their hopefulness for them.

4.5.2 Major Finding: The Therapeutic Relationship

Furthermore, findings reveal BPD symptomatology, the construct of illness and clinicians’ ability to subsume their client’s construing to somewhat impact on the therapeutic relationship. As the therapeutic relationship is an essential driver with regard to successful therapy (particularly for this client group), findings here imply an essential need for clinicians to explore these factors within supportive supervision. Particularly, it may be helpful for clinicians to safely challenge each other’s ability to put themselves ‘in their client’s shoes,’ as often encouraged in MBT and DBT. Attachment difficulties may also present a barrier for people diagnosed with BPD when it comes to developing a productive therapeutic relationship (Guidano & Liotti, 1983). Clinicians need to subsequently be supported in receiving appropriate training to pre-empt and contextualise these relational difficulties. This should help with tackling the BPD stigma, as staff become more skilled in formulating and reframing relational difficulties as part of the therapeutic process.

4.5.3 Exploratory Finding: The Ideal Self

With regard to findings which highlight the relationship between self-to-ideal-self discrepancy and BPD symptomatology, results imply a need for therapeutic approaches to incorporate meaningful goals. This should include aspects of themselves and their future which clients want, as opposed to interventions which only focus on reducing symptoms (e.g. self-harm). Clinicians should take the time to understand what their client’s ‘ideal self’ might look like, being mindful and sensitive to likely obstacles with regard to the client’s ability to construe themselves favourably. The importance of instilling and maintaining hopefulness can therefore not be overstated. Personal construct approaches could additionally monitor progress towards the ‘ideal self’ by regularly administering grids as a valuable measure of change (Ryle, 1976).

4.6 Further Research

It will be important for future research to expand on the influence of the well-ill construct. This could be approached through qualitative methodology, exploring the personal meaning and rich narratives associated with believing oneself and others to be ill. Such research may also benefit from exploring staff perspectives. This would expand on literature which has evidenced staff motivation to treat BPD to be associated with a perception of a lack of *real* mental illness (Feather & Johnstone, 2001; Markham, 2003).

Quantitatively, it will also be important for future similar studies to employ larger sample sizes. This will ensure adequate statistical power and potentially provide further evidence for the more subtle correlational findings detected. It may also be helpful for further research to include prospective and RCT designs, where clients with BPD who identify as *ill* (and, importantly, those who also identify as *well*) are followed throughout the course of psychological treatment. This would enable the exploration of how this construct may be influencing clients' ability to think psychologically about treatment.

Indeed, repertory grids studies could also monitor changes in how people with BPD construe during treatment.³⁸ Grid research could additionally explore the client perspective when it comes to what they believe has helped and hindered them through psychological therapy. Finally, the BPD treatment literature would benefit from studies which explore the personal experiences of individuals who have internalised and pursued an entirely medical treatment pathway.

4.7 Conclusions

The present study has explored the unique construing of a stigmatised yet highly intriguing client group. This has included exploring the controversial and highly debated subject of whether or not BPD indeed exists and, if so, can be conceptualised as a medical illness. The implications of this for both the client and clinician have been considered, particularly with regard to the therapeutic relationship and clients' ability to perceive benefits from psychological therapies.

Results provide new information with regard to important treatment factors for people diagnosed with BPD. In particular, it is possible that a client's experience of symptoms and their ability to perceive benefits from therapy are influenced by how they construe the construct of illness. This research therefore challenges mental health services to stop

³⁸ The grid summary measure known as 'extremity' may be particularly helpful when exploring changes in 'black and white thinking' (Jankowicz, 2004).

pathologising the human experience and personality, and to instead ensure clients have access to psychological and validating understandings of their difficulties. This research also seeks to reassure staff that the therapeutic relationship, particularly for this client group, is complex. In addition to being able to subsume the client's reality, other equally important factors likely contribute to the quality and effectiveness of this relationship (such as validation and therapeutic optimism).

Finally, this research project has hopefully gone some way to honour Kelly's *credulous approach* when exploring the experiences of clients with complex needs (Kelly, 1955). This is particularly important for people diagnosed with BPD, who report a history of rejection from all manner of personal and professional relationships. They now deserve our continued respect and commitment more than ever.

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APPENDICES

Appendix A: Literature Search Strategy

Overview of Procedure

Ideas were firstly shared with supervisors and colleagues, prompting a brief exploration of the literature. A provisional list was drawn up of key psychological models, treatment approaches and researchers in the field of Borderline Personality Disorder. This resulted in the further exploration of key government policies and guidelines with regard to this client group. Initial explorations then became more specific, as a more detailed literature search followed. This involved searching through a number of databases (detailed below) and seeking out specific books, past theses and research articles. Experts in the field were also contacted and liaised with to verify gaps in the literature, recommend books and to inquire about possible literature that the author may have missed. These experts were also searched through ResearchGate, which enabled the inspection of references corresponding to the key authors' publications (the full texts were pursued, if appropriate).

Once the final research questions had been refined, further literature searching was conducting to ensure key literature had not been missed. This involved multiple database searches by the author and librarian assistants (to ensure searches were comprehensive as possible). Appropriate literature was shortlisted by reading through abstracts or book reviews. If unavailable, specific texts were requested through special request. Electronic research articles were stored in computer folders which related to specific areas of the literature search. The articles were then read and critiqued. Further literature was pursued by inspecting the reference lists for key articles. Citations were also searched for by using PsychINFO and Google Scholar, as these search engines enabled the retrieval of additional literature which had cited key articles.

The author noted coming across familiar names, articles and government policies, indicating that the literature had been thoroughly explored. However, the literature continued to be regularly searched, throughout the research process, until the start of June 2015.

Databases searched

The following relevant psychology and healthcare databases were searched: PubMed, PsychINFO, Medline, Scopus, ScienceDirect, APA PsycNet, Allied and Complimentary

Medicine (AMED), British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica Database (EMBASE) and Health Business Elite. The Cochrane database was also sought out and searched through in order to select the most recent and relevant systematic reviews. Finally, the grey literature was additionally searched through the Cochrane Library and the Health Management Information Consortium (HMIC) database. A number of librarian assistants aided the retrieval of difficult to reach texts, including those in different languages.

The following search terms were used (grouped together for readability):

- a) Borderline Personality Disorder, BPD, Emotionally Unstable Personality Disorder, Personality Disorder, PD, affective disorder, complex mental health.
- b) Psychological model(s), psychological theory.
- c) Ill, illness, illness identity, illness belief, illness perception, ill-health, disease, diagnosis, psychological models of health, health beliefs, health locus of control, locus of control.
- d) Recovery, treatment, treatable, treatment effectiveness, treatment efficacy, symptom(s).
- e) Medical Model, medication, medical treatment, medicalised treatment.
- f) Therapy, therapeutic, psychotherapy, psychological intervention, Dialectical Behaviour Therapy, DBT, Metallization Based Therapy MBT, Psychological Mindedness, psychological understanding, insight.
- g) Health-economic factors, economic factors, costs, benefits, cost-benefits.
- h) Therapeutic relationship, therapeutic alliance, therapeutic partnership, working relationship, collaboration, collaborative working, transference, counter-transference.
- i) Mental health staff attitudes, staff beliefs, clinician attitudes, clinician beliefs, staff experiences, staff opinions, staff knowledge, staff training, staff behaviour, Psychiatric Nurse experiences, Psychiatrist experiences, Psychologist experiences.
- j) Identity, personal identity, social identity, illness identity, mental health identity, mental health patient identity.
- k) American Diagnostic and Statistical Manual, DSM, the Internal Classification of Diseases and Related Health Problems, ICD.
- l) Repertory grid(s), personal constructs, constructivist, personal construct theory, personal construct psychology, personal construct approach, construe, tight construing, loose construing.

- m) Qualitative, survey, quantitative, review, meta-analysis.
- n) UK, England, National Health Service, NHS.
- o) Relevant authors were searched (including Linehan, Bateman, Tyrer, Livesly, Paris, Fonagy, Crawford, Winter, Gillman-Smith, Bell, etc).

The following expansion procedures were used during these searches:

- a) Boolean operators (i.e. AND, OR, NOT) were utilised to enable search engines to determine which keywords to include or exclude.
- b) The truncation technique was utilised where an asterisk was indicated at the end of a word to enable them search engine to produce all words beginning with that term e.g. ill* found the terms illness and ill-health (in addition to ill) and recover* found additional terms such as recovery and recovering.
- c) MESH terminology was employed to produce literature which used different terminology for the same concepts e.g. Borderline Personality Disorder and Emotionally Unstable Personality Disorder.
- d) The literature that was produced by major authors in the field was closely inspected, enabling the extrapolation of key terms and concepts (which were used as further search terms).

“A STUDY INVESTIGATING THE FACTORS ASSOCIATED WITH TREATING PEOPLE WITH BORDERLINE PERSONALITY DISORDER.”

CLINICIAN INFORMATION SHEET

Before you decide whether or not to take part, you may want to know more information about the study. Please see the [Frequently Asked Questions](#) below for further information.

I can also be contacted through email or by phone, should you wish to discuss any detail of the study further (email address: e.c.dunne@herts.ac.uk; phone number: xxxxxxxxxxxx).

[What is the purpose of the study?](#)

The study aims to explore some of the factors associated with the recovery of people with Borderline Personality Disorder (BPD).

The study aims to explore the relationship between people with BPD and their clinicians.

[What will happen to the results of the study?](#)

The data collected during the course of the research will be written up and submitted as a thesis to the University of Hertfordshire's Doctorate in Clinical Psychology programme. Efforts will also be made to publish the research in a psychological journal. No participants will be identifiable in any written or published material.

[What will happen next if I choose to take part?](#)

Both you and your client will need to agree to take part in the study (neither of you will be able to participate unless you both agree).

I will firstly telephone you and make an appointment to see you when it is most convenient and at your nearest NHS mental health service.

Your client would have already met with me to talk about their experiences and relationships using an interview technique known as a 'Repertory Grid.' This helps us to understand the links between the way people view themselves and other people.

You will be asked to predict how your client completed this repertory grid. You will then be asked to complete a brief 12 item questionnaire, asking you about your relationship with your client.

All of your answers will remain strictly confidential and your individual responses will not be given to anybody (including your client).

[What will my client have to do?](#)

As explained above, your client will complete a 'Repertory Grid' interview, where they will be asked to think about people they know and rate them across a number of characteristics. This helps us to see how clients with BPD view the world. Your client will complete their Repertory Grid interview before you meet with me.

Your client will also complete the 12-item questionnaire which asks about their relationship with you. They will additionally complete another questionnaire asking about their current symptoms of BPD.

For confidentiality purposes, you will not be able to see your client's answers, just like they will not be able to see your answers. However, should your client tell me something that leads me to feel concerned about **their or someone else's safety**, I will inform you, your team and any other appropriate NHS professionals (for example, the mental health crisis team).

Who is taking part in this study?

People with a diagnosis of BPD and their NHS clinician have been invited to take part in the study. A minimum of twenty people with a diagnosis of BPD, and their clinician, will take part in the study.

Do I have to take part?

No, it is totally up to you whether you decide to take part in the study.

What if I change my mind?

You are free to withdraw from the study at any point during our meeting. You are also free to withdraw your responses after our meeting, up until the research is written up in June 2015. This will be possible by assigning your data a unique identification number which will only be available to the researcher. Withdrawal from the study will then result in your data being destroyed. You do not have to give a reason for withdrawing from the study.

Who will see my responses?

All of the information collected about you during the research will be kept strictly confidential. The information you give will be looked at by supervisors from the University of Hertfordshire and the NHS Trust, but will be kept strictly anonymous. Your client will **NOT** be informed about any of your individual data.

What if there is a problem?

It is possible that predicting your client's Repertory Grid ratings may cause you to feel some discomfort. If you have a concern about any aspect of this study, you can contact me (Emma Dunne) directly and I will answer your questions (email address: e.c.dunne@herts.ac.uk; phone number: xxxxxxxxxx).

Who has reviewed this study?

The South Central Berkshire B Research Ethics Committee (part of the National Research Ethics Service) has reviewed and ethically approved this study (reference number: 14/SC/0256). The University of Hertfordshire School of Psychology has also reviewed and ethically approved this study (reference number: LMS/PG/UH00191). If requested, I can provide you with a copy of the documents stating that the study has ethical approval.

Under the ethical conditions of the study, you will be asked to sign a consent form if you agree to take part in the study. You will also be given a de-briefing sheet after you have participated, describing the study again in case you have any questions afterwards.

Thank you for taking the time to read this information sheet and for considering participating in this study.

“A STUDY INVESTIGATING THE FACTORS ASSOCIATED WITH TREATING PEOPLE WITH BORDERLINE PERSONALITY DISORDER.”

CLIENT INFORMATION SHEET

Please take the time to read this information sheet about the study and feel free to discuss it with your clinician, friends and family.

Before you decide whether or not to take part, you may want to know more information about the study. Please see the [Frequently Asked Questions](#) below for further information.

I can also be contacted through email or by phone, should you wish to discuss any detail of the study further (email address: e.c.dunne@herts.ac.uk; phone number: xxxxxxxxxxxx).

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What will happen to the results of the study?

The data collected during the course of the research will be written up and submitted as a thesis to the University of Hertfordshire's Doctorate in Clinical Psychology programme. Efforts will also be made to publish the research in a psychological journal. No participants will be identifiable in any written or published material.

What will happen next if I choose to take part?

Both you and your clinician will need to agree to take part in the study.

I will telephone you and make an appointment to see you when it is most convenient and at your nearest NHS mental health service. We will firstly go through a very brief form where you will be asked to state your past experiences of psychological therapy (no details will be asked about the content of your therapy sessions).

You will then be asked to talk about your experiences and relationships with people during an interview technique known as a 'Repertory Grid.' This helps us to understand the links between the way people view themselves and other people. The Repertory Grid interview will take approximately 30-45 minutes to complete.

You will then be asked to complete two brief questionnaires. The first questionnaire asks about your current symptoms of BPD. The second questionnaire asks questions about your relationship with your clinician. Completing both of the questionnaires should take no more than 20 minutes. As you may find some of the questions to be of a sensitive nature, your answers will remain confidential and your individual responses will not be given to anybody.

Unfortunately, I cannot give you feedback on your individual scores. However I will be able to send you a copy of the final research report once it is completed.

What will the 'Repertory Grid' interview involve?

As stated above, the 'Repertory Grid' is an interview technique which helps us to understand the links between the way people view themselves and others. Completing a 'Repertory Grid' will involve me asking you to think about people you know and then rate them across a number of characteristics. This helps us to understand a bit more about how you view your relationships and the world.

What will my clinician have to do?

Your clinician will also complete the 'Repertory Grid' interview, where they will try and predict what you have said about your relationships. This will help us see how much they understand you.

Your clinician will also complete one of the questionnaires that you have completed, where they will be asked questions about their relationship with you.

For confidentiality purposes, you will not be able to see your clinician's answers, just like they will not be able to see your answers.

Who is taking part in this study?

People with a diagnosis of BPD and their NHS clinician have been invited to take part in the study. A minimum of twenty people with a diagnosis of BPD, and their clinician, will take part in the study.

Do I have to take part?

No, it is totally up to you whether you decide to take part in the study. Your decision to say yes or no will not affect your NHS mental health care.

What if I change my mind?

You are free to withdraw from the study at any point during our meeting. You are also free to withdraw your responses after our meeting, up until the research is written up in June 2015. This will be possible by assigning your data a unique identification number which will only be available to the researcher. Withdrawal from the study will then result in your data being destroyed. You do not have to give a reason for withdrawing from the study.

Who will see my responses?

I will keep all of the information collected about you during the research strictly confidential. The information you give will be looked at by supervisors from the University of Hertfordshire and the NHS Trust, but will be kept strictly anonymous. Your clinician and responsible NHS team will **NOT** be informed about any of your individual data.

However, if you tell me something that leads me to feel concerned about **yours or someone else's safety**; I will have to inform the appropriate NHS professionals. However, in this case, I will always try to talk to you about what I am going to do before I do it.

What if there is a problem?

If you have a concern about any aspect of this study, you can contact me (Emma Dunne) directly and I will answer your questions (email address: e.c.dunne@herts.ac.uk; phone number: xxxxxxxxxx). It is possible that talking about relationships and reflecting on your current mental health difficulties may cause you to feel some discomfort. Telephone numbers and addresses of services where you can receive further support will therefore be made available, should you need them.

Who has reviewed this study?

The South Central Berkshire B Research Ethics Committee (part of the National Research Ethics Service) has reviewed and ethically approved this study (reference number: 14/SC/0256). The University of Hertfordshire School of Psychology has also reviewed and ethically approved this study (reference number: LMS/PG/UH00191). If requested, I can provide you with a copy of the documents stating that the study has ethical approval.

Under the ethical conditions of the study, you will be asked to sign a consent form if you agree to take part in the study. You will also be given a de-briefing sheet after you have participated, describing the study again in case you have any questions

**Thank you for taking the time to read this information sheet
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PAST EXPERIENCES OF PSYCHOLOGICAL THERAPY

Please take the time to read the following questions about your experiences of psychological therapy. Please answer each question by ticking the appropriate boxes.

1. Have you had therapy before?

- Yes
- No (*if No, you do not need to answer any further questions*).

2. What kind of therapy did you receive? (If you have had more than one type of therapy, please tick the most recent).

- Cognitive Behavioural Therapy
- Dialectical Behaviour Therapy
- Cognitive Analytic Therapy
- Mindfulness Based Cognitive Therapy
- Schema-focused Therapy
- Acceptance and Commitment Therapy
- Personal Construct Psychotherapy
- Psychodynamic/ Psychoanalytic therapy
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Private counselling (non-NHS)
- Other (*please state if known:* _____)
- Unsure

3. How long ago did you stop having this therapy?

- I am still having this therapy
- Between 0-3 months ago
- Between 3-6 months ago
- Between 6 months – 1 year ago
- Between 1-2 years ago
- Between 3-5 years ago
- Over 5 years ago

4. How long did the therapy last?

- Under 1 month
- Between 1-3 months
- Between 3-6 months
- Between 6 months – 1 year
- 1 – 2 years
- Over 2 years

5. How often did you see your therapist?

- Once a month
- Once every two weeks
- Once a week
- Over once a week

Any other comments? (optional)

Thank you for taking the time to complete this questionnaire!

Appendix E Borderline Symptoms List (BSL-23)

Borderline Symptom List 23 (BSL-23)

Code: _____ Date: _____

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt*. Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average.**
Please be sure to answer each question.

In the course of last week...		not at all	a little	rather	much	very strong
1	It was hard for me to concentrate	0	1	2	3	4
2	I felt helpless	0	1	2	3	4
3	I was absent-minded and unable to remember what I was actually doing	0	1	2	3	4
4	I felt disgust	0	1	2	3	4
5	I thought of hurting myself	0	1	2	3	4
6	I didn't trust other people	0	1	2	3	4
7	I didn't believe in my right to live	0	1	2	3	4
8	I was lonely	0	1	2	3	4
9	I experienced stressful inner tension	0	1	2	3	4
10	I had images that I was very much afraid of	0	1	2	3	4
11	I hated myself	0	1	2	3	4
12	I wanted to punish myself	0	1	2	3	4
13	I suffered from shame	0	1	2	3	4
14	My mood rapidly cycled in terms of anxiety, anger, and depression	0	1	2	3	4
15	I suffered from voices and noises from inside or outside my head	0	1	2	3	4
16	Criticism had a devastating effect on me	0	1	2	3	4
17	I felt vulnerable	0	1	2	3	4
18	The idea of death had a certain fascination for me	0	1	2	3	4
19	Everything seemed senseless to me	0	1	2	3	4
20	I was afraid of losing control	0	1	2	3	4
21	I felt disgusted by myself	0	1	2	3	4
22	I felt as if I was far away from myself	0	1	2	3	4
23	I felt worthless	0	1	2	3	4

Appendix F Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR)

A scale to assess the therapeutic relationship

95

APPENDIX. Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR)

STAR-C: Clinician Version ^a	STAR-P: Patient Version ^a
1. I get along well with my patient.	1. My clinician speaks with me about my personal goals and thoughts about treatment.
2. My patient and I share a good rapport.	2. My clinician and I are open with one another.
3. I listen to my patient.	3. My clinician and I share a trusting relationship.
4. I feel that my patient rejects me as a clinician.	4. I believe my clinician withholds the truth from me.
5. I believe my patient and I share a good relationship.	5. My clinician and I share an honest relationship.
6. I feel inferior to my patient.	6. My clinician and I work towards mutually agreed upon goals.
7. My patient and I share similar expectations regarding his/her progress in treatment.	7. My clinician is stern with me when I speak about things that are important to me and my situation.
8. I feel that I am supportive of my patient.	8. My clinician and I have established an understanding of the kind of changes that would be good for me.
9. It is difficult for me to empathize with or relate to my patient's problems.	9. My clinician is impatient with me.
10. My patient and I are open with one another.	10. My clinician seems to like me regardless of what I do or say.
11. I am able to take my patient's perspective when working with him/her.	11. We agree on what is important for me to work on.
12. My patient and I share a trusting relationship.	12. I believe my clinician has an understanding of what my experiences have meant to me.

^a Rate each item on the following scale:

Never	Rarely	Sometimes	Often	Always
0	1	2	3	4

Scoring protocol

A total STAR-C score and three subscale scores can be obtained. Before scoring, scores for the Emotional Difficulties subscale are reversed. Subtract each of the item ratings in this subscale from 4: a rating of 0 becomes 4 (4-0); a rating of 1 becomes 3 (4-1); a rating of 2 remains 2 (4-2); a rating of 3 becomes 1 (4-3); and a rating of 4 becomes 0 (4-4). After reversing items for this subscale, the total STAR-C score is obtained by adding the scores for each of the 12 items (range 0-48). The three subscale scores are each obtained by summing the relevant subscale items as follows:

Positive Collaboration: 1, 2, 5, 7, 10, 12

Emotional Difficulties: 4, 6, 9

Positive Clinician Input: 3, 8, 11

A total STAR-P score and three subscale scores can be obtained. Before scoring, scores for the Non-Supportive Clinician Input subscale are reversed. Subtract each of the item ratings in this subscale from 4: therefore, a rating of 0 becomes 4 (4-0); a rating of 1 becomes 3 (4-1); a rating of 2 remains 2 (4-2); a rating of 3 becomes 1 (4-3); and a rating of 4 becomes 0 (4-4). After reversing, the total STAR-P score is obtained by adding the scores for each of the 12 items (range 0-48). The three subscale scores are obtained by summing the relevant subscale items as follows:

Positive Collaboration: 2, 3, 5, 6, 8, 11

Positive Clinician Input: 1, 10, 12

Non-Supportive Clinician Input: 4, 7, 9

“A STUDY INVESTIGATING THE FACTORS ASSOCIATED WITH TREATING PEOPLE WITH BORDERLINE PERSONALITY DISORDER.”

CONSENT FORM

Name of Researcher: **Emma Dunne**

Please **initial** all boxes

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that all the information I give today will remain strictly anonymous and confidential, and that no identifiable information about me will be published.

4. I understand that the data collected during the study will be looked at by supervisors from the University of Hertfordshire and the NHS Trust. I also understand that this data may be examined by regulatory authorities.

5. I understand that even after giving my consent, I can ask for all my information and data to be erased at any time during or after completion of the session today (until June 2015).

6. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person
taking consent.

Date

Signature

“A STUDY INVESTIGATING THE FACTORS ASSOCIATED WITH TREATING PEOPLE WITH BORDERLINE PERSONALITY DISORDER.”

CLIENT DE-BRIEFING FORM

Thank you for taking the time to participate in this study.

The purpose of the study was to investigate what factors help facilitate the recovery of people with BPD. In particular, the study was interested in how people with BPD think about illness and how both clients and clinicians think about their therapeutic relationship.

The study therefore had the following aims:

1. To consider whether a subset of people with BPD consider themselves to be “ill” and how this may impact on their mental health and therapeutic relationship.
2. To explore whether the Repertory Grid method can aid us further in understanding the problems often reported in BPD client-clinician relationships.
3. To investigate whether clinicians’ predictions of clients’ Repertory Grids are associated with the strength of the therapeutic relationship.

In this research, you firstly signed a consent form stating that you understood the conditions behind participating in the current study. You also completed a Psychological Therapy Questionnaire, where you offered information on your past experiences of therapy; including what type of therapy you had most recently received (if any), how long ago this was and for what duration.

You then completed a Repertory Grid which asked you to think about a number of people in your life and how they are similar or different. The aim of completing the Repertory Grid was to see how you view the world. You were also asked to think about the spectrums of “ill – well” and “will never get better – will get better” in relation to yourself and other people.

You finally completed two questionnaires. The first one was the Borderline Symptoms List (BSL-23) which asked you to rate a number of your current mental health symptoms. You also completed the Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR) where you rated your relationship with your clinician.

Unfortunately, although you have offered a lot of personal information and have completed a number of questions, I cannot give you feedback on yours or your clinician’s individual scores. However, if you would like to receive a copy of a report which will summarise the study’s findings, please email me (e.c.dunne@herts.ac.uk) or leave your contact information with the researcher, Emma Dunne.

Thank you once again for your valuable participation in this study. Please do not hesitate to contact me via the above email address, should you have any further questions or comments. If you would like to speak to someone separate about your participation in the study, please contact Professor David Winter (d.winter@herts.ac.uk), Consultant Clinical Psychologist and Doctorate of Clinical Psychology Course Director at the University of Hertfordshire.

Do you need more people and services to talk to?

MIND: A mental health charity

Tel.: 0845 766 0163.

info@mind.org.uk

Hertfordshire MIND Network: A mental health charity

Tel.: 08444 77 22 12.

Email: info@hertsmindnetwork.org

Emergence: A Personality Disorder charity

admin@emergenceplus.org.uk

NHS Direct: Healthcare information and advice

Tel.: 111 (24 hours a day)

www.nhsdirect.nhs.uk

The Samaritans: A leading UK charity

Tel.: 08457 90 90 90 (24 hours a day)

jo@samaritans.org

Saneline: A mental health helpline

Tel.: 0845 767 8000

www.sane.org.uk

Hertfordshire Mental Health Helpline

Tel.: 01438 843322 (24 hours a day).

Do you need to make a complaint due to participating in this research?

Dr Nicholas Wood
Research Tutor
Doctorate in Clinical Psychology
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB
Telephone: 01707 286322
e-mail: n.l.wood@herts.ac.uk

“A STUDY INVESTIGATING THE FACTORS ASSOCIATED WITH TREATING PEOPLE WITH BORDERLINE PERSONALITY DISORDER.”

CLINICIAN DE-BRIEFING FORM

Thank you for taking the time to participate in this study. The purpose of the study was to investigate what factors help facilitate the recovery of people with BPD. In particular, the study was interested in how people with BPD think about illness and how both clients and clinicians think about their therapeutic relationship.

The study therefore had the following aims:

1. To consider whether a subset of people with BPD consider themselves to be “ill” and how this may impact on their mental health and therapeutic relationship.
2. To explore whether the Repertory Grid method can aid us further in understanding the problems often reported in BPD client-clinician relationships.
3. To investigate whether clinicians’ predictions of clients’ Repertory Grids are associated with the strength of the therapeutic relationship.

In this research, you firstly signed a consent form stating that you understood the conditions behind participating in the current study. You then predicted how your client would have completed a Repertory Grid interview technique. The aim of predicting their ratings was to explore how you believe your client sees the world. You finally completed the Scale To Assess Therapeutic Relationships in Community Mental Health Care (STAR) where you rated your relationship with your client.

Unfortunately, although you have offered a lot of personal information, I cannot give you feedback on yours or your client’s individual scores. However, if you would like to receive a copy of a report which will summarise the study’s findings, please email me (e.c.dunne@herts.ac.uk) or leave your contact information with the researcher, Emma Dunne.

Thank you once again for your valuable participation in this study. Please do not hesitate to contact me via the above email address, should you have any further questions or comments. If you would like to speak to someone separate about your participation in the study, please contact Professor David Winter (d.winter@herts.ac.uk), Consultant Clinical Psychologist and Doctorate of Clinical Psychology Course Director at the University of Hertfordshire.

Do you need to make a complaint due to participating in this research?

Dr Nicholas Wood
Research Tutor
Doctorate in Clinical Psychology
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB
Telephone: 01707 286322

e-mail: n.l.wood@herts.ac.uk

Appendix K: University of Hertfordshire proof of Sponsorship and Indemnity Insurance



Miss Emma Dunne (Professor David Winter)
Department of Psychology
School of Life and Medical Sciences

University of Hertfordshire
Hatfield
AL10 9AB
UK

tel +44 (0)1707 284000
fax +44 (0)1707 284115
herts.ac.uk

20 November 2014

Dear Emma

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: A Repertory Grid study investigating factors associated with treating people with Borderline Personality Disorder (BPD): The construct of 'illness' and the therapeutic relationship
NAME OF CHIEF INVESTIGATOR: Emma Dunne
IF STUDENT, NAME OF SUPERVISOR: Professor David Winter
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PG/UH/00191

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also essential that evidence of NHS Trust Management Permissions (formerly known as R&D Approval) is sent as soon as they are received.

Permission to seek changes as outlined above should be requested from myself before submission to an NRES (NHS) Research Ethics Committee (REC) and notification to the relevant University of Hertfordshire Ethics Committee with Delegated Authority (ECDA), and I must also be notified of the outcome. It is also essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as it is received. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

A handwritten signature in black ink, appearing to read "J M Senior".

Professor J M Senior
Pro Vice-Chancellor (Research and International)



A Charity Exempt from Registration under the
Second Schedule of the Charities Act 1993



NRES Committee South Central - Berkshire B

Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 01173421331
Fax:01173420445

28 May 2014

Miss Emma Catherine Dunne
Trainee Clinical Psychologist
University of Hertfordshire
Doctorate in Clinical Psychology Department, University of Hertfordshire
College Lane, Hatfield, Hertfordshire
AL10 9AB

Dear Miss Dunne

Study title: A Repertory Grid study investigating factors associated with treating people with Borderline Personality Disorder (BPD): The construct of a illness and the therapeutic relationship.
REC reference: 14/SC/0256
Protocol number: N/A
IRAS project ID: 151847

Thank you for your letter of 27 May 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Stephanie Macpherson, nrescommittee.southcentral-berkshireb@nhs.net.

Confirmation of ethical opinion

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

Conditions of the favourable opinion

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

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

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

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

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

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

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

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication times).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

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

Ethical review of research sites

NHS sites

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

Approved documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		01 August 2013
Letter from sponsor		03 April 2014
Non-validated questionnaire [Past experiences of psychological therapy questionnaire v2]	2	18 May 2014
Non-validated questionnaire [Scale to Assess Therapeutic Relationships in Community Mental Health Care]		
Other [clinician de-brief sheet v2]	2	18 May 2014
Other [client de-brief sheet v2]	2	18 May 2014
Other [Repertory Grid Technique v2]	2	18 May 2014
Other [Letter following REC review meeting]	1	18 May 2014
Participant consent form [Consent form v2]	2	18 May 2014
Participant information sheet (PIS) [PIS client V2]	2	18 May 2014
Participant information sheet (PIS) [PIS clinician V2]	2	18 May 2014
REC Application Form		
Research protocol or project proposal	1	31 March 2014
Summary CV for Chief Investigator (CI)	David Winter	
Summary CV for Chief Investigator (CI)	Emma Dunne	
Summary CV for Chief Investigator (CI)	Clare Cardy	
Summary CV for Chief Investigator (CI)	Timothy Acton	
Validated questionnaire [Borderline Symptoms List- 23]		

Statement of compliance

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

After ethical review

Reporting requirements

West London Mental Health 

NHS Trust



Dr Oliver Dale
Consultant Psychiatrist
West London Mental Health NHS Trust
Claybrook Centre
37 Claybrook Road
London W6 8LN

West London Mental Health Trust R&D Office
Medway Lodge
K Block 1st Floor
St Bernard's Wing
Uxbridge Road
Middlesex UB1 3EU

Tel: 020 8354 8738
Fax: 020 8354 8733
Email: rd.office@wlmht.nhs.uk

28 July 2014

Dear Dr Dale

Re: A Repertory Grid study investigating Borderline Personality Disorder
LREC Ref: 14/SC/0256
R&D Reference Number: DALOW1401

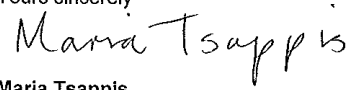
I am pleased to confirm that the above study has now received a full R&D approval, and you may continue your research in **West London Mental Health Trust**. May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998
- **Health & safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Serious Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Research Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Research Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Research Ethics Committee and R&D Office as soon as possible.
- **Monthly/Annual Progress report:** you are required to provide us and the Research Ethics Committee with a progress report and end of project report as part of the research governance guidance.
- **Recruitment data:** if your study is a portfolio study, you are required to upload the recruitment data on a monthly basis in the website:
http://www.crncc.nihr.ac.uk/about_us/processes/portfolio/p_recruitment/
- **Amendments:** if your study requires an amendment, you will need to contact the Research Ethics Committee. Once they have responded, and confirmed what kind of amendment it will be defined as, please contact the R&D office and we will arrange R&D approval for the amendment.
- **Audits:** each year, West London Mental Health Trust selects 10% of the studies from each service we have approved to be audited. You will be contacted by the R&D office if your study is selected

for audit. A member of the governance team will request you complete an audit monitoring form before arranging a meeting to discuss your study.

We would like to wish you every success with your project.

Yours sincerely

A handwritten signature in black ink that reads "Maria Tsappis". The signature is written in a cursive style with a dot above the 'i' in "Tsappis".

Maria Tsappis
Research Governance Officer

Trust Headquarters, West London Mental Health NHS Trust, Uxbridge Road, Southall, UB1 3EU

Tel: 020 8354 8354 | Web: www.wlmht.nhs.uk



Miss Emma Dunne
Trainee Clinical Psychologist
University of Hertfordshire
Doctorate in Clinical Psychology Dept
College Lane
Hatfield, AL10 9AB

R&D Department
Learning and Development Centre
The Colonnades
Beaconsfield Close
Hatfield
AL10 8YD
Tel. 01707 253834
Tel. 01707 253837
Email: t.gale@herts.ac.uk

24th November 2014

Dear Miss Dunne,

Permission for research

I am writing to inform you that permission has been granted on behalf of Hertfordshire Partnership University NHS Foundation Trust, for the following research project, on the basis described in the application form, protocol and supporting documentation.

Study details:

Study Title	A repertory grid study investigating Borderline Personality Disorder
Chief Investigator	Miss Emma Dunne
Sponsor name	University of Hertfordshire
HPFT study number	HPFT/135
IRAS or UKCRN ID number	14/SC/0256

NHS organisations and locations:

Organisation giving permission	Date of permission	Sites to which permission applies
Hertfordshire Partnership University NHS Foundation Trust	24/11/14	All sites within this organisation subject to local management approval

The documents reviewed were:

Document	Version	Date
NHS R&D form	151847/632515/14/910	14/04/2014
NHS REC form	151847/597072/1/478	14/04/2014
NHS SSI form	151847/695585/6/166/240332/311969	10/11/2014
REC ethical approval letter	N/A	28/05/2014
Study Protocol	Version 1	31/03/2014
Client information sheet	Version 2	18/05/2014
Clinician information sheet	Version 2	18/05/2014
Consent form	Version 2	18/05/2014
Clinician de-briefing form	Version 2	18/05/2014
Client de-briefing form	Version 2	18/05/2014
Researcher CVs	Various	Various

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), the Data Protection Act (1998) and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the REC or university ethics committee and which have been authorized by the MHRA (if applicable).

The following local conditions will apply:

- 1. Sponsorship of Study**

The research Sponsor will be the organisation named above; the management and design of the study is not the responsibility of the Trust or Trusts giving permission.
- 2. Confidentiality**

You are required to ensure that all information regarding participants remains **secure** and **strictly confidential** at all times. You must ensure that you understand and comply with requirements of the Data Protection Act (1998) and the NHS Confidentiality Code of Practice. Furthermore, you should be aware that under the Data Protection Act (1998), unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.
- 3. Researcher Authorisation**

Only those researchers holding a letter of access or honorary research contract, as appropriate, from Hertfordshire Partnership University NHS Foundation Trust may have direct contact with the participants of this study or to their patient files, unless they already have a substantive honorary contract with the Trust.
- 4. Urgent Safety Actions**

The research sponsor, the Chief investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. This office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. This office should be notified within the same time frame of notifying the REC and any other regulatory bodies.



- 5. Serious Adverse Events** Should an SAE occur during the course of the project, this office must be notified immediately. This is in addition to your legal duty to report such events to the Sponsor.
- 6. Amendments** All amendments (including changes to the local research team) need to be submitted in accordance with guidelines in IRAS. This office should be informed at the same time as the REC or university ethics committee is notified in order to avoid any unnecessary delays.
- 7. Indemnity** You must check with the Sponsor that the indemnity arrangements, as confirmed in the Sponsor's Declaration and described in the application forms, are in place before any participants are recruited.
- 8. Study Progression** You will inform us of any significant developments that occur as the study progresses. You will complete and return any report forms that we send you and provide up to date information on the number of participants recruited when asked.
- 9. Audit of Study** You may also be subject to a random audit of research which will involve a site visit, a requirement to view study documents and a request to interview researchers.
- 10. Study Completion** You will notify the Chief Investigator and this office when the study has completed recruiting participants and when the study has finally finished at your site. You will complete and return the final report that we send you and inform us of any publications relating to the study.
- 11. Presentation of Findings** HPFT expects that the findings of this study will be presented to members of the appropriate service line. You should contact the service line research lead upon completion of the study to arrange a suitable venue and time.

Finally, I wish you every success with the study.

With kind regards



Dr Tim M Gale
Manager, Research and Development Department
Visiting Professor, Dept Psychology, UoH

Appendix N: Table displaying STAR total and sub-scale scores for client participants

Participant	Total score (STAR-P)	Positive collaboration	Positive clinician input	Non-supportive clinician input
1	40	19	9	12
2	42	24	12	6
3	42	21	9	12
4	42	21	11	10
5	47	24	11	12
6	43	20	12	11
7	47	23	12	12
8	41	20	11	10
9	42	20	10	12
10	48	24	12	12
11	44	23	11	10
12	42	19	11	12
13	37	18	11	8
14	27	14	7	6
15	35	19	10	6
16	24	13	6	5
17	41	24	11	6
18	37	18	9	10
19	39	22	8	9
20	41	23	9	9

Appendix O: Table displaying STAR total and sub-scale scores for clinician participants

Participant	Total score (STAR-C)	Positive collaboration	Positive clinician input	Emotional difficulties
1	40	18	11	11
2	40	21	9	10
3	41	19	11	11
4	38	23	9	6
5	41	19	12	10
6	37	18	11	8
7	39	18	10	11
8	28	15	7	6
9	37	18	10	9
10	44	23	9	12
11	37	18	9	10
12	40	21	11	8
13	27	12	8	7
14	35	18	9	8
15	33	16	9	8
16	28	13	9	6
17	36	17	10	9
18	34	14	11	9
19	29	14	9	6
20	34	18	9	7

Note: 12 clinician participants provided 20 sets of data i.e. 20 STAR measures, corresponding with each of client participant ($n=20$).

Appendix P: Table displaying measures of central tendency: STAR-P.

	STAR-P	Positive collaboration	Positive clinician input	Non-supportive clinician input
<i>N</i>	20	20	20	20
<i>M</i>	40.05	20.45	10.10	9.50
Median	41.50	20.50	11.00	10.00
Mode	42.00	24.00	11.00	12.00
Minimum	24.00	13.00	6.00	5.00
Maximum	48.00	24.00	12.00	12.00
<i>SD</i>	5.98	3.15	1.71	2.50
Skewness	-1.44	-.91	-.94	-.57

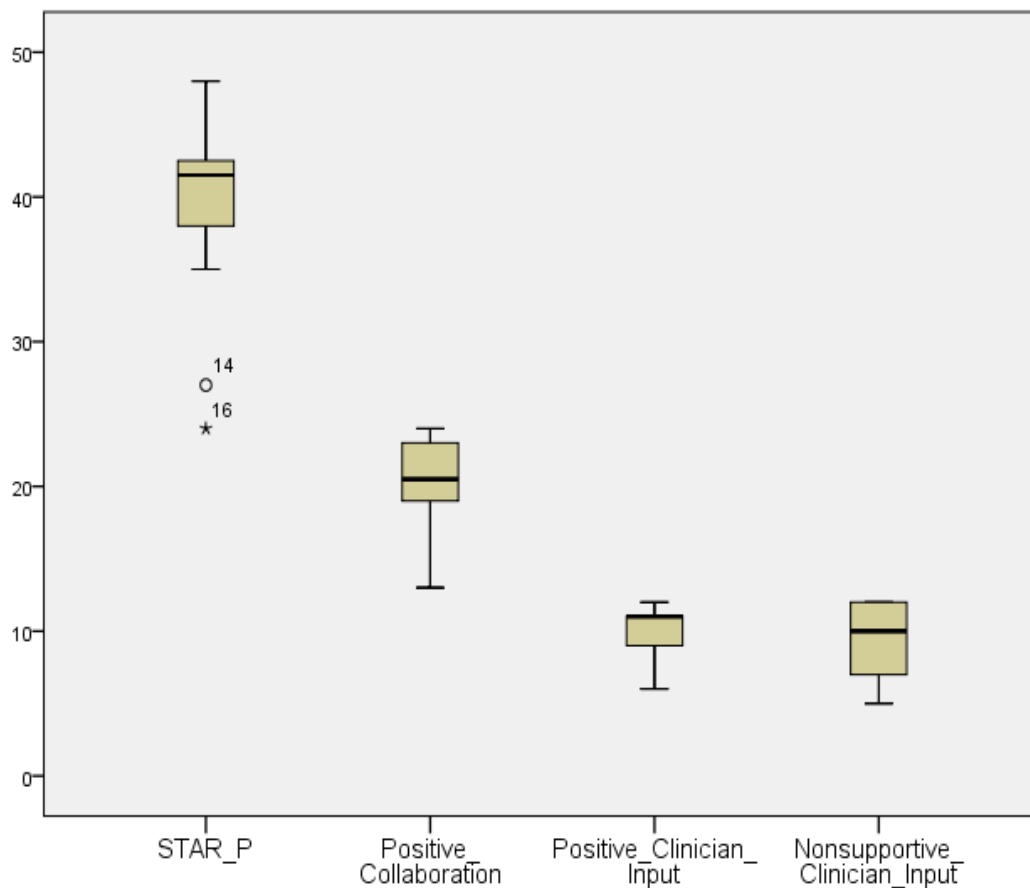
Appendix Q: Table displaying measures of central tendency: STAR-C.

	STAR-C	Positive collaboration	Positive clinician input	Emotional difficulties
N	12	12	12	12
<i>M</i>	35.90	17.65	9.65	8.60
Median	37.00	18.00	9.00	8.50
Mode	37.00 ^a	18.00	9.00	6.00 ^a
Minimum	27.00	12.00	7.00	6.00
Maximum	44.00	23.00	12.00	12.00
<i>SD</i>	4.89	3.03	1.23	1.90
Skewness	-.51	-.03	-.01	.08

a. Multiple modes exist. The smallest value is shown

Note: 12 clinician participants provided 20 sets of data i.e. 20 STAR measures, corresponding with each of client participant ($n=20$).

Appendix R: Box plots to display the dispersion of client (STAR-P) participant scores across STAR total (out of 48) and sub-scale variables.

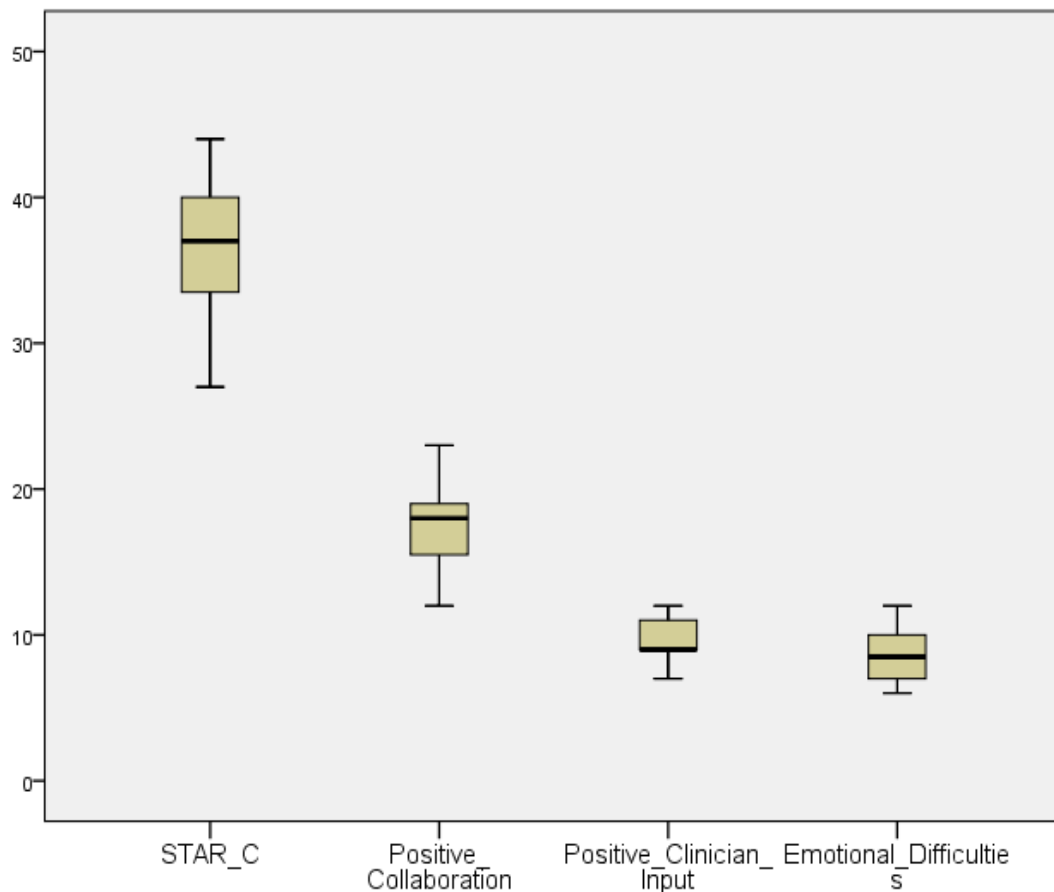


The higher the individual scores on the Positive Collaboration scale (out of 24), the more the client perceives the therapeutic relationship “reflects a good rapport, a shared understanding of goals and the experience of mutual openness and trust” (McGuire-Snieckus *et al.*, 2007; p.9).

The higher the client scores on the Positive Clinician Input scale (out of 12), the more they perceive the therapeutic relationship “reflects to what extent clinicians (is perceived by the patient to) encourage, regard, support, listen to and understand the patient” (McGuire-Snieckus *et al.*, 2007; p.9).

The Non-supportive Clinician Input scale is computed by reversing the individual’s scores for these scale items. Therefore, the higher the client scores on the non-supportive clinician input scale (out of 12), the less they perceive the “clinician withholds the truth and is impatient and authoritarian” (McGuire-Snieckus *et al.*, 2007; p. 9).

Appendix S: Box plots to display the dispersion of clinician (STAR-C) participant scores across STAR total (out of 48) and sub-scale variables.



The higher the clinician scores on the Positive Collaboration scale (out of 24), the more they perceive the therapeutic relationship “reflects a good rapport, a shared understanding of goals and the experience of mutual openness and trust” (McGuire-Snieckus *et al.*, 2007; p.9).

The higher the clinician scores on the Positive Clinician Input scale (out of 12), the more they perceive the therapeutic relationship “reflects to what extent clinicians (is perceived by the patient to) encourage, regard, support, listen to and understand the patient” (McGuire-Snieckus *et al.*, 2007; p.9).

The Emotional Difficulties scale is computed by reversing the individual’s scores for these scale items. Therefore, the higher the clinician scores on the emotional difficulties scale (out of 12), the less likely they are to feel as though “they cannot empathize with and are not accepted by the patient” (McGuire-Snieckus *et al.*, 2007; p. 9).

Appendix T: Tables displaying client participant construct ratings (1-7) for each supplied construct

Well-III supplied construct (n = 20)

Participant	Current self	Ideal self	Future self	Mother	Father	Partner/ person close	A person with physical health problems	A person with psychological health problems	Self before therapy	Self after therapy	Clinician
1	4	7	4	7	7	4	1	1	1	3	7
2	5	7	7	5	6	6	3	3	2	5	7
3	4	7	6	7	3	7	5	2	3	5	6
4	3	7	7	2	1	4	1	1	2	5	4
5	5	7	7	4	5	6	2	2	2	6	7
6	1	7	1	2	1	6	1	3	1	3	6
7	3	7	4	6	6	6	4	2	1	5	6
8	2	6	5	4	5	4	5	4	3	5	4
9	2	7	5	7	4	6	4	3	1	6	7
10	6	6	6	4	4	3	4	3	1	6	7
11	3	7	5	5	4	3	4	3	1	3	6
12	5	7	5	7	7	7	6	6	5	5	7
13	3	7	5	2	5	7	6	3	2	6	7
14	5	6	6	4	7	4	6	5	4	6	6
15	4	7	6	4	5	6	3	2	1	6	5

16	3	7	4	7	7	7	4	3	1	5	7
17	5	7	5	6	6	6	2	2	4	5	7
18	4	6	6	4	3	7	3	4	3	6	7
19	5	7	6	6	5	5	5	3	3	6	7
20	4	7	5	4	2	6	2	5	1	6	7

Will get better-Will never get better supplied construct (n = 20)

Participant	Current self	Ideal self	Future self	Mother	Father	Partner/ person close	A person with physical health problems	A person with psychological health problems	Self before therapy	Self after therapy	Clinician
1	3	7	3	1	1	4	7	1	1	3	7
2	5	7	7	5	6	6	4	5	4	5	7
3	4	6	5	7	2	7	5	2	2	5	7
4	2	7	6	2	1	4	1	1	1	5	4
5	6	7	7	5	5	6	5	4	3	7	7
6	1	6	1	2	1	6	1	3	1	2	6
7	4	7	5	3	3	3	5	5	1	4	3
8	4	7	5	4	4	4	4	5	3	5	5
9	4	7	5	5	3	6	3	5	2	5	5
10	6	7	6	4	4	5	4	4	1	6	7
11	4	5	4	6	1	4	4	5	1	3	5
12	1	7	2	4	4	4	3	4	1	3	4
13	3	5	6	1	4	7	6	1	2	5	7
14	7	7	7	6	7	6	7	7	3	7	2
15	5	7	6	2	3	7	2	3	1	6	6
16	3	7	4	7	7	7	4	5	1	4	7
17	5	7	5	6	6	7	3	2	5	6	7

18	3	6	4	3	3	6	2	4	1	6	7
19	6	7	6	5	4	4	5	4	2	6	6
20	4	7	5	4	1	7	2	6	1	6	7

Appendix U: Table displaying each extracted standardised Euclidean distance between elements ($n = 20$)

Participant	'Current self' and 'A person with psychological health problems'	'A person with psychological health problems' and 'A person with physical health problems'	'Self before psychological therapy' and 'Ideal self'	'Self after psychological therapy' and 'Ideal self'	'Current self' and 'Ideal self'	'Future self' and 'ideal self'
1	1.21	0.81	1.27	1.16	1.14	1.08
2	0.78	0.89	1.86	0.94	1.03	0.36
3	0.50	1.03	1.27	0.48	1.25	0.37
4	1.15	0.19	1.32	0.61	0.93	0.61
5	1.09	0.98	1.86	0.57	0.90	0.24
6	0.78	0.57	1.41	1.15	1.42	1.40
7	0.93	1.48	1.56	0.54	1.07	0.51
8	0.95	0.64	1.60	0.80	1.69	0.71
9	0.45	0.66	1.89	0.37	1.51	0.53
10	1.13	0.57	1.97	0.35	0.39	0.29
11	0.73	0.44	1.67	1.10	1.00	0.67
12	0.87	0.94	1.72	1.00	1.47	1.14
13	0.83	0.95	1.45	0.42	0.99	0.62
14	0.62	1.26	1.23	0.41	0.76	0.49
15	0.78	0.43	1.79	0.65	0.83	0.68
16	1.21	0.70	1.69	0.81	1.55	0.79
17	1.02	0.78	1.70	0.98	0.90	0.77
18	0.73	0.36	1.69	0.24	1.15	0.42
19	0.89	0.95	1.98	0.72	0.89	0.61
20	0.54	0.88	1.66	0.21	1.00	0.72

Appendix V: Table displaying the percentage sum of squares (%) extracted from each client participant ($n = 20$)

Participant	Percentage sum of squares accounted for by the well – ill construct	Percentage sum of squares accounted for by the ‘current self’ (on the ‘differential changes’ grid)
1	8.81	4.43
2	8.07	5.71
3	7.92	11.48
4	7.02	6.51
5	6.73	13.73
6	8.17	2.47
7	8.10	12.43
8	4.72	4.37
9	7.97	5.67
10	6.80	2.47
11	9.99	4.31
12	1.80	13.74
13	8.58	4.67
14	2.97	6.75
15	6.86	7.45
16	7.70	14.92
17	10.23	9.68
18	7.39	4.69
19	6.73	7.43
20	7.50	10.43

Appendix W: Table displaying each extracted Delta correlation ($n = 20$)

Participant	Delta
1	0.55
2	0.75
3	0.24
4	0.64
5	0.64
6	0.30
7	0.60
8	0.51
9	0.79
10	0.74
11	0.62
12	0.48
13	0.51
14	0.32
15	0.65
16	0.36
17	0.60
18	0.69
19	0.61
20	0.80

Appendix X: Table displaying the first principal component (%) extracted from each client participant ($n = 20$)

Participant	Percentage variance accounted for
1	44.64
2	71.28
3	50.25
4	69.79
5	82.30
6	73.87
7	58.13
8	47.61
9	83.49
10	79.68
11	49.16
12	83.95
13	67.67
14	38.27
15	65.11
16	64.24
17	65.87
18	63.10
19	73.86
20	88.06

Appendix Y: Tables displaying the final results and decisions for each Hypothesis

Major Hypotheses

Hypothesis	Results	Can the hypothesis be confirmed?
<p>1) Clients who construe themselves to be ill before psychological therapy will be less likely to construe benefits from psychological therapy.</p>	<p>The correlation hypothesised between ‘self before engaging in psychological therapy’ ratings on the well – ill construct and [standardised Euclidean distance between ‘self before psychological therapy’ and ‘ideal self’] minus [standardised Euclidean distance between ‘self after psychological therapy’ and ‘ideal self’] produced a small effect size and was not found to be statistically significant ($r_s(18) = -0.146$ $p = .540$, two-tailed).</p>	<p>Hypothesis 1 cannot be confirmed.</p>
<p>2) Clients who construe the well – ill construct to be important will be less likely to construe benefits from psychological therapy.</p>	<p>The inverse correlation hypothesised between Percentage sum of squares accounted for by the well – ill construct and [standardised Euclidean distance between ‘self before psychological therapy’ and ‘ideal self’] minus [standardised Euclidean distance between ‘self after psychological therapy’ and ‘ideal self’] was found to be borderline significant, with a medium effect size ($r_s(18) = -0.335$ $p = .074$, one-tailed).</p>	<p>Hypothesis 2 can be tentatively confirmed.</p>
<p>3) Clients who construe the ‘current self’ and ‘a person with psychological health problems’ in a dissimilar way,</p>	<p>The correlation hypothesised between [standardised Euclidean distance between ‘current self’ and ‘a person with psychological health</p>	<p>Hypothesis 3 cannot be confirmed.</p>

will present with more severe BPD symptoms.	problems'] and BSL-23 scores produced a small effect size and was not statistically significant ($r_s(18) = -0.10$ $p = .670$, two-tailed).	
4) Clients who construe 'a person with psychological health problems' and 'a person with physical health problems' in a similar way, will present with more severe BPD symptoms.	The inverse correlation hypothesised between [standardised Euclidean distance between 'a person with psychological health problems' and 'a person with physical health problems'] and BSL-23 scores produced a small effect size and was not statistically significant ($r_s(18) = -0.163$ $p = .247$, one-tailed).	Hypothesis 4 cannot be confirmed.
5) Clinicians' accurate predictions of their clients' personal construct systems will be associated with a good therapeutic relationship.	The correlation hypothesised between STAR-P and Delta scores produced a small effect size and was not found to be statistically significant ($r_s(18) = 0.203$ $p = .196$, one-tailed).	Hypothesis 5 cannot be confirmed.
This will be particularly evident in clinicians' accurate perceptions of their clients' 'current self.'	The correlation hypothesised between STAR-C and Delta scores produced a medium effect size and was not found to be statistically significant ($r_s(18) = 0.274$ $p = .121$, one-tailed).	
	The inverse correlation hypothesised between STAR-P and Percentage sum of squares accounted for by 'current self' produced a small effect size and was not found to be statistically significant ($r_s(18) = -0.179$ $p = .225$,	

one-tailed).

The inverse correlation hypothesised between STAR-C and Percentage sum of squares accounted for by 'current self' produced a small effect size and was found not to be statistically significant ($r_s(18) = 0.04$ $p = .872$, two-tailed).

6) Clients' who construe themselves to be ill will experience a poorer therapeutic relationship.

The correlation hypothesised between STAR-P and 'current self' ratings on the well – ill construct produced a small effect size and was not found to be statistically significant ($r_s(18) = 0.010$ $p = .484$, one-tailed).

Hypothesis 6 cannot be confirmed (despite the presence of one statistically significant relationship).

The correlation hypothesised between STAR-C and 'current self' ratings on the well – ill construct was found to be statistically significant, with a medium effect size ($r_s(18) = 0.383$ $p = .048$, one-tailed).

The inverse correlation hypothesised between STAR-P and percentage sum of squares accounted for by clients for the well – ill construct produced a small effect size and was found not to be statistically significant ($r_s(18) = 0.12$ $p = .602$, two-tailed).

The inverse correlation

hypothesised between STAR-C and percentage sum of squares accounted for by clients for the well – ill construct produced a small effect size and was found not to be statistically significant ($r_s (18) = 0.02$ $p = .926$, two-tailed).

7) Clients who construe more tightly will experience a poorer therapeutic relationship.

The inverse correlation hypothesised between STAR-P and percentage variance accounted for by the first principal component produced a medium effect size and was found not to be statistically significant ($r_s (18) = 0.35$ $p = .126$, two-tailed).

Hypothesis 7 cannot be confirmed.

The inverse correlation hypothesised between STAR-C and percentage variance accounted for by the first principal component produced a small effect size and was found not to be statistically significant ($r_s (18) = 0.19$ $p = .422$, two-tailed).

Exploratory Hypotheses

Hypothesis	Results	Can the hypothesis be confirmed?
8) Clients who construe the 'current self' to be ill will also present with more severe BPD symptoms.	The inverse correlation hypothesised between well – ill construct ratings for 'current self' and BSL-23 scores produced a medium effect size and was not statistically significant ($r_s(18) = -0.282$ $p = .114$, one-tailed).	Hypothesis 8 cannot be confirmed (though there appears to be a trend in the hypothesised direction).
9) Clients who construe 'a person with psychological health problems' to be ill will also present with more severe BPD symptoms.	The inverse correlation hypothesised between well – ill construct ratings for 'a person with psychological health problems' and BSL-23 scores produced a small effect size and was not statistically significant ($r_s(18) = 0.165$ $p = .486$, two-tailed).	Hypothesis 9 cannot be confirmed.
10) Clients who construe themselves to be well will be more likely to construe themselves as getting better from their difficulties.	<p>The correlation hypothesised between 'current self' ratings on the well – ill construct and will get better - will never get better construct was found to be statistically significant, with a large effect size ($r_s(18) = 0.60$ $p < .001$, one-tailed).</p> <p>The correlation between 'self before engaging in psychological therapy' ratings on the well – ill construct and will get better - will never get better construct was also found to be statistically significant, with a large effect size ($r_s(18) = 0.561$ $p = .005$, one-tailed).</p>	Hypothesis 10 can be confirmed.

11) The reporting of a poor therapeutic relationship will be associated with more severe BPD symptoms.	The inverse correlation hypothesised between STAR-C and BSL-23 was found to be borderline significant, with a medium effect size ($r_s(18) = -0.334$ $p = .075$, one-tailed).	Hypothesis 11 can be confirmed.
	The inverse correlation hypothesised between STAR-P and BSL-23 was found to be statistically significant, with a large effect size ($r_s(18) = -0.573$ $p = .004$, one-tailed).	
12) Clients who construe the 'current self' and 'ideal self' in a dissimilar way, will present with more severe BPD symptoms.	The correlation hypothesised between [standardised Euclidean distance between 'current self' and 'ideal self'] and BSL-23 scores was found to be borderline significant, with a medium effect size ($r_s(18) = .305$ $p = 0.096$, one-tailed).	Hypothesis 12 can be tentatively confirmed.
13) Clients who construe the 'future self' and 'ideal self' in a dissimilar way, will present with more severe BPD	The correlation hypothesised between [standardised Euclidean distance between 'future self' and 'ideal self'] and BSL-23 scores was found to be statistically significant, with a large effect size ($r_s(18) = 0.448$ $p = .024$, one-tailed).	Hypothesis 13 can be confirmed.