Volume One

The development of an alternative Personality Disorder coding manual for use with the Adult Attachment Interview (AAI): A psychoanalytical approach.

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Overview of Volume One

Volume one is separated into three parts. Part one, uses the relevant literature to explore how psychoanalytic theory informs our understanding and assessment of personality disorder and directs us towards future research. Part two, is the empirical paper which presents the current study, the development of a new psychoanalytically informed personality disorder coding manual (PDCM) for use with the Adult Attachment Interview (AAI). This study was one of three separate research projects undertaken on the PDCM. In this current study, two dimensions within the PDCM, SELF and AGGRESSION were adapted to measure non-verbal material within videotaped AAIs and the efficacy of using such videotaped methods was examined. This study goes on to examine whether the SELF and AGGRESSION dimensions of the PDCM can differentiate people with personality disorder from a control group. It also addresses issues of reliability and validity, as well as promoting improvement of the measure through re-definition and clarification of the SELF and AGGRESSION dimensions. Part three, is a critical appraisal which addresses the challenges of the study, the wider empirical implications and a personal reflection on the process.

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Dedicated to my wonderful dad

Jeffrey Lee

(1946 to 2004)

Part 1: Literature review

How does psychoanalysis influence our understanding and assessment of personality disorder?

1. Abstract

This literature review aims to explore the contribution psychoanalytical theory has made to our understanding of personality disorder, with particular emphasis on theory, assessment and diagnosis. I begin with a review of how personality disorder is currently defined and diagnosed within the NHS and then give an account of the major theoretical contributions of both academic and clinical psychology to both personality and personality disorder. The review then explores what psychoanalytical theories offer to this knowledge base. I will focus on the major contributions of psychoanalytical theory to our understanding of the symptoms and aetiology of personality disorder and move on to how psychoanalysis has contributed to clinical assessment and diagnosis. I conclude the review with possible future empirical directions for psychoanalysis and personality disorder as indicated by the literature.

2. Personality disorder

Personality disorder is defined by the Diagnostic Statistical Manual of Mental Disorders - fourth Edition (DSM-IV) (APA 1994) within axis II as 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture.' It goes on to label the areas where this pattern might manifest, namely cognition, affect, interpersonal functioning and impulse control. DSM-IV describes the pattern of experience for people with PD as inflexible and pervasive, resulting in significant distress and impairment in social, occupational and other areas of functioning. It describes the onset as having been in adolescence and early adulthood.

Within DSM-IV, personality disorders are split into three clusters. Within cluster A, lie the Paranoid, Schizoid and Schizotypal personality disorders. Within cluster B, one finds the Anti-social, Borderline, Histrionic and Narcissistic personality disorders and within cluster C, the Avoidant, Dependent and Obsessive-compulsive personality disorders.

Magnavita (2004) emphasised the importance of considering personality when conducting a psychological assessment as it can be a central component within any clinical syndrome e.g. schizophrenia, and may have a major impact on prognosis and treatment. He also argued that clinical syndromes if left untreated could have a detrimental impact on the personality structure itself.

Epidemiological estimates have put PD at between 9 and 13% in the community (Lenzenweger, Loranger, Korfine and Neff 1997). More recent studies have placed

the prevalence of PD in the general population at almost 29%, although it should be noted that the screening tool used is known to produce a number of false positives (Coid, Yang, Roberts et al 2006). This indicates that PD presents a real public health concern, for which we need reliable and valid methods for assessment and diagnosis. People with personality disorder seeking help from NHS services, can present real challenges to staff in the form of poor engagement, sabotaging of treatment plans, anger and even violence (Adshead 1998). Recent documents produced by National Institute for Mental Health in England (NIMHE) have attempted to address the growing need to better understand and address the needs of people with PD. The most recent of these documents, titled 'The Personality Disorder Capabilities Framework' (2003) highlighted the need to address the cycle of exclusion and rejection that people with personality disorder so often experience within NHS services as well as reducing the strain placed on services by this so called 'revolving door patient' (p7). The NIMHE also highlighted that NHS staff were lacking an 'explanatory framework for the challenging behaviours which may be exhibited' which may result in them responding 'with negative judgements and exclusionary practices.' This document recommended improvements in how NHS services meet the needs of people with PD. One of the ways of achieving this is through an improved framework for understanding people with PD and their range of behaviours.

2.1 Major theories of personality and personality disorder

2.1.1 The relevance of theory in personality disorder

The importance of using theory to understand PD was emphasised by Magnavita (2004) as it offers a system of organising all the variables, which enable us to make

sense of a range of phenomena. He likened it to using a map which enables us to work effectively with people with PD. Lenzenweger and Clarkin (2005) also argued for the use of theory in understanding PD remarking that 'personality disorder research will only move forward appreciably when guided by rich and sophisticated models' (P1).

Many of the major theories of personality have stemmed from academic psychology, whilst theories of personality disorder have often risen from clinicians working with psychopathology. The boundary between normal personality and PD remains a troubling theme (Lenzenweger et al 2005), with some theorists such as Allport (1937) claiming that normal and pathological personality were separate domains of enquiry. Whilst others such as Goldberg (1993), have attempted to bridge the divide using dimensional models for explaining both. Rychlak (1973) felt it was impossible to understand personality disorder without understanding normal personality.

Major theories of PD have also grappled with differing views on conceptualisation and function. Theories of PD can follow dimensional or categorical approaches, the former being generally preferred by academic or clinical psychology and the latter by psychiatry (Lenzenweger et al 2005). The importance of a personality theory being able to answer the question of how a personality 'gets sick' was emphasised by Rychlak (1973). Magnavita (2004) suggested that ultimately PD theories should have clinical utility i.e. assist the clinician in the selection of techniques and the use of explanatory formulations.

2.1.2 Some major theories of personality and personality disorder

Early personality and psychopathology theories began to emerge in the 1880's with the rise of Freud and psychoanalysis. These were largely intrapsychic theories with little emphasis on social or cultural forces (such theories and their contemporary forms are covered later in this review).

Trait psychology later emerged as the study of personality differences, with its beginnings in the work by Allport (1937). It attempted to describe individuals categorically using a set of characterising attributes, which were thought to be based on underlying basic traits. A study by Warren Norman (1963), developed trait psychology further and featured 5 major dimensions of personality or 'the big five' which included extroversion (or surgency), agreeableness, conscientiousness, emotional stability and cultural sensitivity/ openness to experience. Hans Eysenck added to these ideas by suggesting that all personality and personality pathology could be explained by two of Norman's original dimensions neuroticism/ emotional stability and extroversion/ introversion (Eysenck and Rachman 1965). Individuals falling upon the unstable (or possibly pathological) end of the dimension might be moody and anxious if introverted and aggressive and impulsive if extroverted. However, trait theories are based on the premise that personality traits are stable and enduring. Mischel (1968) argued that such traits and their corresponding behaviours appeared to lack cross-situational or cross-time consistency.

Behavioural approaches to personality offered a contrasting perspective to trait theory, suggesting that what governs how a person behaves comes from outside e.g. the environment, rather than from within. B.F Skinner's theories on conditioning

suggested individual's reinforcement histories predicted their individual character differences (Skinner 1971). Such ideas suggest that pathological behaviour may arise by conditioning within negative or traumatic environments. In fact the impact of traumatic experiences on personality is well documented with extensive clinical and naturalistic material (Herman 1992), with high incidents of childhood sexual abuse and maltreatment being documented particularly in individuals with borderline PD (Jacobson and Rowe 1999). However, behaviourist explanations of personality were eventually seen as lacking in depth. Later theories attempted to add cognitive dimensions, involving an individual's beliefs, ways of interpreting and expectations in order to better predict individual differences (Mischel 1984).

More recently, cognitive theories of personality disorder have been developed which aim to understand the role of thought, feeling and action in personality pathology. Such theories emphasise the role of internal dysfunctional schemas that individuals hold about themselves and their world and how such self-perpetuating cognitive – interpersonal styles can be persistent and resistant to change (Beck et al 1990, Pretzer and Beck 2005).

Bridges between the different theoretical schools such as behaviourism and psychoanalysis began to form (Magnavita 2004). Theories began to emerge with intrapsychic, environmental and relational elements. Interpersonal theory of personality (Sullivan 1953), is one such theory, which emphasised the interpersonal dyad as the locus of personality expression and pathology. Recent advances in neuroscience may now also offer a new theoretical perspective on PD, for example

as a way of understanding how the pervasive impact of trauma may alter or reorganise neural networks (Magnavita 2004).

Contemporary theories have often had a tendency to integrate existing theories of PD. This strategy appears to build upon ideas by Von Bertalanffy (1968) who developed 'Systems Theory.' This views human's as complex systems with inter-related elements. Such integrated approaches have lent themselves well to the task of creating comprehensive theories of personality. Magnavita (2004) considered the unification of theories, into 'metatheory,' to have major implications for understanding the diverse domains of the personality system. In his paper in 2002 he puts forward a theory of personality disorder which seeks to integrate all the relevant domains including dyadic relationships, genetics, temperament, environment and psychological processes (Magnavita 2002).

2.2 Diagnosing PD

2.2.1 The function of diagnosis for PD

The question of why diagnose PD was addressed by Nancy McWilliams (1994) who suggested diagnosis had advantages for people with PD, namely in guiding treatment planning, exploring prognosis, improving therapist effectiveness, as well as contributing to the protection of consumers of mental health services. She argued that a diagnosis should always take personality into account and never be made on the manifest problem alone, as a phobia in someone with Depressive PD can have a different treatment plan and prognosis to someone with Avoidant PD. She also stated that diagnosis was advantageous in 'times of crisis or stale-mate' (Mc Williams 1994 p7). This latter point is particularly relevant for patients with PD, who often present

in crisis to services and provoke repeatedly negative reactions in others staff (NIMHE 2003). However, McWilliams also warned of the limitations of diagnosis in that 'when a label obscures more than it illuminates, one is better off discarding it' (Mc Williams 1994 p17).

The DSM –IV (APA 1994) offers a classification system which enables clinicians to diagnose personality disorder, within the NHS. PD appeared on a separate axis in DSM II in 1980. Currently, DSM-IV Axis II presents us with 10 personality disorders, clumped into 3 clusters: odd - eccentric, impulsive – erratic, anxious-avoidant. This classification system offers an atheoretical, categorical approach often favoured by psychiatry (Lenzenweger and Clarkin 2005).

2.2.2 The challenges of diagnosis for PD

Some of the difficulties in classifying PD using DSM have been highlighted by Livesley (2001) who spoke of the high overlap and co-morbidity between personality disorders. It appears that clear differentiation of the disorders is rarely possible and raises questions about classification, diagnosis and aetiology. Kernberg also argued that there was an over-reliance on observable behaviours in any classification system, which could be misleading as one behaviour may have many causes (Kernberg 1996). He also criticised DSM's atheoretical stance, suggesting instead that theories and models should be used to guide measurement of PD pathology, which include aetiology, mechanism and developmental path.

Other difficulties in using DSM include the fact that Axis II leaves out the milder PDs, e.g. Hysterical PD and Depressive Masochistic PD, which are more often seen

in clinical practice (Westen 1998). DSM also often relies on assessment questionnaires, such as the MCMI-III (Millon et al 1997) and the personality assessment inventory PAI (Morrey et al 2006), which closely reflect the DSM criteria. However, self-report methods have been criticised as measures of personality as they rely on self-awareness and are influenced by social desirability (Torgerson et al 1990).

Other issues which impacted on methods of diagnosis include the dimensional versus categorical debate. Major theories of PD have grappled with whether to use dimensional or categorical approaches to diagnosis (Kernberg 1996). Categorical and atheoretical approaches are often favoured by psychiatry and are used in DSM-IV classification of PD, whilst dimensional approaches which suggest that traits exist on a continuum are preferred by academic and clinical psychology. The use of empirically based dimensional models of personality for diagnosing PD have been explored, such as the five factor model. A new self-report measure called OMNI Personality Inventory and OMNI-IV personality Disorder Inventory by Loranger (2002) based on the five factor model, seeks to capture both normal personality and PD. However, a major concern about using such dimensional models for diagnosing PD are that not all pathological symptoms have their anchors in normal psychology or address the subtleties of PD (Kernberg 1996).

Another relevant issue for the classification and diagnosis of PD is state e.g. anxiety versus trait e.g. personality feature. Dysfunctional states and traits often co-exist and it is assumed that states may vary whilst traits remain constant over time. However, how state factors influence the development, manifestation and diagnosis of

personality pathology needs further clarification (Lenzenweger and Clarkin 2005). The life span of PD is also an issue for further exploration and has implications for diagnosis. DSM IV states that personality disorders are stable and trait like over time. However, very little is known about the natural history of PD (Lenzenweger and Clarkin 2005). Some longitudinal studies are attempting to address this issue, such as the Collaborative Longitudinal Personality Disorders Study (CLPS) by Shea et al (2002). This study is already suggesting changes in personality features over time, with many PD patients eventually dropping below thresholds. However, methodological issues, such as PD patients being in treatment during the study, throw the findings into doubt. As more begins to be known about the possible differing life spans of the PDs, DSM methods for classifying and diagnosing may need to be re-defined (Lenzenweger and Clarkin 2005).

Contemporary stances on diagnosing PD suggest 'creative new approaches' with the aim of increasing validity, discerning the latent symptomology and moving away from clinical features. Such ideas place emphasis on creating models of PD which are testifiable and falsifiable, inform assessment and diagnosis and 'transcend' the descriptions of DSM and speak instead of mechanisms and processes (Lenzenweger and Clarkin 2005). Despite the behavioural focus of DSM, which often promotes greater diagnostic reliability, field trials report relatively low inter-rater reliability for Axis II disorders. One attempt to address this would be through the use of reliable assessment instruments (Oldham, Clarkin, Appelbaum, Carr, Kernberg, Lotterman and Haas 1985).

2.3 Assessing PD (and the challenges of doing so)

Outlined below are some of the contemporary methods frequently used to assess PD and the challenges of attempting to do so. Ozer stressed the importance of personality disorder assessment instruments having good reliability, an internal structure based on relevant theory and demonstrably high validity (Ozer 1999). From Millon's evolutionary model arose an assessment of personality disorder, the Millon Clinical Multi-axial Inventory, 3rd Edition (MCMI-III 1994). His model built on Freud's theory of mental life being governed by 3 polarities: active –passive, pleasure -pain, self – other (Freud 1915, 1925). He suggested all DSM PDs could be included in this polarity model and also viewed as representing one of three possible conditions: The deficient (unable to emphasise either pole), Imbalance (sits at one side of pole only) and conflicted (oscillating between the two.) The MCMI, uses self-report and focuses on the identification of PD based on the DSM Axis II classifications, and is used for the for the purpose of diagnostic screening (Erdburg 2004). Clinical psychology has also contributed assessments such as the Minnesota Multiphasic Personality Inventory in (MMPI) which is another self-report measure (Hathaway and Mckinley 1943). The MMPI was designed to help identify personal, social, and behavioral problems in psychiatric patients. The test provides relevant information to aid in problem identification, diagnosis, and treatment planning.

The big five model was derived from a lexical approach which hypothesised that natural language would yield a taxonomy of personality attributes (Goldberg 1993). Costa and McCrae built upon this model to produce the Five factor Model (FFM) based on neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness (Costa and McCrae 1990). This soon became a widely used and

accepted model, from which the Neuroticism Extroversion Openness Personality Inventory – Revised (NEO-PI-R) was developed. This assessment attempted to move away from the DSM classification system and provide a measure based on a dimensional theory. Although predominantly an assessment of normal personality it appears to have some utility in exploring personality pathology (Clark and Harrison 2001).

Assessment of PD gradually moved away from self-report questionnaires towards structured interviews. Concerns were raised over whether personality could be effectively assessed using questionnaires due to its reliance on self awareness and the influence of social desirability (Torgerson 1990). One such structured interview was the SCID-II (Spitzer 1987) which reliably assesses PD from DSM classifications. The structured interview approach is now a well accepted method of assessment (Zimmerman 1994).

Some of the assessments above appear to conceptualise PD as variants of basic personality dimensions e.g. NEO-PI-R, whereas others lean heavily on atheoretical DSM classifications e.g. MCMI-III and SCID-II. None of these assessment tools meet Kernberg's recommendations of using a theory or model of PD for the purposes of diagnosis and whilst the use of structured interviews has addressed some of Torgerson's concerns, they continue to rely upon patients' abilities to accurately communicate their difficulties.

3. Psychoanalytical theories and diagnosis of personality disorder

3.1 Early theories of personality

Freud defined psychoanalysis as theory of the mind or personality (Freud 1923). In his comprehensive review of Freud's models of personality Calvin Hall suggested that 'psychology became a science of behaviour and psychoanalysis became a science of personality' (p54 in Hall 1954). Freud developed a series of models and theories of personality, with a particular focus on psychopathology. Outlined below are some of these models and how they have informed our understanding of personality disorder.

Freud's picture of personality went through three phases: affect-trauma, topographical and structural. Firstly he speculated that childhood trauma could overwhelm the 'mental apparatus' leaving it unable to deal with resulting affects, thus providing the motivational force for pathology. This may be particularly relevant for people with PD who frequently have traumatic histories (Herman 1992). In a study exploring childhood trauma in people with BPD, 71% reported physical abuse, 68 % reported sexual abuse and 62% reported witnessing serious domestic violence (Herman, Perry and Van der Kolk 1989). Freud then went on to explore a structure of the personality, firstly with his topographical model which was divided into the unconscious, preconscious and conscious (Freud 1900).

The topographical model

The system unconscious is central to psychoanalytical theory and Freud systematically explored it in his work. It is seen as a home for unacceptable memories, fantasies and wishes and as a reservoir of latent meaning. The

preconscious houses the non-repressed phenomena which could be brought to mind easily, it also modifies instinctual wishes from the system unconscious and makes them acceptable to the system conscious (Bateman and Holmes 1995). The system conscious houses thoughts of which the person is immediately aware. Alongside this topographical theory came his ideas on primary processes i.e. dreaming/ fantasy/ infantile life and on secondary process thinking i.e. rational thinking following logic, time and space (Hall 1954).

Drives and Instincts

Alongside the topographical model came 'instincts or drive theory,' which was Freud's attempt to explain human motivation. Instincts were thought of as a mental representation of a bodily need and as always trying to bring about a regression to an earlier condition. Initially sexual drives were emphasised as origins of personality pathology and later emphasis was given to aggressive or destructive drives or death instincts (Freud 1920, 1930). Freud saw humans as being at the mercy of these drives. The defences which they called upon to deal with their drive demands often resulted in psychological illness. Freud also spoke of humans having instinctual 'wishes' which have a source, aim and object i.e. forming a complex interactional fantasy represented in the system unconscious. However, Freud started to realise, that values and morals were relevant to personality and he began to explore how the external world influences the internal world.

Structural model

In response to these concerns Freud developed the structural model (Freud 1923). This described the id, containing basic inborn drives such as sexual and aggressive

impulses (related to the unconscious), the superego, containing a person's conscience and moral ideals based on real and fantasised internalised parental relationships and the ego, containing the rational, reality orientated structures. The ego was viewed as partly conscious, partly unconscious. It functioned to control the primitive id impulses and adapt these to outer reality in accordance with the 'reality principle' (Freud 1911). The structural model incorporated elements of the topographical model whilst placing more emphasis on the role of external reality and relationships with others in personality development.

Conflict and defence

Conflict occurs between the instinctual wishes influenced by the 'pleasure principle,' the domain of the id and the demands of reality (Bateman and Holmes 1995). By the time they have reached consciousness wishes have been modified by mechanisms of defence. Freud suggested that 'personality is a battlefield' with tension and conflict as innate in the system. (Hall 1954).

How Freudian theory contributes to our understanding of PD

Freud's theories of personality pathology go some way in providing an explanation for the development of at least some of the psycho-social features of PD.

Freud felt that the id was the foundation of the personality. However, it lacked organisation, could not tolerate tension and wanted immediate gratification. It housed the death instinct, derivatives of which were destructiveness and aggression. It also invested energy in objects (object –cathexis). Freud hypothesised that as one system of the personality gained psychic energy the others lost it e.g. a strong id results in a

weak ego or superego. Freud suggested that impulsivity, a common feature of people with PD (in DSM-IV under general diagnostic criteria), is a result of an individual having most of their psychic energy invested in their id. This theory goes some way toward explaining why people with PD suffer from increased impulsivity as well as aggression and difficulties with loved objects, as the result of a powerful id and a weak ego/ superego.

The superego, may also be a source of intra-psychic pain in people with PD. The superego internalises the child's conceptions of what his parents consider moral or good as well as immoral or bad. The child learns such events bring reward or punishment, therefore reducing or increasing inner tension. Freud argued that the superego subsequently punishes or rewards the ego (for the person's thoughts or actions) and produces feelings of pride, guilt, inferiority and shame. One might imagine that if an individual has internalised an abusive parental relationship (as is often in the histories of individuals with PD), one might expect increased levels of shame, guilt or inferiority. This appears to be the case, as people with PD suffer increased levels of negative affect (Kernberg 1996).

Freud also felt that sometimes a strong and punitive superego might even attempt to destroy the ego, thus satisfying the aggressive drives within the id. This was why the superego was sometimes referred to as the 'agent of the death instincts.' Such an event may result in an individual becoming aggressive against himself, through feeling unworthy or doing bodily harm or committing suicide. The superego can also fulfil the ids wishes by attacking other people who are deemed immoral, i.e. 'cruelty masquerading as moral indignation' (p48 in Hall 1954). Freud's theory of the

pathological superego may offer some explanation for the recurrent suicidal, aggressive and self-mutilating behaviours seen in borderline personality disorder as classified by DSM-IV. Freud's structural theory of personality in particular the relationship between the superego and the ego, is also thought to explain many of the anti-social features seen in PD (Fonagy, Target and Gergely 1995).

Freud's structural model hypothesised that the mind developed a relation between internal and external reality: 'separation between mind and the physical world of reality takes place as a result of frustration and learning,' i.e. humans learn the differences between images or inner mental states and external reality (p42 in Hall 1954). It is possible that some of the difficulties with self image in Borderline PD or ideas of reference in Schizotypal PD may be explained by developmental problems in separating the internal from the external world, or as a difficulty with 'reality testing' (Kernberg 1996).

Anxiety states are commonly found in people with PD, including Schizotypal, Borderline and Dependent PD (DSM-IV). Freud hypothesised that anxiety states had their aetiology within interactions between the id, ego and superego. Neurotic anxiety arose out of the ego's fear of the id, namely being overwhelmed by the instinctual object choice of the id or the urge to act in a harmful way towards it. Panic behaviour resulted from this neurotic anxiety, often featuring impulsive acts to neutralise the pressure from the id. It is possible that some of the anxiety states commonly found in PD may be explained by this pathological intra-psychic interaction.

Freud also argued that pathological character traits might represent individuals who have become 'fixated' at particular psychosexual stages. Fixation at say the anal stage might result in traits such as obstinacy and orderliness. Psychoanalytic theorists have long associated personality pathology with such fixations in development (Lane, Quintar, Goeltz 1998).

Finally, Freud thought that humans had 'methods to alleviate anxiety which deny, falsify or distort reality' known as defence mechanisms. However, he hypothesised that the persistence of some such defences into adulthood might 'impede personality development' (p96 in Hall 1954). Freud argued that an environment which offers the child a 'succession of experiences that are synchronised with his capacities' will promote maturation of the ego and its defensive strategies. He went on to suggest that in infancy the 'hazards of existence should be small' growing larger as the child develops (p96 in Hall 1954). It is arguable that in people with PD, the observed frequencies of early traumatic experiences are likely to impede ego maturation and promote continued primitive defences. Some of the diagnostic features of PD may be explained using Freud's account of defence mechanisms. For example the defence of projection, is thought to relieve anxiety originating from the id by attributing causation to an external source. Symptoms of paranoia which dominate the Paranoid, Schizotypal and Borderline personality disorders (DSM-IV) may result from the uses of such a defensive mechanism (Kernberg 1996).

Evaluating the Freudian approach to personality pathology

Freud's models of pathological personality development provide an explanation for some of the dominant features of PD namely increased aggression, impulsivity, self

harm, anxiety and paranoia. However, Freudian models have been criticised for failing to take into account social factors which may influence interpersonal functioning or the extent to which humans are 'historically and culturally situated' (p62 in Westen and Gabbard 1999). Hartmann also questioned Freud's view that the intrapsychic world was a battlefield and stressed the non-defensive aspects of the ego. He argued that satisfaction need not come only from the pleasure principle but by good experiences in the external world (Hartmann, 1939, 1964).

Freud has also been criticised for neglecting a number of relevant psychological issues in his models of personality and its pathology. It is argued that he neglected the spiritual values of humankind and drives such as curiosity, which are both likely to have a significant influence on an individual's values, motivations and behaviours (Fonagy and Target 2003). In addition, Freud's work was based on single case studies from a small sample of middle class Viennese individuals, which were then generalised widely and indiscriminately. Such methodology is lacking in scientific rigor and it is claimed that Freud rejected more systematic methods of study (Fonagy and Target 2003.) Although it is widely argued amongst the academic and clinical community that Freudian theories in their original form are outdated, sexist and limited in utility, they do provide a foundation from which many contemporary theories have grown and evolved. Neurological evidence for some of Freud's ideas around unconscious thought, affect and memory, have even begun to be explored and identified (Westen 1998).

3.2 Modern psychoanalytical theories of personality disorder

Kernberg expressed a view that fundamentally, psychoanalytical theories of PD should reflect pathological features (observable and subjective) of underlying psychological structures, which can often be inferred from the observable features of personality. Kernberg defined such structures as 'stable and enduring configurations ...that organise the individual's behaviour and subjective experience' (p114 in Kernberg 1996). Outlined below are post-Freudian models of personality which have attempted to explore the underlying structures of PD as well as their corresponding observable features.

3.2.1 Object relations theory

One such attempt to define underlying structures contributing to observable features of PD is Fairbairn and Guntrip's theory of object relations (Fairbairn 1952 and Guntrip 1961). Edith Jacobson also explored the dyadic nature of early internalisations, which was thought to be the basis for object relations theory (Jacobson 1964). Interest in the relevance of object relations theory for PD grew as clinicians began to realise that people with PD appeared to be unable to sustain satisfying relationships with others as well as being preoccupied with fantasies about intimate relations with others (Fairbairn 1952).

Object relations theory is defined as 'those psychoanalytical approaches that seek an understanding of psychopathology in terms of mental representations of the dyadic self and object relationships that are rooted in past relationships, at first dyadic, later triadic and still later multiple....'' (p713 in Fonagy, Target and Gergely 1995) Bateman and Holmes suggest that different object relations theorists always settled

on common themes, including object seeking i.e. the primary motivation is to seek a relationship with others and the representational world and that there is an internal world populated by the self, its objects and the relationships between them. These then act as templates for subsequent relationships (Bateman and Holmes 1995). These accounts suggest that in disorders which feature relational difficulties, such as PD, early traumatic relational patterns may be repeated, causing the individual to have on-going distressing relations. Fairbairn saw the withdrawal from and the defence against the trauma of not being intimately loved or understood as fundamental to all pathology (Fairbairn 1952).

Winnicott hypothesised that object relations have aggressive and pathological elements. He thought that the infant 'uses the object' in its struggle to recognise and be recognised, the driving force of which is hatred (Winnicott 1965). Rage is thought to be a core affect of aggressive internal object relations, which can result in hate and envy, often experienced within the context of interpersonal relationships by people with PD (Fonagy and Target 1996; 2003). Where the mothering is not good enough a compliant 'false self' arises in the infant, concealing frustrated and sequestered instinctual drives (Winnicott 1965). The false self helps to protect the hidden true self from annihilation (Winnicott 1960). The idea of the false or alien self later came to be viewed as a critical underlying feature of PD (Fonagy 2002). (These ideas are covered later in the review.)

Winnicott also explored 'transitional phenomena' in object relations e.g. how a blanket can be used to soothe and conjure up the image of the mother. Individuals with borderline PD were thought to relate to people as if they were transitional

objects and were hypothesised as having been used as such by their own parents (Modell 1963).

Evaluating object relation theory relevance for PD

Object relations theories soon came under criticism, with suggestions that they relied too heavily upon 'a naïve reconstruction of infancy in the adult mind' (p718 in Fonagy, Target and Gergely 1995). In addition, object relations theorists make strong claims that early adverse experiences during critical periods of development have permanent effects, whereas in reality such claims are arguably poorly founded (Bruer 1999, Fonagy and Target 2003). It is argued that early experiences can only provide lasting effects in so far as they are reinforced and maintained by the environment and that early risk factors do not in fact close off opportunities for change in adulthood (O'Connor 2003).

3.2.2 Modern developmental perspectives on personality disorder

The developmental perspective is heavily acknowledged by the majority of psychoanalytical theorists. Fonagy described how 'disorders of the mind are best understood as maladaptive residues of childhood experience, developmentally primitive modes of mental functioning' (Fonagy, Target and Gergely 1995). Margaret Mahler's work with infant observation influenced developmental theory of PD (Mahler 1974). She wanted to help clinicians reconstruct early preverbal phases and hypothesised that the separation - individuation process, might be particularly relevant for PD. Narcissistic traits were thought to develop due to inadequate soothing by the mother during symbiotic phases and inadequate re-fueling during separation - individuation, resulting in continued feelings of omnipotence. In

Borderline PD, the adult experiences residues of the rapprochement phase i.e. wanting to separate but also clinging and longing, leading to a dread of fusion with the other and loss of the already fragile sense of self. Such psychological experiences were thought to be associated with aggression and withdrawal on the mother's part. Mahler also hypothesised that individuals with schizoid personalities had experienced severe deprivation early on.

Evaluating developmental theories of PD

Many of Mahler's theories regarding fixation at certain phases (e.g. that BPD patients are fixated in a rapprochement) as well as her theories regarding post-natal pathological processes, have been criticised due to having a lack of empirical evidence (Fonagy et al 1995). Her ideas about BPD fixation also do not explain the high incidents of trauma and sexual abuse in the early histories of individuals with BPD (Herman 1989). In addition, Mahler's assumption that serious disorders are actually caused by social events in the first few months of life has not been substantiated (Fonagy and Target 2003.) Recent literature suggests that self development relies more on early mechanisms of attachment and mentalisation within the parent-infant dyad. It is suggested that childhood maltreatment is capable of causing a developmental delay in mentalisation ability and subsequently profound deficits in the skills required to negotiate social interactions in adulthood (Fonagy, Gergely and Target 2007.)

3.2.3 Klein-Bion model and personality disorder

The work by Klein and Bion provided us with an account of the odd self-destructive behaviours in adults and children. Klein built her theory on Freud's self-destructive

drive or death instinct. She postulated two positions, the primitive paranoid- schizoid position i.e. splitting of mother into good and bad and the depressive position, i.e. seeing the good and the bad in the whole mother. Both positions are felt to result in anxiety, the latter causing 'depressive anxiety' and the former 'persecutory anxieties,' resulting in splitting and projection practices. The constant oscillation between the two positions was termed the 'borderline position.' Bion felt that the mind cycled between the two positions, each position addressing the anxiety in the other. The model also gives an account of projective identification i.e. the projecting of parts of the ego out into another person and behaving in manipulating ways towards the person, making them identify with the projections. In contrast to Freud's ideas this was viewed not as a defence but as an interpersonal process. The Klein-Bion model suggests that psychopathology occurs due to a persistence of such primitive paranoid schizoid states, resulting in primitive envy, persecutory anxiety and fragmentation of the self (Klein 1946, Bion 1957). The narcissistic character structure for example is thought to be a defence against such primitive envy (Fonagy et al 1995) whilst the process of projection is thought dominate the psychology of the paranoid personality (McWilliams 1994).

Evaluating efficacy of the 'two basic positions' theory for PD

Klein's ideas that the intense and disorganised affects and mental states of young children are comparable to the psychotic adult's have come under heavy criticism. It has been pointed out that her use of the term psychotic bares little relation to the formal psychiatric descriptions (Willick 2001). It is also argued that terms such as the 'depressive position' are highly ambiguous. The depressive position implies a shift in the perception of an object from part to whole, yet it is not clear if conflictual

feelings towards the object are unconsciously integrated or consciously recognised (Fonagy and Target 2003).

3.2.4 Attachment and personality disorder

Attachment theory is likely to be relevant for people with PD where pathological interpersonal relationships are a key diagnostic feature (Adshead 1998). The original theory of attachment was developed by Bowlby (1973) and empirically validated and extended by Ainsworth in (1985). Bowlby hypothesised that the affectional bond between a mother and an infant was a survival mechanism, its function being to maintain proximity between mother and child. If the mother was a sensitive caregiver, the infant expected it's needs would be met, resulting in a secure attachment. If parenting was insensitive, an insecure attachment arose, resulting in a variety of anxiety fuelled behaviours in the infant. Ainsworth (1978) initially described three main attachment categories; secure, anxious avoidant and anxious resistant. A further category of disorganised attachment was later developed to describe severely disorganised and disorientated behaviour. Attachment theory, appears to link well with psychoanalytic theories such as 'object relation theory' (Bretherton 1995) and processes such as identification, although it also contains more behavioural classifications. Attachment theory became increasingly compatible with psychoanalytical thinking with the development of the Adult Attachment Interview (AAI) by Main, Kaplan and Cassidy (1985). This assessment is covered in more depth later in this review.

Bowlby and Ainsworth hypothesised that early attachment experiences were involved in the development of adult personality (Bowlby and Ainsworth 1991).

Bowlby described how early internal working models of attachment (IWM) could be reactivated in an adult's relationships, for example, if attachment was insecure, adult relations were likely to be fraught with anxiety and maladaptive coping strategies (Bowlby 1973). There is now a growing body of evidence linking insecure attachment to adult psychopathology, with PD thought to be most closely linked to difficulties with attachment (Widiger and Francis 1985). People with PD suffer predominantly from difficulties in their relationships with others. They also often present with a history of childhood abuse and trauma (Ogata et al 1990), which is likely to have negatively impacted on their ability to form early secure attachments.

Evaluating attachment theories contribution to understanding PD

Bowlby's ideas were initially not well received by psychoanalysts and he was criticised for assuming complex representational capacities in infants (Spitz 1960). His ideas also contrasted somewhat with psychoanalytic theories due to his suggestion that developmental trajectories could be multi-tracked (depending on early attachment experiences) rather than a single track along which regression and fixation could occur (Fonagy and Target 2003). In addition, whilst attachment theory intuitively addresses the relational difficulties in BPD, it has been unclear whether it can offer a comprehensive explanation for other personality disorders, particularly those without overt interpersonal pathology e.g. Obsessive compulsive PD (Aaronson, Bender, Skodol and Gunderson 2006).

3.3 Two contemporary theories of personality disorder

3.3.1 An integrated object relations approach to PD

Kernberg attempted to understand PD using a psychoanalytical object relations approach, which integrated ideas on cognitive development as well as environmental and biological influences. He argued for a dimensional approach, which included temperament, cognitive capacities, character and internalised value systems, to be used alongside a categorical approach which grouped personality disorders as either mild (neurotic organisation), moderate (borderline) and severe (psychotic). He argued that personality disorders such as anti-social PD and narcissistic PD, had an underlying borderline structure, indicating pathological object relations and requiring a therapeutic approach aimed at modifying these underlying pathological structures. Outlined below are the key components of his theory, namely how affect, identity, value systems, developmental factors and motivational drives are relevant for PD (Kernberg and Caligor 1996).

Kernberg felt that affect and object relations were intertwined. He defined an internalised object relation as 'a particular affect state linked to an image of a specific interaction between the self and another person' (Kernberg et al 1996, p116) and he added that personality disorders reflect the internalisation of object relations under conditions of abnormal affective development (Kernberg et al 1996). Kernberg argued that object representations are derived from both inborn affect dispositions and interactions with caretakers. They reflect actual and fantasised interactions as well as defences (Kernberg et al 1996).

At the core of Kernberg's model of personality and PD is 'identity.' He hypothesised that people with PD, have unstable, polarised and an unrealistic sense of self and others. People with a pathological identity can have crude, intense and often negative affects, with primitive defences, such as splitting, which functions to protect the idealised sector of experience from contamination by the persecutory sector. In addition, Kernberg argued that people with PD may have pathological internal value systems which fail to manage primitive aggressive drives, resulting in violence to others or self. The model also explored the developmental factors involved in PD. Kernberg described how early biological and genetic factors such as abnormal neurotransmitter systems and inborn hyper reactivity to painful stimuli, might influence aggression or affect control in individuals with PD.

Three motivational systems were described by Kernberg, involving erotic, dependent and aggressive strivings. In PD these were thought to be poorly integrated, in particular aggression and sexuality. Pathological sexuality was thought to operate in people with hysterical and obsessive-compulsive PD, who had sexual inhibitions related to the oedipal complex, resulting in'acting out of unconscious guilt over childhood impulses' (p132).

Evaluation of Kernberg's model of PD

This contemporary model of PD has been generally well received by other clinicians (Fonagy et al 1995). Kernberg's ideas that people with PD are poor at effortful control and experience high negative affects such as fear and sadness has also been echoed by other's findings (Clarkin 2001). However, a school of thinking which is thought to greatly contrast with Kernberg's model, is Heinz Kohut's self-psychology

(Kohut and Wolf 1978). Kohut, in contrast with Kernberg's idea that a grandiose self or narcissistic self is a pathological development, argued that a grandiose self indicates an arrest in the development of the self, which should be encouraged to unfold during therapy rather than challenged and modified as Kernberg suggested (Consolini 1999).

3.3.2. Mentalisation theory approach to PD

The mentalisation based approach presents the argument that Bowlby's inner working model assumes a shared awareness between self and other or an appreciation of each other's mental states, which is powerfully influenced by the quality of the attachment relationship. The mentalisation model focuses on the development of the 'agentive self,' which is revealed by a developing capacity to mentalise other's behaviour.

In contrast to Bowlby's emphasis on attachment affording safety and protection from a care giver, Fonagy suggests that proximity affords access to social learning and meaning making (Fonagy 2003). Infants develop the ability to view others from an intentional stance, viewing others as rational agents with beliefs and desires. This is conceptualised as the interpersonal interpretative function (IIF), which is a mechanism for processing and understanding interpersonal encounters and is afforded by a close attachment relationship. The better the attachment, the better the capacities of IIF i.e. labelling and understanding affect, arousal regulation, effortful control, and mentalisation abilities. One can therefore make empirical predictions on an individual's performance on such tasks based on their attachment status (Fonagy et al 1995).

Mentalisation skills are thought to develop through the mother's empathic congruent mirroring and 'marking' of a baby's affective displays, allowing him or her to differentiate their internal states and find their psychological self in the social world. Fonagy and Target (1996; 2003) suggest that it is the mother's marking i.e. her communication that she has noticed and empathised with the child's affect but does not share it, as well as her mirroring ability, which affects the child's ability to represent his and others emotional experiences. In order to form a coherent image of one's own mind, one needs to have had the experience of being perceived as having a mind by the attachment figure. This also promotes an understanding that others have minds and beliefs different from ones own. The mother also regulates the infant's attention, enabling the infant to learn 'effortful control' and so attend to others mental states which may differ from his or her own (Fonagy et al 1995).

Mentalisation in people with personality disorder

Mentalisation offers a developmental model of PD and hypothesises that severe PD is linked with a disrupted agentive self and a disfunctioning IIF. It is argued that this comes about through poor contingency and congruent responding by the mother. Incongruent unmarked mirroring by the mother is thought to result in enfeebled affect representations in her baby, poor attentional control and disorganisation of attachment. Such experiences may lead to a disorganised self or a part within the self structure which is the 'alien self' i.e. the part which should represent the mother's representation of the baby's mind (Fonagy, Gergely, Jurist, and Target 2002).

This alien self is thought to be experienced by people with PD, particularly with Borderline PD. The alien self houses ideas and feelings not seeming to belong to self.

Thus the alien self may be externalised by controlling and manipulating behaviour. If such experiences are combined with additional trauma experiences, the result for the child may be that they have very poor mentalising skills. If the child identifies with an abuser i.e. internalises this representation of the abuser into his/her alien self, the alien self is experienced as torturing. The self is felt as evil and hateful, and externalised wherever possible, forcing the perceived attack to come from the outside and not from within. This may explain why people with Borderline PD often seek out relationships where they will be further abused and where they can externalise their torturing alien self (Fonagy et al 1995).

It is further suggested that in contexts of high arousal such as in attachment relationships, the ability to mentalise is further diminished. In the absence of mentalisation skills, developmentally primitive modes of operating may occur, such as the psychic equivalence mode, where mental reality is thought to equate with outer reality. The pretend mode is another example, where ideas are recognised as not real, which yields emptiness and dissociation. A teleological stance, might also be adopted, where the person might only recognise changes in the physical world as an index of others intentions. Such modes are described in developmental studies (Gopnick 1993) and are thought to re-emerge in people with PD (Fonagy et al 1995). Individuals with Borderline PD may also experience emotions as coming through other people, due to early unmarked mirroring by their mother and a perceived externalising of their own experience (Fonagy 2002).

Evaluating a mentalisation based approach to PD

Although the mentalisation approach to PD offers a useful way of understanding many of the noted difficulties with social relations, affect regulation and self concept, its broadness as a theory and its wide ranging application for other psychiatric disorders may weaken its utility as a theory of personality disorder. In addition, it is ambiguous whether individuals with PD have a dysfunctioning IIF as a result of deficiencies in early parenting as suggested (Fonagy et al 2002) or in fact a reluctance to use their mentalisation capacity in order to protect themselves against accessing the malevolent mental states of abusive caregivers (Fonagy 1991, Fonagy, Gergely and Target 2007).

3.4. How psychoanalytical theories compare to other approaches

Is psychoanalysis a good approach to the study of personality? It has been argued that it studies human subjectivity at its most complex level and is not guilty of the oversimplification of such approaches as neuroscience (Fonagy et al 1995). Others argue that many modern theories of psychopathology have stood on the shoulders of psychoanalysis and it is not unusual for variations of psychoanalytical concepts such as object representations to be 'discovered' by cognitive or social scientists (Lane et al 1998). It is also suggested that psychoanalysis offers a deeper more complex 'understanding' of behaviour than 'omnibus theories' such as CBT, and may be particularly helpful to address the complex array of subjective and objective features of PD (Fonagy et al 1995).

Psychoanalysis has made enduring contributions to personality theory, in the form of testable propositions and guiding assumptions (Westen and Gabbard 1999). A review

of the empirical data by Westen (1998), found five basic postulates of contemporary psychoanalytic thinking that have stood the test of time. These include: 1. the theory of the unconscious, 2. the idea that people can have conflicting mental processes that operate in parallel, 3. the role of childhood development on shaping adult personality, 4. the role of mental representations of self and other in guiding interactions (which can be pathological) and 5. the theory that personality development involves regulating sexual and aggressive feelings and moving from a dependent state to an interdependent state. Many of these lasting postulates address personality disturbances, illustrating the usefulness of psychoanalysis as an approach to understanding PD.

Critiques of psychoanalysis

Psychoanalysis has been the target of much criticism over the years. One such criticism is that most psychoanalytic theorising is done by clinicians who have not tested their theories empirically, resulting in a lack of an evidence base for the discipline (Fonagy and Target 2003). Another criticism of psychoanalysis is its inappropriate assumption of uniformity among humans and the idea that there is a one to one relationship between an abnormality and its developmental cause, when clinical data is not able to confirm this i.e. there being no specific developmental link to eating disorders (Stern, Dixon, Jones et al 1989). Similarly, psychoanalysis has long assumed the cultural universality of its concepts. The idea of the individuated self is rooted in Western culture and contrasts with the relational self with an emphasis on family and community which is represented strongly in non-western cultures (Sampson 1988). In addition, psychoanalysis has also long been criticised for its poor interest in environmental influences on the development of

psychopathology and it's over emphasis on the maternal relationship. Alternative ideas suggest a reciprocal relationship between child and environment, where both constitutional and parental factors interact to generate risk (Rutter 1993).

Challenges for psychoanalysis

Psychoanalysis is largely built on a foundation of the patient's narrative. Experimental and scientific methods are therefore generally ineffective in evaluating the complex interpersonal relationship between patient and therapist. Psychoanalysis utilises mostly non-standardised interventions and has as its goal insight and self awareness, rather than symptom reduction. All these variables present great challenges to the scientific processes of measurement and quantifying, weakening the psychoanalytical model's ability to demonstrate itself as an empirical science (Lane, Quintar, Goeltz 1998). However, in the current clinical and academic climate, the drive for evidence based practice presents a real threat to psychological models which are unable to stand up to scientific rigor (Parry 2000).

Psychoanalytic therapists are now beginning to recognise the importance of high quality research, in order to compete in the psychotherapy market place (Holmes 2002). In line with this, psychoanalysis has begun to embark upon a 'paradigm shift to empirical science' as analysts start to produce theories in line with general systems theories (P726 in Fonagy et al 1995). These theories can address multiple components within a system, as well as offering predictions and hypotheses, therefore better lending themselves to research. Bowlby's attachment theory is a good example of the use of psychoanalytic theory within a general systems theory (Fonagy et al 1995). Another such model, the mentalisation based approach (MBA),

integrates attachment theory with evolutionary and social learning rationale, to explore the human capacity for awareness of mental states in the self and other (Fonagy et al 1995).

4. Psychoanalytical assessment of PD

4.1 The psychoanalytic interview

From the literature, it appears that in general psychoanalytical theories such as those mentioned above are used to inform and shape psychoanalytical interviews with potential patients, rather than the use of standardised assessment tool per se. During a psychoanalytical interview, the therapist can for example elicit through questions (and lack of questions), a person's central preoccupations, their experience of anxiety, their primary conflicts, object relations, and sense of self, for a 'comprehensive analytical psychodiagnosis.' (McWilliams 1994.) The combination of interviewing and formulating often comprises the psychoanalytical assessment. However, Bateman and Holmes argue that there are major difficulties with producing a 'standardised diagnostic schema.' They argue that formulations are often 'idiosyncratic' and based on the style of the analyst. Most explore developmental schema, deficit or conflict and maturity of defences as a measure of personality developmental, although Bateman and Holmes (1995) argue that there is no 'generally accepted framework for differential diagnosis' (p149 in Bateman and Holmes 1995). Often the motivation for the assessment interview is to explore how 'analysable or treatable' a person was, rather than for classification/ diagnosistic purposes (Bateman and Holmes 1995).

A literature search on psychodynamic/ psychoanalytical assessment tools for PD, revealed a small number of studies, a few of which are outlined below. Studies which assess people with PD for improvement during therapy often appear to rely on general measures of functioning e.g. global assessment scale, symptoms and severity scales etc rather than assessing changes in personality functioning (Kanas 2006). However, Shulman (1988) produced the narcissism projection test (NP), which used thematic descriptions and childhood memories. The test was compared to standard clinical interview assessment methods and found to be as effective in identifying narcissistic disturbance. Another popular method of assessing and formulating a patient relationship patterns is Malan's 'triangle of person' (Malan 1979), which formulates the patient's relationship with their therapist, current other relationship and their parental relationships.

In general, standardised approaches for assessing personality pathology have been developed mainly for research purposes, and to promote acceptance of psychoanalysis within the scientific community (Bateman and Holmes 1995). A few of the major psychoanalytically informed assessments used to investigate personality pathology are outlined below.

4.2 The Rorschach test

The Rorschach is a descriptive atheoretical assessment and goes about the task of providing personality descriptions based on a very different technology (Erdburg 2004). The assessment presents the person with a perceptual/ cognitive task and codes the various ways they project their internal worlds onto the tasks and go around solving them. The end result of the assessment is a collection of variables

which characterise the person, such as their problem solving styles, coping resources, affective volatility and interpersonal styles. Exner (1986) compared people with Schizotypal PD and Borderline PD using the Rorschach and found significant differences in each group's problem solving style. Another study by Blais, Hilsenroth and Fowler (1998) found the Rorschach test to be useful in identifying the specific behavioural markers of Histrionic PD. It is also argued that the Rorschach could be effective in pinpointing areas for specific intervention for people with PD (Erdburg 2004)

4.3 The Adult Attachment Interview (AAI)

Another assessment tool which has been used with people with PD is the adult attachment interview (AAI), devised by Mary Main and colleagues (Main 1991) which is based on principles of attachment theory. It uses transcripts and is concerned not with content but the form and style of narrative. It is a psychodynamic assessment interview concerning past and present relationships and losses. It assumes that underlying relationship dynamics (even if unconscious) will be present in the structure of the narrative. People are assigned to one of three major categories 'autonomous free' (talk free, openly, resolved) 'dismissive detached' (non elaborated, few memories, denial and devaluing) and 'preoccupied-enmeshed' (muddled, confusing, dominated by affect,). The AAI has been used to explore intergenerational transmission of attachment patterns (Fonagy, Steele and Steele et al 1995). The AAI has also been used to track changes in therapy showing how people can move from insecure to secure styles. In the Cassell Hospital Study, 40% of the patients discharged from the intensive inpatient psychotherapy program (n=35) were assigned a 'secure-autonomous' classification using the AAI whereas on admission

they had been classified as 'insecure' (Fonagy et al 1995). However, its is important to treat these results with caution as change might be accountable by test re-test measurement error as may have been revealed by the presence of a control group (Daniel 2006).

The AAI has increasingly been used in developmental research and has been shown to discriminate between clinical and normative groups, indicating a relationship between pathology and early experiences (Patrick et al 1994 and Fonagy et al 1995). Studies using the AAI with personality disorder patients showed a significantly higher rate of insecure attachment (VanJIzendoorn and Bakermans-Kranenburg, 1996) and were able to demonstrate that the AAI can differentiate normal personality from personality disorder. However, limitations in the AAI coding procedure soon became apparent (Turton et al 2001). Significantly, the AAI failed to distinguish different clinical groups, i.e. it could not relate a type of insecure attachment to a distinct pathology. Personality disordered patients were classified in some studies as 'preoccupied' (Fonagy 1996) and in others as 'dismissive' (Buchhein and Kachele 2001). These findings raised significant concerns as to the reliability and validity of the measure for use with personality disorder (Turton 2001).

4.4 The Core Conflictual Relationship Theme (CCRT)

An attempt to put psychoanalytical concepts into a reliable replicable assessment tool is the Core Conflictual Relationship Theme developed by Luborsky and Crits-Cristoph (1990). The CCRT involves therapists/ researchers extracting 'relationship episodes' from patient transcripts. These episodes are then passed to a second set of judges who form them into the person's 'wishes', the 'response elicited in other' and

the 'reactions of the self'. This characterises the patient's core mental state. Studies have proven the tool to be an effective and reliable assessment tool which can monitor change in treatment. A study which assessed suicidal patients with Borderline PD using the CCRT found that the relational pattern most often described by participants was a wish to be loved and understood, experiencing others as rejecting, and responding with depression and disappointment (Chance, Bakeman, Kaslow, Farber, Burge-Callaway 2000)

4.5 The Structured Interview for Personality Organisation (STIPO)

Finally, a more recent addition to the small but growing array of psychoanalytical assessment tools for PD is the STIPO, developed by E. Caligor, B. Stern and J. Clarkin (2004). The STIPO, which uses both dimensional and categorical approaches, is based upon Kernberg's three level theory of personality organisation (neurotic, borderline and psychotic), as well as using other psychoanalytical concepts such as object relations. The STIPO is also thought to explore and thus enrich understanding of attachment patterns in relation to psychopathology and treatment (Caligor, Stern, Kernberg, Buchheim, Doering and Clarkin 2004). The STIPO is a structured interview and the authors propose that its strict administration procedures alongside its clear theoretical grounding make it unique among psychoanalytical assessment tools. Specific STIPO domains were found to correlate with symptom indices within the three DSM–IV personality disorder clusters, although the STIPO was less successful at discriminating across the clusters (Caligor et al 2004). Whilst the STIPO is successful in addressing the need for measures which are theory led, reliable and valid, it appears to rely on self-report which has been criticized as a method for personality assessment (Torgerson et al 1990).

5. Summary, conclusions and future directions

This literature review has attempted to summarise the key relevant issues in defining, understanding, diagnosing and assessing personality disorder. It aimed to highlight some of the main benefits and challenges of understanding personality and its pathology, to emphasise the role of integrative theory in diagnosis and to illustrate the efficacy of assessment techniques in improving classification. This review in particular focused on how psychoanalytical theories and postulates assist us with these objectives. The literature reviewed indicates that psychoanalytical understanding has greatly assisted our understanding of the complex array of symptoms in PD as well as offering a conceptualisation of the latent structures which contribute. Psychoanalysis has also guided the development of some crucial assessment tools.

In reviewing the relevant literature on multiple approaches to PD, a number of issues have become clear. These issues may help guide future directions in understanding and assessing PD. Firstly, a theoretical understanding of PD is crucial and such a theory should assist a clinician in building formulations and selecting techniques for intervention (Magnavita 2004). It should integrate a number of systems, including intra psychic, relational, biological and environmental elements (Kernberg 1996). This theory can be used to inform assessment and diagnosis of PD. Future assessment tools should address long standing difficulties such as co-morbidity between PDs (Livelsley 2001), as well as be able to capture common milder forms of personality difficulties (Westen 1998), explore latent symptomology and promote greater diagnostic reliability (Lenzenweger and Clarkin 2005). Assessment tools

should also offer creative new forms of measurement which do not rely entirely on the individual's capacity for self awareness (Torgerson et al 1990).

This review has tracked the movement of psychoanalysis into more empirical domains, including the development of reliable and valid assessment tools. It is hoped that the new psychoanalytically informed assessment tool described in the following empirical paper will address the issues raised by this review. As is recommended by NIMHE (2003) it is hoped that this new assessment capability will further our knowledge on how best to understand and meet the needs of people with personality disorder within the NHS.

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Part 2: Empirical paper

The development of an alternative 'Personality Disorder' coding manual for use with the Adult Attachment Interview (AAI): A psychoanalytical approach.

1. Abstract

In response to concerns that the Adult Attachment Interview (AAI) does not adequately distinguish personality pathology, as well as the need for a personality disorder (PD) assessment tool which could overcome the well documented limitations of self report measures and DSM based diagnostic tools, a new psychoanalytically informed personality disorder coding manual (PDCM) was created. The PDCM offers an alternative coding method for AAI data and contains dimensions thought to represent characteristic features of PD, which are conceptually relevant to attachment. Initial pilot studies on the PDCM using audio taped AAI's revealed a need to use video-taped AAI's to further improve coder accuracy and reliability.

This study further developed the PDCM, by adapting the selected PDCM dimensions SELF and AGGRESSION, for use with non-verbal data within videotaped AAI's. The results indicated that inter-rater reliability was in the good to excellent ranges for the majority of the scales in the PDCM. We also found that using videotaped AAI's improved reliability for the PDCM, when compared with the pilot study. This study also compared PD and control group performances on the scales within the SELF and AGGRESSION dimensions and found significant group differences on some scales. Validity was also explored for the SELF and AGGRESSION dimensions, with evidence for validity again found for some of the scales. Finally, a content analysis offered a detailed account of the themes arising within three target scales from the SELF and AGGRESSION dimensions, which were used to compare the groups and to further inform PDCM development.

2. Introduction

This study seeks to explore the utility of using psychoanalytically informed dimensions for classifying and understanding pathological personality features. This new personality disorder coding manual (PDCM) has been constructed for use with the Adult Attachment Interview (AAI) for a number of reasons. Firstly, the AAI has the potential to be emotionally arousing and elicit strong affects in the interviewee, whilst encouraging the interviewee to share their internal representations of themselves and significant others (previous and current). The AAI is therefore well placed to access symptoms and features which are well documented in PD literature, for example, difficulties with affect regulation (Sarkar and Adshead 2006), self concept (Fonagy 2002) and dysfunctional internal working models (Page 2001). Secondly, using an attachment based interview is highly relevant for PD, as these individuals are believed to have insecure attachment patterns which are thought to result in significant difficulties with relating to others and the self (Widiger and Francis 1985).

Finally, as an offshoot of psychoanalysis, attachment theory has historical links with the discipline, it offers a way of crossing the barrier between psychoanalysis and research and with the rise of object relations theories (and with the downgrading of sexuality and drive theory) its focus on relational phenomena has begun to compliment psychoanalytic theory and share common ground (Target 2005). The PDCM offers a further way of reconciling and advancing the two fields, by exploring and categorising the array of defences, conflicts and affect management strategies that people with PD typically employ in relation to their internal working models (as elicited through the AAI).

2.1. Attachment theory

The original theory of attachment was developed by Bowlby (1973) and empirically validated by Ainsworth in (1985). Bowlby hypothesised that the affectional bond between a mother and an infant was a survival mechanism, its function being to maintain proximity between mother and child. If the mother was a sensitive caregiver, the infant anticipated its needs would be met, resulting in a secure attachment. If parenting was insensitive, an insecure attachment arose, resulting in a variety of anxiety fuelled behaviours in the infant. Ainsworth (1978) initially described three main attachment categories: secure, anxious avoidant and anxious resistant. A further category of disorganised attachment was later developed to describe severely disorganised and disorientated behaviour.

2.2. Personality development and psychopathology

Bowlby (1973) described how early internal working models of attachment (IWM) could be reactivated in an adult's relationships, for example, if attachment was insecure, adult relations were likely to be fraught with anxiety and maladaptive coping strategies. Ainsworth and Bowlby (1991) also hypothesised that early attachment experiences were involved in the development of adult personality. There is now a growing body of evidence linking insecure attachment to adult psychopathology, including depression (Roberts 1996), and obsessive compulsive disorder (Myhr 2004). However, personality disorder (PD) is thought to be most closely linked to difficulties with attachment (Widiger and Francis 1985). Patients suffer predominantly from difficulties in their relationships with others. They also often present with a history of childhood abuse and trauma (Ogata 1990), which is likely to have negatively impacted on their ability to form early secure attachments.

2.3. Adult Attachment Interview

Attachment theory, although appearing to link well with psychoanalytic theories such as 'object relation theory' (Bretherton 1995) and processes such as identification, ultimately began to move in a different direction. Attachment theorists pursued more behavioural classifications of attachment, whilst psychoanalysis pursued the internal world of object relations (Fonagy 1999b). However, attachment theory became increasingly compatible with psychoanalytical thinking with the development of the Adult Attachment Interview (AAI) by Main, Kaplan and Cassidy (1985). This interview sought to assess a person's representations of early (object) relations by evoking unconscious feelings and desires. The structured interview focused on an individual's relationships with early attachment figures and their account of the effect of those experiences on present functioning. A coding and classification system was later developed which used discourse analysis to assess the 'coherence' of the person's narrative (Main and Golwyn 1994).

The AAI coding system described four categories: autonomous (secure), dismissing (avoidant), preoccupied (resistant) and finally unresolved (disorganised). The AAI has increasingly been used in developmental research and has been shown to discriminate between clinical and normative groups, indicating a relationship between pathology and early experiences (Patrick 1994).

Limitations in the AAI coding procedure soon became apparent (Turton 2001). Significantly, the AAI failed to distinguish different clinical groups, i.e. it could not relate a type of insecure attachment to a distinct pathology. Personality disordered patients were classified in some studies as 'preoccupied' (Fonagy 1996) and in others as 'dismissive' (Buchhein and Kachele 2001). These findings raised significant

concerns as to the reliability and validity of the measure for use with a PD population (Turton 2001).

2.4. A new PD coding manual

In response to these concerns, a new coding manual for the AAI was developed by Dr Anthony Bateman, Dr Marco Chiesa, Professor Peter Fonagy and Dr Mary Target. The authors of the PDCM have considerable experience in working with individuals with PD in the NHS, within a psychoanalytical framework and have bought a contemporary object relation orientation to the PDCM. The authors collaborated to put together seven core dimensions (each with their distinct scales), which they thought to be conceptually relevant to personality disorder as well as attachment theory.

1. Affect
2. Aggression
3. Cognition
4. Relatedness
5. Self
6. Self and object
7. Sexualisation.

These dimensions are thought to represent 'characteristic features' of PD, and are informed by Bateman and his colleague's clinical experience of working with PD patients as well as by psychoanalytical theory. The manual aims to resolve some of the coding and procedural difficulties described by Turton (2001) and explore further the relationship between distinct clinical presentations and attachment related personality difficulties.

2.5. The development of the PD coding manual

The PD coding manual underwent a pre-pilot and pilot phase using a total of 42 AAIs from clinical populations, in order to explore inter-rater reliability. These pilot studies were undertaken previous to this current project, by Anouschka Buettner as part of her PhD thesis. The data generated by these pilot studies is represented in table 1. The scales and their corresponding sub-scales underwent reorganisation and extension during these pilot stages. The coding reliability was improved using audio-taped recordings of the AAI interviews in addition to using transcripts alone. This was done in order to improve coder's access to interviewee's affect, evident in their speech tone and manner. However, inter-rater reliability remained generally low (see table 1) and this was felt to be due to transcript and audiotape limitations. Many of the scales relied on non-verbal information, which was not available in the transcripts and audio-recordings. The main conclusion from the pilot phases was that videotapes of the interviews should be used for coding, in order to further improve accuracy and reliability.

Table 1: Intra-class correlations coefficients (95% confidence interval) reflecting agreement between two coders for the overall score of the scales of the revised version of the personality disorder AAI coding manual and using transcripts and audio-taped coding technique (n=16).

Dimension	**Scale**	**ICC (single rating)**
Affect	Down-regulation	0.28
	Up-regulation	0.58
	Lability	0.23
Aggression	Externally-directed	0.77

	Internally-directed	0.39
	Passive aggression	-0.02
Cognition	Disturbance of thinking	0.64
Relatedness	Anxious dependency	0.75
	Hostile Grievance	0.56
	Oscillation	-
(Inappropriate	Non-attachment	0.70
Attachment)	Over-extended attachment	-0.06
	Lack of concern towards the other (Empathy)	-0.19
Self	Over-evaluation	0.86
	Under-evaluation	0.22
	Lack of self-structure	0.45
Self- and Object	Lack of integrated object representation	0.21
	Inappropriate affect tone	0.31
Sexualisation	Erotisation	0.77

(-) ICC can not be calculated as there is no variability in the scores (one of the coders assigned the score value "1 = not present" for all 16 interviews)

2.6. The current study

This study seeks to further develop the PD coding manual, by improving its reliability and validity. In statistics, reliability is the consistency of a measuring instrument. For this study, we will be exploring the inter-rater reliability of the measure using three independent assessors. We will also be conducting a preliminary

exploration of validity, specifically construct and criterion validity, in order to gather evidence that the PDCM is measuring what it is designed to measure. Issues of internal and external validity will be addressed in the critical appraisal section.

We addressed the concerns raised by the pilot study, by using videotaped AAIs and by comparing PD patients with a control group. We also attempted to adapt and improve on the manual by incorporating non-verbal measures into the scales for use with video-taped material.

I intend to focus on two dimensions, the Self dimension and the Aggression dimension, and their corresponding scales. These scales can be conceptualised as methods individuals with personality disorder employ as defences against anxiety, such as distorting reality in relation to the self and acting out in order to defend against unconscious conflicts (Vaillant 1994).

2.6.1. The Self dimension.

PD patients are thought to hold dysfunctional self-representations (Fonagy 2002). It is hypothesised that a person's sense of self emerges from representations arising from a secure attachment relationship (Cicchetti 1991). PD patients are thought to fail at integrating positive and negative parts of themselves and thus struggle to hold a stable and balanced self-perception (Kernburg 1996). The 'self' dimension contained three scales which represented defensive strategies used in relation to the self.

Self over evaluation:

Individuals present themselves as stronger and more powerful. It is thought that in some individuals with Narcissistic PD, a pathological grandiose sense of self replaces the underlying lack of integration of a normal self (Akhtar 1989).

Self under evaluation:

Individuals down play their importance and role. Individuals with depressive personality characteristics are thought to have a pervasive feeling that they are bad, a defence resulting in a reduction of anxiety, as the badness becomes placed within themselves rather than the cherished object (Mc Williams 1994).

Lack of self-structure:

Deliberate exclusion of the self from the narrative. The borderline patient's experience of their self identity is full of 'inconsistency and discontinuity' and when asked to describe themselves they may be 'at a loss' (Mc Williams 1994).

2.6.2. The Aggression dimension

Patients with PD are often seen to exhibit inappropriate and uncontained aggression, often thought to reflect a combination of dispositional factors, such as excessive affect activation and environmental factors, such as childhood trauma, which 'intensifies aggression as a motivational system'(Kernburg 1996). It is argued that children raised in abusive and violent environments (often typical of individuals with PD) were more likely to show aggressive and angry responses themselves (Main and George1985) and develop psychiatric difficulties later in life (Bowlby 1984).

Goldberg (2000) explored this idea further, arguing for a relationship between disorganised attachment and hostile-aggressive behaviour in children. Again three scales distinguish the defensive strategies typically used:

External aggression:

Aggression which is directed outwardly, such as in violent acts. Physical assaults on psychiatric staff are often associated with individuals diagnosed with types of personality disorder (Adshead 1998). Similarly, assaults on close relatives or colleagues commonly prompted hospital admissions in people with paranoid PD, whilst those with anti-social PD are noted as having a high incidence of criminality and aggression (Fagin 2004).

Internal aggression:

Aggression which is directed internally such as by self-harm. It was noted by Freud (1917a) that individuals in depressive states aimed most of their negative affect away from others and towards themselves, which was thought to be a form of aggression against the self. A study by Haw, Hawton, Houston and Townsend (2001), found that almost half of self harming patients in their UK sample had an identifiable PD, suggesting that such patients have a high propensity for directing aggression internally.

Passive aggression:

This scale describes in-direct or passive expression. Vaillant (1994) described passive aggression as an immature defence amongst individuals with personality disorder, involving anger being turned against the self in a provocative way.

2.7. Main research questions

- Question 1

How does the PDCM (as a whole) perform in terms of reliability? The null hypothesis being that consistency between raters is not achieved and the alternative hypothesis being that good consistency is achieved.

- Question 2

Are the Self and Aggression dimensions valid? To address this question, the evidence for construct and criterion validity will be explored for the scales within these two dimensions. The null hypothesis being that they are not valid, whilst the alternative hypothesis suggests that they do achieve these forms of validity.

- Question 3

Do the two groups perform significantly differently on the Self and Aggression dimensions? The null hypothesis being that there are no significant differences between groups on these dimensions and the alternative hypothesis being that there are significant differences.

- Question 4

What themes arise within the Self and Aggression dimensions and do the groups differ in their thematic content? A qualitative content analysis will be used on the scales within these dimensions in order to address this question. The resulting themes and examples will then be re-integrated into the PDCM in order to improve the scales.

3. Method

3.1 Design

Firstly, the PDCM underwent a series of phases in order to adapt it for use with video-taped material (see manual development later in this section). The AAI was then administered to a group of patients with personality disorder (PD) as well as to a normative control group. In addition, a DSM-IV based personality measure was also administered to both groups in order to verify personality pathology for the PD group and identify any possible pathology in the control group (see measures section). All AAI's were videotaped and coded using the alternative PD coding manual. The interviews were not coded using the traditional AAI coding and classification methods. Fourteen AAI's (7 from the PD group / 7 from the control group) were used to assess inter-rater reliability for the PDCM as a whole. Finally, the numerical and descriptive data from the Self and Aggression dimensions of the PDCM (coded using all AAI's from both groups) were used to explore group differences, validity and thematic content for the two target dimensions.

3.2. Participants

3.2.1. The PD group

The clinical group consisted of 21 NHS community patients with a suspected or formally diagnosed PD diagnosis and 3 control group participants who met criteria for a personality disorder using the DSM-IV based PD measure (see measures section). Many of the PD participants met criteria across clusters with a total of 5 people meeting criteria for one cluster only (cluster A and cluster B), a total of 7 meeting criteria across two clusters (typically A and B), and a total of 8 people meeting criteria across all clusters A, B and C. The most commonly seen PD

categories were Paranoid (26.6%) and BPD (26.6%), followed by Avoidant (17.2%), Schizoid (9.4%) and Narcissistic (6.3%). The least commonly seen categories were Obsessive compulsive (4.7%), Schizo-typal (4.7%), Dependent (3.1%) and Anti-social (1.5%). No participant met criteria for histrionic PD.

The NHS patients with PD were recruited from three locations. Initially recruitment focused on a consultation and therapy centre for people with mental health difficulties in West London. Recruitment then expanded to include another centre in West London which offered day program treatments to people with personality disorder. Recruitment from these first two sites was carried out by a PhD student at UCL, who interviewed 11 patients.

Finally, in order to increase numbers in the clinical sample, recruitment expanded again to include a Community Mental Health Team and a Day Unit in Harlow, Essex. These final sites were felt to be socially and economically comparable to the London sites. A total of 10 patients were recruited and interviewed from these last two sites. Interviews were carried out by myself and the other Trainee Clinical Psychologist.

3.2.2. The control group

The control group consisted of 30 adult participants recruited from GP surgeries and University departments in North London (see table 1). Attempts were made to recruit control group participants from GP centres, post offices and community centres local to the clinical sites, but this was unsuccessful. The majority of the control group were interviewed by myself and the other Trainee (25/30) and the remainder were interviewed by the PhD student (5/30).

Table 2: The demographic data for both the clinical and control group

Demographics	**PD group**		**Control group**	
Average age	42.8		27.8	
% males & females	29% M	71% F	24% M	76% F
Education				
No qualifications:	25%		0%	
Educated up to 16:	83%		100%	
Educated over 16:	63%		100%	
Degree level:	29%		87%	
Nationality				
British White	54.2%		33.3%	
British Black	16.7%		13.3%	
Chinese	4.2%		10%	
British mixed race	12.5%		6.7%	
European	4.2%		16.7%	
American	0%		10%	
Other	8.3%		10%	
Employment status				
Employed	20.8%		26.6%	
Student	8.3%		60%	
Unemployed	70.8%		13.3%	

As can be seen in the table above, there were some differences between the demographics of the clinical and control group, namely with regard to age, education and employment. These group differences were found to be statistically significant and were explored further in part 2 of the result section.

3.3 Measures

Both groups were interviewed using the Adult Attachment Interview (AAI) (Main & Kaplan 1985) an interview which elicits childhood memories of family relationships in order to explore an individual's internal working models of attachment. This measure was chosen due it its relevance for individuals with PD who have been found to experience significant difficulties in their relationships with others often stemming from childhood (Widiger and Francis 1985). The measure was also chosen due to its ability to arouse emotion in the recipient. In an individual with PD it can elicit many of the characteristic features for this population e.g. poor affect regulation and thinking disturbances.

In addition we administered the Structured Clinical Interview for DSM-IV Personality Disorder (SCID II), (First, Spitzer, Gibbon and Williams 2002) which is a semi structured diagnostic interview (used in both clinical and research contexts) for assessing DSM-IV Axis II Personality disorders. The SCID-II interview was administered in order to verify that participants in the clinical group had a PD diagnosis and also to exclude any control group participants who met criteria for PD. There appears to be evidence of good reliability for the SCID-II interview when interviews are coded using joint observers, giving an average rater agreement of 0.89 (Kappa) (Maffei, Fossati, Agostoni, Barraco, Bagnato, Deborah, Namia, Novella and Petrachi 1997), although rater agreement can fall during test re-test studies, giving average rater agreement of 0.62 (ICC) (Dreessen 1998). There appears to be less evidence of validity for the SCID-II interview, with studies showing poor agreements with other personality assessments, such as the Millon Clinical Multiaxial Inventory

(Renneberg, Chambless , Dowdall et al 1992), although no conclusion could be reached about which instrument was more valid.

The SCID-II patient questionnaire, when used alone, has been found to have a very low rate of false negatives (Ekselius, Lindstrom, Von Knorring, Bodlund and Kullgren 1994). For the purposes of avoiding false positives when using the SCID-II-PQ as a screen for our control group, the full interview was administered when participants from either group met criteria for any PD category, in order to discount or verify the diagnosis.

3.4 Procedure

3.4.1 Researchers involved

Three separate research projects were carried out on the PDCM, one was a PhD project and the remaining two were conducted as Trainee Clinical Psychologist projects. All three researchers were involved in adapting the PDCM for use with non verbal material (although each focused on different dimensions) recruiting both the PD and control group and assessing the reliability for the PDCM. The PhD project focused on the development of the PDCM as a whole, whereas the other Trainee project focused on the Affect and Cognition dimensions of the PDCM, specifically exploring non-verbal measurement (see appendix 1 for further information). As this study involves coding procedures it is helpful to comment on the background of the researchers, which may have been influential. The PhD student was a white German female in her thirties, who was experienced in psychoanalytic theory and practice. She was experienced in using the existing PD manual (albeit with audio-taped material) and also in conducting AAI's with clinical populations. The two Trainee

Clinical Psychologists were white British females in their twenties with experience of working with multiple client groups and treatment models, mainly CBT and psychodynamic therapy.

3.4.2 Training on PD manual coding techniques

Myself and the other trainee were given training on how to administer the AAI and how to use the PD manual by our supervisor (one of the creators of the manual) and her PhD student.

3.4.3 PDCM development

The development of the PD manual is separated into three phases outlined below.

Phase 1: Manual development and reliability training

The new PD coding manual underwent an initial period of adaptation for use with videotaped data. This involved incorporating non-verbal features into the scales. Within this phase, I developed the scales self under valuation, self over valuation, external aggression, internal aggression and passive aggression (see table 2). This was done using existing literature on non-verbal behaviour and observing the non-verbal material within 4 videotaped AAIs, comprising two clinical and two control group participants. Table 2 below outlines the identified non-verbal behaviours, which were subsequently incorporated into the relevant scales for use in the manual.

Table 3: Identified non-verbal behaviours which were incorporated into the scales.

PD manual Scale	Non verbal behaviour: from the literature search	Non verbal behaviour: from observing four AAIs
External aggression	Involuntary twitches, tight muscles or posture, tight jaw, raised or lowered voice beyond normal range, short sighs (Gottman et al 1998) Tension in context of angry verbal content e.g. difficulty speaking, fidgets, pluck at clothes rub face, bite nails, shifting posture (Gottman 1998).	Any threatening behaviour towards the interviewer e.g. pointing gestures, leaning in forming a fist or facial grimace
Internal aggression	None found.	Mild self-harm e.g. scratching picking or slapping self.
Passive aggression	Constrained anger signs e.g. the 'unfelt' smile, short burst sighs, as well 'contempt' signs e.g. sarcasm, hostile humour and rolling eyes (Geise-Davis et al 2005)	Avoidance of eye contact or too much eye contact. Moving around so the camera needs adjusting. Disruption of interview process.
Self over evaluation	None found.	Non verbal behaviour depicting high confidence e.g. head high/ good eye contact
Self under evaluation	Non-verbal behaviour depicting low confidence: Failure related emotion (embarrassment or shame) marked by downwards gaze and head movements and rigid, slouched (Heckhausen 1984) Embarrassment marked by gaze aversion, nervous smile, shifty eyes, speech disturbances or face touches (Asendorpf 1990) Signs of blushing (Edelmann 1987) which is also in shame (Lewis 1993).	Downward eye gaze Speech changes (slower or faster.) Self soothing behaviours such as hand or body rubbing.

The above non-verbal behaviours were incorporated into the relevant scales in the manual. In addition, 'hunched posture' was included under the non-verbal behaviour for self under evaluation, as this had often been seen within personal clinical experience. In addition the manual was developed further through clarifying some of the scales, and re-defining the 9 point severity scale to include the option 'absent/ no sign.' At this point, one of the scales, 'internally directed aggression' was incorporated into the 'self under evaluation' scale, as it was felt to overlap considerably.

During this first phase we also trained for reliability, evaluating and improving our inter-rater consistency using the 4 'training' AAI videotapes. Each of the 4 AAIs was individually scored and then compared in detail in order to reach a consensus.

Phase 2: Reliability

During this phase, the three of us each coded 14 interviews separately (using 7 PD and 7 control AAIs) and then compared our inter-rater reliability using intra-class correlations (see part 1 of the results section). As a result of this phase, two scales, 'inappropriate affect tone' and 'lack of self structure,' were excluded due to being significantly unreliable.

Phase 3: Coding the remaining sample

We each separately coded the remainder of the sample (17 clinical AAIs and 23 controls) using the adapted PD manual, which was around 13 AAIs each.

3.4.4. Coding procedure

The coding procedure involved watching a few minutes of videotaped material at a time and examining it to see if it applied to any of the PD manual coding scales. If the video material was relevant to a particular scale, for example, if aggressive features were present, then it would be compared with criteria within either the external aggression scale or passive aggression scale, to see if it fit. If it was thought to fit well with the definition of either scale, it would then be assigned to a category of mild, moderate or severe (indicating the severity of the phenomena). Once the videoed interview had been analysed thoroughly in this way (sometimes watched two or three times) the coder then assigned a number to each scale (based on a 9 point scale), depending on how many mild, moderate or severe examples each scale had been allocated.

The 9-point scale

1.No signs

3. Mild

5. Moderate

7. Marked

9. Extreme aggression

A scale could be assigned an intermediate score, say for example a '2' if it were felt that the phenomena were present but in a form which did not meet criteria in the mild category.

3.4.5. Reducing coder bias

For the purpose of reducing coder bias, I and the other trainee clinical psychologist interviewed a proportion of the clinical sample (13 out of the 24 clinical interviews). In turn, the PhD student interviewed a proportion of the control group (5 out of 30 control interviews). The aim being that when the videotapes were coded it would not be apparent which group the participant belonged to based on the interviewer's identity alone. A further step towards reducing coding bias involved allocating a randomised number to each participant. Again reducing the possibility that the coder could tell which group the participant belongs to based on their participant number. Finally all participants were filmed in front of a plain white wall, in order to disguise setting.

3.4.6. Recruitment procedures

Clinical participants were identified by staff at the NHS sites. Staff gave identified patients information about the current study (see participant information sheet in appendix 5) and invited them to get in touch with the researchers if they were interested in taking part. Upon receiving either a verbal or written invitation (see appendices 7 and 8) from the patient, the researchers then contacted the patient to arrange a time to meet. Interviews were carried out at the respective NHS sites.

The control group were recruited through advertisements placed in University buildings and in local GP practises (see appendix 12). The participants either emailed or called the researchers and a meeting was arranged. The control group were interviewed in university buildings.

Neither group were informed that the study was investigating personality disorder. The clinical group were informed that they had been chosen due to having mental health difficulties and both groups were told that the study investigated the relationship between childhood memories and adult personality. This step was recommended by the ethics committee. Informed written consent was obtained from clinical and control group participants and they received a payment of £15 for their participation.

3.5. Power calculation

For the purpose of comparing the two independent groups we used an online power calculation. It was difficult to ascertain effect size as this being a new measure, therefore we entered alpha at .05, the power level at .08 and an estimate of the sample size in each group e.g. 30. The power calculation suggested a medium effect size of .57. However, we only managed to recruit 24 clinical participants, (compared to 30 controls) due to predictable recruitment difficulties with this population. Therefore power is likely to have been compromised.

3.6. Ethics

The project was granted ethical approval by St Mary's Research Ethics Committee in January 2006 (see appendix 4). Two site amendment applications were also submitted, in order to expand recruitment, the first was submitted to St Marys REC and approved and the second to Essex 1 Research and Ethics Committee and approved (see appendix 4).

4. Results

This section is separated into six parts. The first section addresses inter-rater reliability for the PD manual as a whole, whilst the second section investigates group differences for the demographic variables and their relationship with the four target scales, *external aggression, passive aggression, self over evaluation* and *self under evaluation.* The third section explores whether there were significant differences between the two groups on the four target scales, whilst the fourth section explores the measure's construct and criterion validity using correlations between scales and the SCID-II questionnaire. The fifth session briefly explores additional findings in the analysis. Finally, the sixth section uses a content analysis to explore and compare the themes arising for both groups on the *self over evaluation scale, self under valuation scale* and the *passive aggression scale.*

4.1.Inter-rater reliability

Table 3 below outlines the intraclass correlations (ICC) carried out on the 19 scales for the reliability sample (n=14). The sample consisted of 7 PD participants and 7 control participants. A reliability sample size of 14.4 was recommended by Walter, Eliasziw and Donner (1998) for use with three raters, in order to reliably detect a coefficient between 0.5 and 0.8.

As can be seen, 7 out of the 19 scales achieved coefficients >0.75 and 4 scales achieved coefficients >0.6, based on single rater reliability coefficients. The remaining 8 scales achieved coefficients <0.6. Two scales, indicated by * in table 3, showed a lack of data range, with the majority of scores falling at 1, (indicating that

the participant showed no signs of the scale being present). As a result of the reliability analysis, two scales 'lack of self structure' (relevant to my Self dimension) and 'inappropriate affect tone' were removed due to having particularly low reliability coefficients.

Table 4: Intraclass correlations for the 19 scales (95% confidence interval) indicating the level of agreement between three raters (ratings recommended by Cicchetti 1994)

Dimensions	**Scales**	**Reliability Coefficient (single rater)**	**Rating**
Affect	Down regulation	0.57	Fair
	Up regulation	0.86	Excellent
	Lability	0.68	Good
Aggression	External aggression	0.87	Excellent
	Passive aggression	0.38	Poor
Cognition	Thinking disturbance	0.85	Excellent
Relatedness	Anxious dependency	0.43	Poor
	Hostile grievance	0.90	Excellent
	Non-attachment	0.74	Good
	Over-extended attachment	0.50*	Fair
	Oscillation	0.37*	Poor
	Lack of Concern	0.87	Excellent
Self	Self over-evaluation	0.93	Excellent
	Self under-evaluation	0.63	Good
	Lack of self structure	0.19	Poor
Self and object	Lack of integration A	0.54	Fair
	Lack of integration B	0.72	Good
	Affect tone	0.17	Poor
Sexualisation	Erotisation	0.92	Excellent

*lack of range in data (majority of scores =1, not present)

Tests for normality

Normality for both groups and for all 17 scales was explored using tests for skewness and kurtosis (see appendix 3 for the data distribution on the four target scales). One outlier was identified within the PD group for the self over evaluation scale through its z-score of 3.221. It was not removed as its presence was found not to significantly

alter the outcome of the statistical test. Positive skewness was found for some of the scales, particularly for the control group, where scores often clustered around a score of 1. In order to try and correct skewness these scales underwent square root transformations. These transformations were successful in correcting skewness for some of the scales, but for the remaining scales, the non-parametric test Mann Whitney U was used in addition to independent T-tests. In all cases the Mann Whitney U test was found to produce the same results, suggesting that the skewed scales did not affect the T-test outcome.

4.2. Group differences in demographic data

Group differences in 'age,' 'education' and 'employment' were explored. The mean age in the clinical group was 42.7 (SD 13.6) and mean age for the control group was 27.7 (SD 10.99). The 'education' and 'employment' variables were split into groups, see table 4 and 5 for the group frequencies. An independent T-test found significant group differences in age, (t(50) 4.398, p=0.000), whilst a Pearson Chi-Square test found significant differences in education (X_2=22.23, p=0.000) and employment status (X_2=22.08, p=0.000). This finding suggests that the groups had significant differences other than PD.

Table 5: The group frequencies for the demographic 'education.'

	No qualifications	GCSE level	A level	Degree level
PD group	6	6	5	7
Control group	0	1	2	27

Table 6: The group frequencies for the demographic 'Employment'

	Student	Employed	Unemployed
PD group	2	5	17
Control group	18	8	4

4.2.1. The demographic data and the four target scales

In order to investigate the relationship between the demographic data and our four target scales, *external aggression, passive aggression, self over evaluation* and *self under evaluation*, a number of tests were carried out, which are outlined below.

4.2.2. Analysis of 'age'

Under this analysis a total of 5 statistical tests were carried out (4 correlations and one Ancova) and a Sidak correction was used to reduce type 1 error ($1-(1-0.05)1/5 = \alpha=0.0102$). Using a Pearson correlation (two tailed), 'Age' was found to significantly correlate with *self under evaluation* ($r=0.484$, $p=0.000$) but not with *self over evaluation* ($r=0.067$, $p=0.642$), *external aggression* ($r=0.304$, $p=0.029$) or with *passive aggression* ($r=.039$, $p=.783$). This suggested that 'age' only influenced the self under evaluation scale and that self under evaluation scores tended to increase with age. However, this finding may simply be explained by the higher ages found within the clinical group.

In order to explore further how 'age' might be interacting with *self under evaluation*, an Ancova was used with 'age' as a covariant. 'Age' was **not** found to be significant, $F(1,49)=2.792$, $p=0.101$, whereas 'group' was, $F(1,49)=16.034$, $p=0.000$, which

allowed us to conclude that when 'age' was controlled for, there were significant differences between the groups in their *self under evaluation* scores.

4.2.3. Analysis of 'education'

'Education' was split into four ascending groups, no qualifications, GCSE level, A-level and degree level (see table 4). A univariate Anova revealed that 'education' produced no significant effect for *self under evaluation* scores ($F(3,20)=0.549$, $p=0.655$), *self over evaluation* scores ($F(3,20)=2.159$, $p=0.125$), *external aggression* scores ($F(3,20)=0.414$, $p=0.745$) or in *passive aggression* scores ($F(3,20)=0.581$, $p=0.634$). Again, these findings suggest that although education level was significantly different for the groups, it did not appear to influence any of the four scales.

4.2.4. Analysis of 'employment'

'Employment' was split into 3 discreet categories (see table 5). Further analyses were not carried out to explore how 'employment' influenced the four target scales, due to the small N in particular groups e.g. the student group within the PD group. However, the possible impact of 'employment' upon the four scales is explored in section 1.2 of critical appraisal.

4.3 Group differences

4.3.1 Group differences on the four target scales

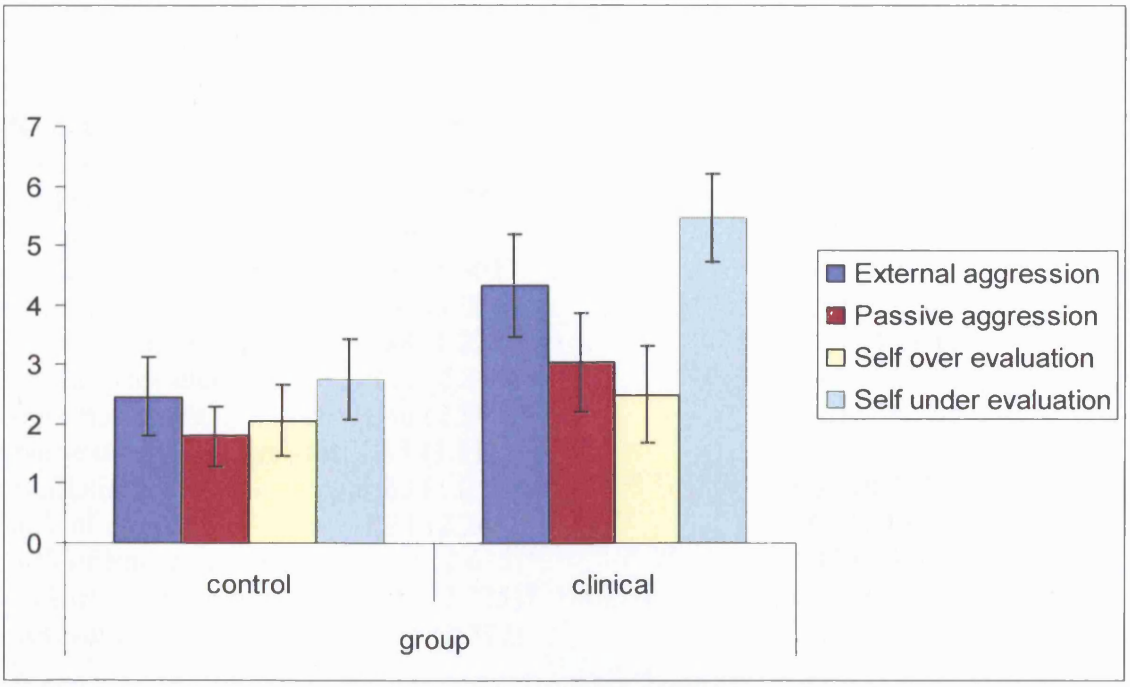
The two groups were compared on the four target scales, *external aggression, passive aggression, self over evaluation* and *self under evaluation*, using an independent T-test (see table 6 and graph 1). In order to control for type 1 error a Sidak correction was used to adjust the significance threshold (1-(1-0.05)1/4, α = 0.0127). The group differences on the scales *self under evaluation* and *external aggression* were found to be significant, whereas the groups were not found to significantly differ on the scales *passive aggression* and *self over evaluation.* It should be noted that the poor reliability coefficients for *passive aggression*, discussed in part 1 of the results section, suggest that any further statistical findings be treated with high caution.

Table 7: The group differences on the four target scales, including the mean, standard deviation and significance value.

	PD group Mean (SD)	Control group	Statistic	P-value
External aggression	4.33 (2.099)	2.47 (1.795)	t(52)=3.538	p=0.001*
Passive aggression	3.04 (2.053)	1.80 (1.375)	t(52)=2.594	p=0.0131
Self under evaluation	5.46 (1.817)	2.77 (1.870)	t(52)=5.322	p=0.000*
Self over evaluation	2.50 (1.978)	2.07 (1.617)	t(52)=0.839	p=0.406

* = significant at p=0.0127

Graph 1: The group means and standard error margins for the four scales



4.3.2 Group comparison on the remaining 13 scales

In order to see how the manual performed as whole, the two groups were compared on the remaining 13 scales. In order to reduce type 1 error rates, a more stringent Bonferroni correction was used (0.05/13 = 0.004). The results indicate that almost half of the remaining scales show significant group differences (see table 7).

Table 8: The clinical and control group means for the 13 remaining scales of the PDCM

PD manual scales	Clinical group means (SD)	Control group means (SD)
Down regulation	4.92 (2.283)	3.93 (1.639)
Up regulation	3.29 (2.331)	2 (1.438)
Lability	1.92 (1.501)	1.43 (1.223)
Cognition	6.08 (1.954)*	2.50 (1.570)*
Anxious dependency	1.88 (1.227)	2.33 (1.561)
Hostile grievance	6.21 (1.817)*	2.93 (1.799)*
Non-attachment	4.46 (2.395)*	2.40 (1.632)*
Over-extended attachment	1.54 (1.318)	1.13 (0.571)
Oscillation	1.63 (1.013)	1.30 (0.702)
Lack of concern	3.21 (2.265)*	1.60 (1.133)*
Lack of integration A	5.17 (2.615)*	2.47 (1.306)*
Lack of integration B	3.42 (2.225)*	1.57 (1.223)*
Erotisation	3.21 (2.322)	1.67 (1.184)

*= significant at p= 0.004

4.4 Validity

4.4.1 Construct validity

This section concentrates only on the four target scales, *external aggression, passive aggression, self over evaluation* and *self under evaluation.* In order to test whether the four scales have construct validity, both their convergent and discriminant validity were investigated. A total of six correlations were undertaken, using a Sidak correction (1-(1-0.05)1/6, $\alpha = 0.0085$). The first two correlations were carried out within the *self* and *aggression* dimensions to establish the convergence within their composite scales. The remaining four correlations explored the relationship between all four scales and a theoretically unrelated variable, in order to explore their discriminate validity.

Firstly, convergent validity was explored by correlating the scales within the aggression dimension (*external* and *passive*), which are theoretically similar. They were found to have a significant correlation (two tailed) Pearsons r= 0.446, p=0.001. Convergence was also explored using the scales within the self dimension, (*self under evaluation* and *self over evaluation*) which were expected to have a negative correlation. However, no significant correlation was found, Pearsons r=0.068, p=0.630. Therefore there is some evidence for convergent validity within the *aggression* dimension, but not the *self* dimension.

Discriminant validity for all four scales was explored by correlating them with a personality trait which was a theoretically unrelated personality construct e.g. 'obsessive compulsive PD' which was randomly selected from SCID-II questionnaire for both groups. The prediction being that no relationship should exist. This indeed was found for *external aggression* (r=.103, p=0.457), *passive aggression* (r=-0.025, p=0.859), *self under evaluation* (r=0.172, p=0.213) and for *self over evaluation* (r= -0.238, p=0.086). This finding suggests that all four scales show evidence for discriminant validity.

4.4.2 Criterion validity

For the scales to have criterion validity (specifically concurrent validity) it would be predicted that they would correlate with the scores of another established test which measures the same characteristic e.g. personality. Three scales, *self over evaluation, self under evaluation* and *external aggression* were correlated with three PD diagnostic categories Narcissistic PD, Paranoid PD and Anti-social PD respectively, within the SCID-II questionnaire, as they were thought to be theoretically

comparable constructs. The *passive aggression* scale was not thought to intuitively or comprehensively relate to any PD category, so was not tested. A total of five correlations were carried out across groups (N=54) and a Sidak correction was used to reduce type 1 error (1-(1-0.05)1/5, α=0.0102).

The *self over evaluation scale* was correlated with the narcissistic category, however, a Pearson's correlation (two tailed) revealed no linear association, r=0.126, p=0.370. Interestingly, the *self under evaluation scale* had a stronger correlation with the narcissistic category but was not significant under the Sidak correction, r=0.268, p=0.05. As predicted, *The self under evaluation scale* was highly correlated with the paranoid category, r=0.543, p=0.000. The *external aggression scale* narrowly missed being significant when correlated with the anti-social category, r=0.332, p=0.014. *External aggression* also showed evidence of a relationship with the narcissistic category, although this was not significant r=0.267, p=0.05. The findings offer some evidence for criterion validity, for the *self under evaluation* scale and the *external aggression* scale.

4.5 Additional findings

Due to the above unexpected finding that there may be a tentative relationship between the aggression and self image, the following explorative correlations were carried out. A Pearsons correlation (two tailed) found a significant relationship between the external aggression scale and the self under evaluation scale (r=0.466, p=0.000) and between the external aggression scale and the self over evaluation scale (r=0.419, p=0.002) See section 5.5.2 of the discussion section.

4.6. Content analysis

The purpose of this analysis was to explore the major themes and examples arising within the scales, with the aim that these would then be incorporated back into the existing manual to improve scale definitions and offer more specific examples (see discussion section 5.6 for further details on theme/ example incorporation). The following content analysis focused on three scales, the *self under evaluation scale,* the *self over evaluation scale* and the *passive aggression scale*. The *external aggression scale* was left out of this analysis (see discussion section 5.4). The content analysis focused on sections of dialogue (from both groups AAI's) which had been categorised under the three scales and recorded on the individual score sheets. A list of scale specific 'statements' were subsequently compiled for each group and these were examined in order to identify thematic sub-categories for each scale, as recommended by Smith (2000). The resulting thematic categories and sub-categories for each group were explored for areas of similarity and difference.

4.6.1 *Self under evaluation scale* content analysis

Within the control group 18 out of the sample of 30 (60%) met criteria within the *self under evaluation scale* (either for mild, moderate or severe). Whereas within the PD group 23 out of the sample of 24 (96%) met criteria.

Table 9: Indicates the major thematic categories found in both groups within the *self under evaluation scale*. It also illustrates the differences in frequency between the groups (see appendix 2.3 for more detailed information on minor themes and frequencies).

Self under evaluation	PD group	Control group
Major thematic categories	**frequency**	**frequency**
Aggression towards the self	55	11
Harm and rejection by others	134	42
Failure	24	4
Being different and alone	19	4
The self being harmful to others	15	4
Insecurities with interview performance	9	12
Hopelessness and shame	23	0

Aggression towards the self

The PD group talk aggressively about themselves more frequently than the control group and appear to hold a more consistently negative attitude towards the self involving at times severe self disgust, ideas around self destruction and fantasies about death.

Clinical participant 31: *'I am the one who should be locked in the mental institution, locked in the attic or the cellar and forgotten about.'*

Clinical participant 40: *'Everything I do, is a kind of destroying myself.'*

Clinical participant 37: *'I can't wait for my time to come, that is how I feel.'*

This level of aggression against the self was not seen in the control group. The control group did show some evidence of aggression towards the self in terms of physical self harm, although the clinical group, were four times more likely to talk about self harm. Instead, the control group tended towards milder self criticism and self put downs.

Control participant 39: *'I was very childish when I was a child.'*

Control participant 20: *'The earliest I can remember is 7, I am a bit behind.'*

Harm and rejection by others

This was the most commonly found thematic category for both groups. Both the PD and control group exhibited similar themes around other people being viewed as somehow harmful or threatening to the self. Both talk about experiencing paranoia, being mistreated and feeling helpless, fearful and intimidated by others.

Clinical participant 51: *'Since she's died I think she is haunting me, making things go wrong in my life.'*

Control participant 18: *'I was frightened of my father until I was about 8 or 9, to the degree that I used to lock myself in the cupboard if he was coming in.'*

Both groups also talk frequently about feeling rejected by family and peers. This theme is dominant in both group's narratives. The PD group exhibited more severe examples, such as feeling completely unloved and unwanted throughout their lives, whereas the control group exhibit milder forms, describing feeling uncared about or not thought about enough by parents.

Clinical participant 40: *'I have never felt loved, I have never felt wanted.'*

Control participant 3: *'I was their youngest child and they had been through it all before, I don't think they would have thought, oh it's her first day at school.'*

Another relevant theme within this category involves valuing others over the self, to the extent of sacrificing the self for the needs of the other person. This theme was only present in the clinical narratives.

Clinical participant 31: *'and like in this last relationship I ended up doing everything for them and they wanted a mother. I cooked, cleaned and cared for them.'*

Failure

Both groups talk about having an expectation that they will fail and that they are not good enough. The PD group appears to take this theme further however, enlarging and generalising their own failures.

Clinical participant 11: *'I have spoiled my life and my family's life.'*

Control participant 25: *'I should have done more...'*

Being different and alone

Both the PD and control group talk about feeling different/ not fitting in and of feeling alone and isolated. With the control group this tends to relate to their peers or siblings whereas the PD group talk about more global and consistent feelings.

Clinical participant 30: *'I feel I have got no one but myself and that I've got to look after myself, be strong for myself.'*

Clinical participant 37: *'I always felt that I did not fit in. I always felt that I was the black sheep of the family and even now I feel like I am different.'*

Control participant 19: *'My brother was always closer with my mum and my sister with my dad, just family dynamics really.'*

The self being harmful to others

Interestingly both groups perceive themselves to be somewhat harmful at times to other people, blaming themselves in the narrative for hurt or upset they believed they had caused. The PD group talked about themselves being very destructive to others and ruining other people's lives, whereas the control group gave milder examples and talked about upsetting or burdening others.

Control participant 20: *'Now I think about it, they (parents) had to put up with me for 12 years, so she (mother) was pretty good!'*

Clinical participant 60: *'I didn't work and I didn't go and see him (father), partly because of selfishness and partly because I was ashamed of myself. So I was an unhappiness and a disaster to him.'*

Clinical participant 31: *'I never got him (baby son) back. So in his eyes I've done to him what my mother did to me. I deserted him. So that's another life down the line that's been ruined.'*

Insecurities with interview performance

This was the only theme for which the control group were found to have a slightly higher frequency than the PD group. Both groups exhibited under evaluation of their interview performance, both seek and elicit reassurance from the interviewer and both have a tendency to negatively label their performance. However, the control

group appeared to have more examples of apologising to the interviewer for perceived failures within the interview.

Control participant 14: *'This sounds so lame...' 'Is that Ok? Sorry, I am rubbish.'*

Control participant 3: *'Oh sorry, I can't think of anything, I'm sorry.'*

Clinical participant 11: *'I don't know why. Maybe I wasn't observing enough?'*

(Interviewer: 'that's fine.')

Hopelessness and shame

The PD group also differed from the control group in terms of talking about feelings of hopelessness in their lives and shame for things they had done or had had done to them. These themes were absent from the control group narratives. The PD group also on occasion report feeling that they contain some sort of badness.

Clinical participant 37: *'what is the point in going on...at times it seems pointless.'*

Clinical participant 22: *'She taught me to be ashamed of myself and I really do feel ashamed of myself most of the time.'*

Clinical participant 26: *Yes, my whole childhood experience, of violence at home. I create them, it's in me.'*

4.6.2 *Self over evaluation scale* content analysis

Within the control group 15 out of the sample of 30 (50%) met criteria within the self over evaluation scale (either within mild, moderate or the severe range). Similarly, within the PD group 12 out of the sample of 24 (50%) met criteria. There was

therefore no difference between the groups in terms of the frequency with which subjects over evaluated themselves in their AAI narratives.

Table 10: Indicates the major thematic categories found in both groups within the *self over evaluation scale*. It also illustrates the differences in frequency between the groups (see appendix 2.6 for more detailed information on minor themes and frequencies)

Self over evaluation Thematic categories	**PD group frequency**	**Control group frequency**
Being special and valued	18	19
Being powerful and superior	45	16
Praising the self	8	11
Denigration of others and idolisation (of others and self)	8	6
Emotional resilience and fearlessness	18	5
Instructing and controlling others	6	3

Being special and valued

There was very little difference in terms of frequency of appearance or what got talked about between the two groups with regards to the theme of being valued and feeling special to others. Both groups talked about being favoured, being special and being needed. They both talked about being valuable and important to other people, although this was found more commonly in the control group. Both also spoke about others being preoccupied with them or their well being, although this idea was most commonly found in the PD group. Within the 'being special and valued' category,

the groups also spoke in a way which assumed the interviewer had a special interest in them. Examples of some of these themes are given below.

Control participant 45: *'I was my dad's favourite child. I know that. And I was also my grandmother's favourite child.'*

Clinical Participant 8: '*Everyone knows that she (mum) was very proud of me and my sister. She would die for us.'*

Clinical participant 24: (to the interviewer) *'I believe the other example was even more interesting, slightly outside the parameter of being normal here... just put it in your, your memory of delights of human behaviour, human experience...um...like the occasional jewels, the little sparkling gems... of human existence, human experience.'*

<u>Being powerful and superior</u>

This was the most common *self over evaluation* thematic category for the PD group, found in almost half of all examples and the second most common theme for the control group. At the mild end of the spectrum, individuals spoke being capable and talked about their abilities and skills. They also spoke about others being jealous of them. At the more severe end, individuals spoke about having superhero like skills, being superior to others in intellect and ability and likened themselves to famous or powerful people. Although, similar themes came up in both groups, the PD group had a greater frequency for talking about others being jealous of them, than the control group. The PD group also had a far higher frequency for talking about their own general strength, power and ability. Some examples within the strong and superior thematic category are shown below.

Control participant 10: '*Quite frankly, Linford Christie would have had some trouble catching up with me...I left that dog in my dust.*'

Clinical participant 21: *'I felt so strong one day, so strong, like supernatural.'*

Clinical participant 35: *'Because she is jealous of me, because I am prettier than her... I have a human sense, I am very good heart, because I can attract people, nice hair, nice make up, nice clothes.'*

Praising the self

This was also one of the less common thematic categories for both groups. Examples for both groups included statements about their high self confidence and descriptions of themselves which were flattering and complimentary.

Clinical participant 13: *'When I see how kids turned out (at his old school), I think I am actually quite sensible.'*

Clinical participant 35: *'I have beautiful hair, I always had beautiful hair, even now, look, I am 46!'*

Control participant 39: *'Although I remember being quite confident in it, I was quite able, I think.'*

Denigration and idolisation

This thematic category represents two ends of spectrum which represents others in either highly positive or negative terms. Within both groups, participants could be critical of others, be mildly insulting and put others down in their narratives, under this thematic category. Whilst two participants in the control group spoke about being served and worshipped at times by others and individuals in the PD group

spoke about being idolised and in turn idolising others. One participant in the control group spoke on a couple of occasions about their talents not being appreciated enough by others, whilst a participant in the PD group talked about demanding others give their best.

Control participant 10: *'as far as I was concerned they (parents) were pretty much my servants, clean me, feed me, do what I say, that was pretty much it.'*
Clinical participant 21: *'I never did anything wrong, as far as my granny was concerned I was an angel.'* (then later) *''She (grandmother) was my queen, she was the food to my soul.'*
Clinical participant 29*: 'I did go to the top person I could find.'*

Emotional resilience and fearlessness

This thematic category was found in both groups, although appeared with much greater frequency in the PD group. Both groups claimed to be emotionally unaffected by stressful events, spoke about being fearless and unafraid and claimed not to need the help or support of others. One participant in the PD group also claimed that he was capable of being without emotions.

Clinical participant 13: *'I've always been a believer in the paranormal, so it wasn't really upsetting for me. To be honest I was already in the process of losing my emotions anyway.'* (Spoken with pride)
Clinical participant 49: *'I cleared all the clothes up and took them down the charity shop because my step father couldn't do it. In fact I was a rock. I was the only one who could take it in hand really.'*

Control participant 45: *'I was taller than him, bigger than him, I was not afraid of my father.'*

Instructing and controlling others

This was the thematic category found least in both group's narratives. Examples within this theme found in both groups include criticising or instructing the interviewer and attempting to take control of the interview process. There was also an example of talking about controlling others within the control group, whilst the PD group spoke about guiding or teaching others.

Control participant 1: *'well you can take it down as one (AAI adjective) and then we can explore it as two...you need to put them down as two different words.'* (a few minutes later) *'You put down religious and spiritual together!'*
Clinical participant 21: *'My little sister is not a racist and she is not a racist because I am teaching her.'*

4.6.3. Passive aggression scale content analysis

The *passive aggression scale* was found to have poor inter-rater reliability (see part 2 of the results section). The aim of analysing this scale was firstly to explore what themes/ behaviours the raters were coding in order to build a clearer scale definition and secondly to investigate any major differences between raters. Within the control group 11 out of the sample of 30 (37%) were classified under the *passive aggression scale* (either for mild, moderate or severe), compared with 18 out of the sample of 24 (75%) in the clinical group.

Table 11: Indicates the major themes within the *passive aggression scale* and illustrates the differences in frequency between groups.

Passive aggression themes	**PD group frequency**	**Control group frequency**
Unacknowledged anger towards someone in the narrative e.g. a sarcastic tone.	7	1
Obstructing interview process	25	12
Behaviour which upsets or provokes anger in another (acknowledged and unacknowledged)	11	7
Unacknowledged anger towards interviewer e.g. in remarks and provocations	6	0
Behaviour which elicits increased effort in the interviewer e.g. interviewer required to repeatedly prompt, clarify and reiterate.	4	2

Unacknowledged anger towards someone in the narrative

This theme was seen in both groups, although more frequently in the PD group. It often involved the participant talking in a sarcastic or aggressive tone (often towards an attachment figure), without clearly acknowledging their anger.

Clinical participant 37*: (talking about a couple who regularly visited her and her brother in the care home) 'how should I put it, we filled a gap in their life, because she couldn't have children...an auntie and uncle who take you home and show you a normal life.'*

Obstructing the interview process

This theme was common in both groups, although more frequently seen in the PD group. Examples include giving vague or very brief responses, interrupting the interviewer, requesting breaks, claiming not to remember childhood episodes (despite remembering previously) or claiming not to understand interview questions (despite clarification by interviewer). The clinical group occasionally refused to answer questions. There were also examples of disruptive non verbal behaviour such as answering of mobile phones.

Clinical participant 35: *'I can not talk about everything here, you understand, because I have secrets.'*

Control participant 54: *Participant is asked repeatedly for specific memories for all five of her descriptive adjectives for her parents, to each one she repeatedly replies: 'again, I can't think of anything specific.'*

Behaviour which upsets or provokes anger in others

This theme was found in both groups and involved the participant talking about an event in which they had provoked anger or upset others, either through their action or inaction. The participants role in provoking others anger could be either acknowledged or unacknowledged.

Clinical participant 6: *'I remember I had this friend 'Mike' and I kissed his girlfriend (smirks) and I remember he waited outside my house for days and days and I would not go out because he was gonna beat me up (smiles).'*

Control participant 5: *'I was having a sweet picnic with my siblings and my mother turned livid, that was quite fun.'*

Unacknowledged anger towards interviewer

This theme only appeared in the narratives of the PD group and included comments and provocations suggesting undisclosed aggression towards the interviewer.

Clinical interview 8: *'I beg to differ (uses interviewer's first name)... there was none (uses her name again), there was none, I can't think of anything.'*

Clinical interview 35*: The participant becomes tearful and asks the interviewer if she too is upset, 'I make you upset (uses interviewer's first name)...your reaction... (laughs and points at interviewer) ...your face!'*

Behaviour which elicits increased effort in the interviewer

The final theme, found in both groups described statements and behaviours by the participant which appeared to elicit increased effort from the interviewer, such as requiring that the interviewer repeatedly prompt, clarify and reiterate questions.

Clinical participant 29: *The participant maintains an unexpected silence for a minute with her head lowered. The interviewer prompts the participant for a response to the previous question, and the participant raises her finger up and says 'I need one minute.' The unexplained silence continues for another minute or so as the interviewer waits.*

Differences between coders on the *passive aggression scale*

The analysis revealed that there were no apparent differences between the coders in terms of what was being observed and coded. All three coders identified similar themes and behaviours as described above. However, there were differences between

the three coders in terms of who most frequently coded AAI responses under passive aggression. One coder was responsible for almost half (43%) of all responses coded under passive aggression, whilst the other two coders coded the remainder of the responses (33% and 24%) (see appendix 2.9 for further information on coder frequencies within this scale).

5. Discussion

This section addresses the four research questions outlined in the introduction session, as well as discussing some additional findings, revisiting the literature on PD diagnosis and offering some suggestions for future research.

5.1. Reliability for the PDCM

The study addressed the first research question, is the PDCM a reliable measure. Under the rating recommendations of Cicchetti (1994), the reliability analysis revealed that eleven out of the nineteen scales achieved good to excellent reliability (>0.60), whilst three achieved fair reliability (>0.40) and five achieved poor reliability (<0.40). These findings suggest that the manual is showing promising signs of becoming a reliable measure of personality. The reliability phase prompted some revision of the PDCM and two scales, inappropriate affect tone and lack of self structure, which achieved particularly poor reliability, were thought to be inadequately defined constructs and were subsequently removed from the manual. Reliability was also difficult to calculate for other scales, namely over extended attachment and oscillation, where there was a lack of data range. It is possible that these two scales would require a larger clinical sample in order to detect this

phenomena, suggesting that further research on the PDCM would be needed in order to adequately test them.

With regards to the four target scales, excellent reliability was achieved for external aggression and self over evaluation, good reliability was achieved for self under evaluation, whilst poor reliability was found for passive aggression. The reliability analysis indicated that scales falling within the fair to poor ranges e.g. passive aggression might need further clarification and more concrete examples, in order to achieve better consistency amongst raters. The content analysis which was later carried out on the passive aggression scale attempted to further clarify the construct and improve its reliability by exploring the themes typically arising within the scale (see later discussion section 5.4.3).

The reliability analysis also indicated that using video-taped AAIs was a more reliable method than using audio-tapes and transcripts alone. When comparing this current study's interclass correlations with those achieved in the pilot study (which used only audio-taped and transcribed AAIs – see table 1) we found that inter rater reliability had improved for all four target scales, as well as for thirteen out of the remaining fifteen scales of the PDCM. Although the manual had undergone some revision and adaptation, prior to the current study, the use of videotaped data was the most substantial difference and is likely to account for the improvement in PDCM's reliability.

5.2. The validity for the four target scales

Validity was only explored for the four remaining target scales, within the Self and Aggression dimensions. There was evidence of construct validity within the Aggression dimension, as shown by the convergent validity between the scales external aggression and passive aggression. This suggested that the two scales were related in that they were based on a theoretically similar construct. Within the Self dimension, no relationship was found between the self under and self over evaluation scales, when a negative correlation would have been predicted. This suggested that the two defensive strategies could be being used by individuals in tandem rather than using either one or the other and that they might not be related to the same underlying construct i.e. they may have a function other than to defend self identity.

Further evidence was found for construct validity for both the Self and Aggression dimensions, in that evidence for discriminant validity was found i.e. they displayed no relationship with a theoretically different personality construct, 'obsessive compulsive personality disorder', taken from the SCID-II questionnaire. This suggests that they were representing constructs which did not overlap with theoretically different constructs. Overall there appeared to be some evidence of construct validity for both the Self and Aggression dimensions. The Self scales however, may need to undergo further clarification or revision in order to better tap the underlying construct. The lack of significant group difference for the self over evaluation scale, along with evidence from the content analysis that the scale measured healthy self esteem in addition to self-grandiosity, is suggestive that the scale may not always be measuring pathological self-defensive strategies. If the self

over evaluation scale were revised, in order not to measure examples of healthy self esteem, the construct validity may be found to improve.

In order to explore criterion validity (specifically concurrent validity), the SCID-II questionnaire was used as a comparable personality measure. However, it should be noted that the SCID-II is a DSM-based measure and was therefore difficult to relate to the scales of the PDCM, as these are based on psychoanalytical theory rather than behavioural categories. However, some useful comparisons were drawn, namely for the scales self under evaluation and external aggression, which significantly correlated with the theoretically comparable SCID-II PD categories 'Paranoid' and 'Anti-social' PD, respectively. It was predicted by the literature that external aggression had a strong relationship to 'Anti-social' PD (Fagin 2004). Whereas the content analysis for the self under evaluation scale revealed themes of 'fear of harm and rejection by others,' which appear to account for its strong relationship with 'Paranoid' PD (BPD was not selected for this correlation as it was felt to be too heterogeneous as a category). The failure of the self over evaluation scale to correlate with 'Narcissistic PD', suggests again that the scale might be measuring something less pathological e.g. healthy self esteem. The passive aggression scale was not thought to strongly relate to any specific SCID-II PD category, so was not explored.

In conclusion, there is evidence that some of the scales namely external aggression and self under evaluation are valid. Self over evaluation appears to be lacking in both construct and criterion validity. In addition, reliability for the passive aggression scale needs to be improved before any conclusive validity conclusions can be drawn.

5.3. Group differences on the four scales

The PD group was found to score significantly higher on the external aggression scale and the self under evaluation scale, compared with the control group. This suggests that these two scales are successfully measuring personality pathology. These results support the literature, which suggests that individuals with PD have particular difficulties managing aggression (Kernburg 1996), as well as maintaining a coherent and integrated self image (Fonagy 2002).

The groups failed to perform significantly differently on the passive aggression scale. There is some evidence of a mild difference between group means on the passive aggression scale (not significant under the Sidak correction), although this should be treated with caution given the poor reliability for this scale. The lack of significant differences between the groups on the passive aggression scale, may be related more to the difficulties the three raters experienced in adequately identifying and coding this often subtle form of aggression, rather than it not being a relevant construct for PD.

The groups also failed to perform significantly differently on the self over evaluation scale. As mentioned previously, the self over evaluation scale might in part have measured healthy self esteem e.g. the content analysis themes of 'praising the self,' as well as measuring more pathological self over evaluation e.g. themes of 'feeling powerful and superior'. This may have elevated the self over evaluation scores of the control group, who given their high levels of academic attainment might have had relatively high self confidence. It may also be that type two errors were occurring for both the self over evaluation scale and the passive aggression scale, which may have

relatively small effect sizes and necessitate a larger sample to detect their group differences.

5.3.1. Group differences for the PDCM

With regards to the manual as a whole, it appears to have significantly differentiated the PD and control group on six of the remaining thirteen scales. This suggests that the manual is able to measure some analytically informed personality features which are relevant for PD. The remaining scales which are not significant may need redefinition and more concrete examples adding, in order to improve the rater's detection of them in the AAIs and hopefully in turn improve the scale's reliability. There may indeed be a link between a scale's reliability and its ability to differentiate the groups, as some of the scales with poor reliability e.g. 'oscillation', was also not significant. Some features of personality disorder may be seen more rarely e.g. 'over extended attachment' and may need a larger sample to detect it.

5.4. Content analysis

The content analysis added to the statistical group comparison by revealing the themes arising within the narratives of both groups on the selected scales and exploring whether the groups differed in their themes. The aim being to use this information to improve the scales by adding extra criteria and examples. Obviously much of the individual's narrative which was classified under a scale related directly to the criteria within that scale and therefore themes which were identified for that scale strongly related to its existing scale criteria. However, the scales often contained limited criteria, requiring raters to flexibly generalise from the scale criteria to the material they were witnessing in the AAIs. This led to a broader array

of phenomena being classified under the scales and increased the utility of a thematic analysis.

Three of the four scales were analysed, self under evaluation, self over evaluation and passive aggression. External aggression was not analysed as it was felt that given its focus on the presence of aggressive behaviour in the interview or in the narratives, themes would be limited to types of behaviour e.g. swearing or hitting, and therefore would be less psychologically informative.

5.4.1 Self under evaluation scale

Many of the same under evaluation themes come up in both the PD and control group, including having 'aggression towards the self', 'fears of harm and rejection by others', themes of 'failure', being 'different and alone', being 'harmful to others' and showing 'insecurities with their interview performance'. However, the PD group exhibited a greater frequency of such themes, gave more severe examples and appeared to be more consistently aggressive and destructive towards the self both physically and psychologically. In addition only the PD group showed evidence of the 'hopelessness and shame' theme in their narratives.

Some of these findings appear consistent with the psychoanalytical literature. Freud hypothesised that a pathological superego can become the 'agent of the death instinct,' using internalised punitive parental values to punish the individual and produce feelings of guilt, inferiority and shame as well as a drive to do harm to oneself (Freud 1923). Such feelings of self hate and wishes to self harm appear consistent with the themes mentioned above. Included in the self under evaluation

themes were strong feelings of paranoia and a view that others were harmful or threatening to the self. Again this finding is reflected in the literature and might be thought of as a projective defence, common in individuals with paranoid characters, whereby negative parts of the self are projected into others, who are then perceived as persecutory (McWilliams 1994).

5.4.2 Self over evaluation scale

Overall, the content analysis revealed that there were no major differences between the themes arising in the clinical and the control group for this scale, as the same thematic categories were clearly identifiable in both group's narratives. This finding echoes the statistical comparison. However, the groups did differ on which thematic categories were more salient e.g. themes of being 'powerful and superior' and 'emotionally resilient and fearless' were more common and more severe for the PD group. Such themes may reflect the PD individuals attempt to create a 'delusional system to protect from unbearable reality,' which is thought to be common in Narcissistic PD (Millon and Davis 1995). Self grandiosity may also function specifically to protect the individual's fragmented sense of self (Akhtar 1989).

Themes of 'denigration and idolisation' as well as 'instructing and controlling others' emerged from the narrative. These may reflect how individuals using self over evaluation typically view and interact with others. Indeed the literature suggests that individuals with narcissistic PD learn to devalue others and see them as weak and subservient (Millon and Davis 1995).

The theme 'praising the self' and possibly the theme 'feeling special and valued' appeared to access the milder end of the self over evaluation scale. Indeed many of the thematic examples found within this scale might be considered markers of good self esteem, such as feeling valued by others and acknowledging ones own abilities. These themes were frequently found in the control group. In addition, the PD group were more likely to under evaluate themselves than over evaluate. These findings might help explain why the group means for self over evaluation were not significantly different. It is possible that if such mild self praising was excluded from the scale, there would be a greater differentiation found between the groups.

5.4.3 Passive aggression scale

Both groups shared similar themes within this scale, including 'exhibiting unacknowledged anger' and 'provocative behaviours' in their narratives. Three out of the five themes observed within the passive aggression scale appeared to involve aggressive feelings and obstructive, provocative behaviours directed particularly at the interviewer. Individuals would disagree with the interviewer, refuse to answer or behave in a way which was antagonistic to the interview process. These incidents did not involve overt signs of aggression, but rather subtle, disguised aggression, often detectable in their non-verbal behaviours. The PD group exhibited these themes more frequently and with greater severity than the control group. Vaillant (1994) described passive aggression as an immature defence, involving anger being turned against the self in a provocative way. This suggests that the passive aggressive behaviours observed in these AAI's may be damaging to the self in a way that additionally provokes and antagonises others.

As well as wanting to explore in what ways the groups differed on the passive aggression scale, it was hoped that a thematic analysis might illuminate why reliability was so poor and provide a clearer more useable scale definition.

The analysis revealed differences between raters' frequency for identifying examples of passive aggression, which was likely to have contributed to poor reliability. This suggests that the poor reliability between raters may have been more to do with raters missing examples of passive aggression rather than differing on what they classified as passive aggression (see critical appraisal section 2.1 for further comment on this). Many of the examples of passive aggression are challenging to identify as the coder must often judge the intent of the participant, e.g. are they being defiant in not answering or do they simply not remember. The rater must often look towards subtle non-verbal clues for such a judgement.

5.5. Additional findings:

5.5.1 The relationship between self over and self under evaluation scales

The defensive practice of under evaluating the self appears to be more commonly found than self over evaluation in this particular sample of PD patients, with 23/24 patients under evaluating compared to 12/24 over evaluating. This may indicate that self under evaluation is a more commonly used PD defence or it may suggest that it is more typical in PD individuals requiring mental health services. It may be that self over evaluation is more frequently found in PD individuals who manage to function adequately without services, as it is a less personally disabling defence and may even be a beneficial personality feature in some socially competitive settings.

Individuals in both the PD and control group could often be found using both self over and self under evaluation defences in the same interview, suggesting that some individuals may oscillate between the two. This raises the question of under what circumstances do individuals 'switch' defences? Another interesting finding was how individuals enlisted the interviewer in his or her strategy of under or over evaluating the self. Individuals who under evaluated themselves often criticised their interview performance and invited the interviewer to do the same, whereas individuals who over evaluated themselves invited the interviewer to share their inflated self-view by assuming the interviewer must be especially interested in them. It is likely that through such coercive behaviour, individuals can influence the attitudes and behaviours of those around them, in order to reinforce and perpetuate their self image. This form of object manipulation was recognised by Joseph Sandler (Sandler 1976).

5.5.2 The relationship between Self and Aggression dimensions

A mild, although not statistically significant association was found between the external aggression scale and the 'Narcissistic PD' category of the SCID-II during tests for validity, which suggested a possible relationship between an individual's aggression levels and how they manage their self representation. This unpredicted finding prompted further exploration and strong positive associations were found between external aggression and self under evaluation, as well as external aggression and self over evaluation.

A subsequent literature search revealed an article by Stolorow and Harrison (1975), who suggested that in borderline and arguably narcissistic personalities, injuries to

the self representation or 'narcissistic wounds' can result in self fragmentation. Hostile aggression is then used to repair or restore self esteem, by retaliating against others who may have inadvertently caused the injury. Indeed, more recent ideas describe a possible link between anti-social PD, (in which individuals can be aggressive) and narcissistic PD, (in which individuals defensively idealise the self), suggesting perhaps that the two lie on a continuum (Gabbard 2000). These articles help explain our findings i.e. that individuals in our sample using self over or self under evaluation, were more likely to show aggression, which may have functioned to defend perceived injuries to the self.

Alternatively, idealisation of the self can be used as an attempt to control an external world perceived as dangerous and persecutory. This perception often results from the individual projecting out their own aggressive internal objects (Kernburg 1996). This theory may help explain why there was a mild, although again not statistically significant association between the self under evaluation scale and 'Narcissistic PD,' suggesting that individuals in our sample were defending against an underlying painful negative sense of self, using self-grandiosity.

The strong association between scales within the Self and Aggression dimensions could be considered a threat to their construct validity and raises questions about whether they have overlapping underlying constructs. Our findings suggest that the external aggression scale may function to protect self identity and it is arguable that it could therefore potentially be incorporated into the Self dimension. Further research is needed in order to distinguish the external aggression scale as having separate additional psychic functions and therefore protect its validity. It is clear that

these tentative findings need further exploration using larger sample sizes to increase power.

5.6. Revising the Self and Aggression dimensions

One of the purposes of undertaking a content analysis of the scales was to incorporate the themes and their specific examples back into the scales in order to improve reliability and validity. The analysis revealed a range of themes within the self under evaluation, self over evaluation and passive aggression scales (some consistent with existing scale criteria and some brand new), which in turn contained specific examples ranging in severity. Some of the themes were only found in the PD group and were only amenable to a severe category, whilst other themes were consistently mild in nature, frequently seen in the control group and warranted allocation to a mild category. In addition examples within the themes were matched as far as possible with existing scale criteria within the mild, moderate and severe categories. The process of re-integrating the themes/examples into these three scales is likely to need careful discussion with the authors of the PDCM and therefore this attempt should only be considered a preliminary step.

5.6.1 Additions to the self under evaluation scale

Table 11 below outlines suggested ways to integrate thematic examples into the mild, moderate and severe categories.

Table 12: reintegrating the self under evaluation examples

Self under valuation thematic categories	**Mild**	**Moderate**	**Severe**
Aggression towards the self	Self chastising and put downs	Self criticisms, self dislike or self mocking	Wishing to die or destroy the self
Harm and rejection by others	Mild paranoia and feeling overlooked	Feeling persecuted and uncared for	Global and consistent feelings of persecution and being unloved
Failure	Wishing to have achieved more	Feeling one has failed in a selected area	Global and consistent feelings of failing self and others
Being different and alone	Feeling different to peers and siblings	Having no one but yourself to depend on	Feeling like the black sheep throughout life
The self being harmful to others	A sense of having burdened others	Feeling as if one has hurt and upset others	Feeling as if one has ruined the lives of others
Insecurities with interview performance	A single apology for one performance	Repeated apologies for ones performance	Criticising own performance, apologising and eliciting reassurance
Hopelessness and shame	N/A	N/A	Feeling life is pointless, reporting self shame or a badness in the self

5.6.2 Additions to the self over evaluation scale

Table 12 below outlines suggested ways to integrate thematic examples into the mild, moderate and severe categories.

Table 13: reintegrating the self over evaluation examples

Self over valuation thematic categories	**Mild**	**Moderate**	**Severe**
Being special and valued	Being mum or dads favourite	Feeling overly precious and valued (including by the interviewer)	Feeling that others would die for you.
Being powerful and superior	Being capable having notable skills	Feeling superior in intellect and ability	Having supernatural powers and gifts
Praising the self	Complimenting the self	N/A	N/A
Denigration of others and idolisation (of others and self)	Being insulting or praising others	Feeling that others should serve and take care of you	Feeling that others should worship you or that others are akin to 'angels'
Emotional resilience and fearlessness	Claims of not being afraid and not needing others	Claiming to be unaffected by stressful events	Claiming to be completely fearless or without emotions
Instructing and controlling others	Giving suggestions or advise to the interviewer	Attempting to take control of others or interviewer	Instructing others and claiming to guide or teach others

5.6.3 Additions to the passive aggression scale

Table 13 below outlines suggested ways to integrate thematic examples into the mild, moderate and severe categories.

Table 14: reintegrating the passive aggression examples

Passive aggression thematic categories	**Mild**	**Moderate**	**Severe**
Unacknowledged anger towards someone in the narrative	Talking in a sarcastic voice tone	Talking in an aggressive voice tone	Increasing levels of sarcasm, aggression or mocking of others
Obstructing interview process	Claiming not to remember	Delaying or deviating from interview e.g. answering phone	Refusal to answer the question e.g. claiming that it's a secret
Behaviour which upsets or provokes anger in another (acknowledged and unacknowledged)	Action or inaction which causes mild irritation	Action or inaction which results in others feeling hurt or upset.	Action or inaction which causes distress and anger in others
Unacknowledged anger towards interviewer e.g. in remarks and provocations	N/A	Remarks towards interviewer which are argumentative, teasing of sarcastic	Mocking remarks or laughing at interviewer
Behaviour which elicits increased effort in the interviewer.	Interviewer required to prompt or reiterate	Interviewer required to repeatedly prompt, reiterate or clarify.	Interviewer made to wait for unusually long periods for a reply

5.7. Addressing issues of diagnosis and assessment

It is arguable that the PDCM addresses many of the challenges to PD diagnosis and assessment raised in the literature review. Both the self over and self under

evaluation scales appear to reflect symptoms described within PD diagnostic categories of DSM-IV (APA 1994), such a Depressive PD, Paranoid PD and Narcissistic PD. However, the scales within the Self and Aggression dimensions along with the remaining scales of the PDCM attempt to go beyond behavioural descriptions and instead represent testable underlying psychological processes and mechanisms which are hypothesised to occur in PD. This idea of assessing underlying processes as a diagnostic strategy was recommended by Lenzenweger and Clarkin (2005). The PDCM also addresses Kernberg's argument that measures of PD should be guided by theory (Kernberg 1996). The PDCM is based on a variety of psychoanalytically informed theories including attachment theory, aspects of object relations theory and also covers a range of psychological defences.

Another criticism of traditional methods of PD diagnosis based on DSM-IV, is that the milder and arguably more common pathological personalities are not included (Westen and Arkowitz 1998). The PDCM offers a new way of conceptualising PD by presenting personality features commonly found across DSM based PD categories and allows milder pathological personality features to be captured within the 1-9 scoring range. Finally, the PDCM offers a method of assessment based on observing what and how the patient is communicating. It therefore is less influenced by the patient's levels of self awareness or efforts to be socially desirable, which is a common challenge for self-report assessment tools such as the SCID-II (Torgerson Ainaeus 1990).

5.8. Future directions

So far this study has only attempted to achieve the same claims of the traditional AAI coding scheme i.e. to successfully differentiate the PD and control populations. The

next challenge to the PDCM is to differentiate types of PD, a task which has not proven possible for the traditional AAI (Turton, McGauley, Marin-Avellan and Hughes 2001). Other possible future uses of the PDCM might be to assist in designing treatment programs, tailored to the individual's specific pathological personality profile. Once more PD profiles have been collected using the PDCM, it could also be used to help predict treatment outcomes or prognosis. The PDCM also offers opportunities for use as a possible treatment outcome evaluation tool, which could present a way of assessing changes in personality features and defences post treatment. This will allow psychoanalytic based treatments a more empirical method of competing in the evidence based market place of the NHS.

Finally, it is hoped that this study has helped build further bridges between psychoanalytic theory and attachment theory. It has attempted to categorise and measure the types of defences and dynamic strategies people with PD employ in relation to their attachment related internal working models. Defences such as under evaluating the self may serve to pre-empt perceived attacks to ones self identity from others and re-direct aggressive feelings towards the self (and away from others), in accordance to the internal model one has on how to safely relate with and to others (based on early experience with care givers). As mentioned in the introduction, the PDCM (if proved consistently to be a reliable and valid assessment tool) may offer a way for psychoanalytic theory to use the empirical strength of attachment concepts to demonstrate its utility and effectiveness as a tool for assessing, formulating and guiding treatment of personality disorder in the NHS.

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Part 3: Critical appraisal

This section is split into three main parts. The first addresses challenges and issues specific to this current study and how things might have been done differently, the second explores wider considerations including cultural issues, the implications of using video recordings, diagnostic issues and considerations for future use of the PDCM. The final part includes a personal reflection on working with individuals with PD and using the AAI.

Part 1

1.1 Blindness during coding

A number of possible threats to validity were identified during the course of this study. Many were anticipated and attempts were made to reduce them. One such threat was the difficulty in ensuring that the three raters were blind to which group the participant belonged to when coding the interviews. Attempts were made to increase rater blindness by allocating randomised numbers to the PD and control group participants, filming both groups against a blank white wall and ensuring that PD group/ control group participants were interviewed by all three researchers.

However, despite these attempts it was often possible to identify the group membership of the participant through the content of their AAI. PD participants frequently referred to their psychiatrist, psychologist or their mental health problems during their AAI, which clearly differentiated them from the control group. A strategy of erasing these tell-tale sections of dialogue for the PD group was briefly

considered, however sections of potentially useful dialogue would also need erasing for the control group too, in order to avoid the PD/ control group videos appearing different. One way to avoid this difficulty in future trials of the PDCM would be to use other psychiatric populations as the comparison group.

1.2 Differences in group demographics

Significant group differences were found on the demographics of age, education and employment. This too offers a threat to the validity of the PDCM, in that it jeopardises the assumption that group differences were due to personality pathology alone. This issue was anticipated and we originally planned to match the PD group and control group on their demographics as much as possible. However, this was made challenging for a number of reasons, firstly delays and difficulties recruiting the PD group meant that the majority of the control group were recruited first. Recruiting PD participants who matched the demographics of the pre-existing control group was far more difficult than if it had been the other way round. Secondly, due to well documented challenges of working with and engaging a PD population (and a danger of not gaining a viable sample size), PD participants were accepted more on their willingness to be take part rather than on their matched demographics. Finally our attempts to recruit the control group through GP surgeries, community centres and job centres in the same geographical location as the PD group, was largely unsuccessful. This meant that we needed to rely heavily on a more easily attainable student population, in order to achieve adequate numbers.

Fortunately, statistical analysis on the demographics of age and education suggested that only age appeared to have a relationship with the self under evaluation scale and

that when this was controlled for, the two groups continued to perform significantly differently on this scale. The relationship between age and education was only explored on the four target scales for this study and it is likely that they may influence the remaining scales of the PDCM. This will need further exploration. Employment could not be reliably analysed due to the fact that the 'student group' within the PD group as well as the 'unemployed group' within the control group, had extremely small N. It is possible therefore that differences in employment status account for some of the variability between the groups. One way to explore this in future studies would be to provide a control group which was well matched on this variable e.g. through recruiting from job centres.

1.3 Generalising beyond our samples

A study is thought to possess external validity if the results hold across experimental settings and participants. This issue will need to be assessed by future trials with the PDCM. However, we can hypothesise that having such a large student group in our control group is a possible threat to external validity. The control group personality profile achieved on the PDCM, is likely only to represent educated and relatively affluent populations and therefore can not be generalised to other normative groups. Similarly the PD group represent community patients in regular contact with mental health services and as such the results can only cautiously be generalised beyond this group, i.e. to inpatient PD groups. In order to improve external validity, larger group samples would need to be achieved from multiple settings and populations. In addition, future research is needed in order to further verify the reliability of the PDCM using test-re-test reliability as well as inter-rater reliability.

1.4 Procedures and practices which would be changed in hindsight

On the whole the study went largely according to the original research plan however, it is worth highlighting challenges which were experienced and things that would have been done differently in hindsight.

1.4.1 Recruitment

Firstly delays and difficulties experienced in recruiting the PD sample meant that the two groups were less well matched on their demographics, presenting a real threat to validity. Some of these delays and difficulties reflect the challenges of engaging this population but they also reflect our initial use of only one recruitment site and how this limited numbers of referrals for the study. Recruitment of the PD sample also taught us the importance of having good working relationships with the staff who will be making these referrals. As our recruitment sites grew from one to eventually four sites, so did our sample size, helped by the fact that I was on placement at one of the final sites chosen. This meant that I was regularly able to personally advise, remind and thank the staff who assisted us with finding suitable PD patients. In hindsight, recruitment should have taken place through multiple clinical sites from the start, preferably sites where we were on placement or held good local contacts.

1.4.2 Removal of scales post reliability phase

Another practice which looking back may have been done differently, was the removal from the PDCM of two scales, inappropriate affect tone and lack of self structure, the latter of which was included within the Self dimension (which was a focus of this study). These scales were removed after the reliability phase, due to having considerably poor reliability. The rationale being that any further analysis

undertaken on these two scales would have been of questionable use. However, removal was undertaken without any attempt to firstly explore why the scales were unreliable and if reliability could be improved through clarification and modification of the scales. This decision was taken due to the limited time frame of our study.

It may however have been better to keep the scales and include them in the coding of the remaining sample (N=40) in order to collect concrete examples of what each may look like in the AAIs. These examples could then have been discussed with the authors of the PDCM and the two scales could have undergone re-definition based on the new material found. This is particularly relevant for the scale lack of self structure, which is a common feature of PD, reported by patients and clinicians alike (Mc Williams 1994). The absence of this scale was felt as a loss by the coders, who frequently saw potential examples within the remaining forty AAIs, but had nowhere to code it under. It might therefore be advisable to reinstate the lack of self structure and inappropriate affect tone scales, so that further trials of the PDCM can enable more data to be gathered on them.

Part 2

2.1 Cultural issues for both coders and participants

It is possible that cultural differences between the three coders, contributed to differences in interpreting the scale criteria as well as identifying and coding interview material, resulting in a reduction in inter-rater reliability. The relevance of cultural differences in coders for influencing their coding practices has been observed and can affect the scores coders assign to phenomena as well as how they

score video-taped individuals from their own or a difference ethnic background (Melby, Hoyt, Bryant 2003). As mentioned in the method section (section 2.4.1) the coders differed in their country or origin, first language and preferred treatment models. It is possible that these factors contributed to the poor reliability for the some of the scales.

In addition, differences in the coder's preferred treatment model may also have led to differences in coding practices. The passive aggression scale is conceptualised well in psychoanalytic literature (Vaillant 1994) but arguably less so in cognitive behavioural models, suggesting that individuals with psychoanalytic training might be better placed to identify it. This was found to be the case, in that the psychoanalytically trained coder identified passive aggression much more frequently than did the remaining two eclectically trained coders. However, during the reliability analysis the three coders were found to vary in who they were more reliable with and it was not the case that the eclectically trained coders were more typically reliable with each other.

It is also important to consider cross cultural differences in participant performance. The PDCM was designed by western authors and therefore is likely to contain personality constructs relevant for western populations. This means that the constructs may be less relevant for participants from other cultures and indeed may result in misleading scores and even wrongly diagnosed pathology (Cheung and Cheung 2003). Although both groups contained some ethnic diversity, the largest sub-group was 'British white,' meaning that one can only tentatively generalise the findings beyond a white British population. In order for the PDCM to be reliable and

valid in other cultures it may need to be standardised to different local ethnic populations. In doing so one might find that some of the constructs in the PDCM are redundant for certain ethnic groups, whereas other culturally relevant constructs may need to be added in.

2.2 The use of videotape

The use of videotape offered many advantages to coders, namely improved access to participant's affect and intentional meaning as revealed by their non-verbal behaviour. This is likely to have greatly improved reliability for the PDCM (see discussion section 1). However, it is important to appreciate the potential disadvantages to using video-taped methods over audio-tape. It may be that being video-taped raised participant's anxiety levels and subsequently increased the paranoia levels of some of the more Paranoid PD participants, through the process of projecting out their internal aggression (McWilliams 1994). This is relevant when you consider that Paranoid PD was one of the most commonly found types of PD in our PD group.

Increased levels of paranoia are likely to make participants more susceptible to being classified within the self under evaluation scale, whose criteria includes examples of paranoia. In line with the hypothesis raised in the discussion (section 5.2) levels of aggression might also be found to increase in order to defend threats to the self (from the persecutory video camera), resulting in raised scores on the external aggression or passive aggression scales. This was indeed observed in one PD participant diagnosed with Paranoid PD, who as soon as the video was switched off post interview, presented as significantly more relaxed and affable compared with his

tense and suspicious presentation during the AAI. However, it is possible that audio-taped AAIs produce similar psychological effects on participants.

Finally, it is also possible that people are more selective about what they are willing to say on video rather than audio-tape, given that it is a recording method which is arguably more personal, more invasive and more difficult to hide things from. PD participants often asked if their psychiatrist would be given access to the video and this suggests that they might have gone on to present themselves in more socially desirable (or pathological) ways, with this belief in mind. However, given the long duration of the interview and the considerable attentional control required to maintain a false image (often under levels of high emotional arousal), it is likely that any attempts to present oneself in a certain way would have minimal impact on the PDCM scores.

2.3 Addressing diagnostic concerns in the literature

The PDCM attempts to address some of the longstanding issues with the assessment and classification of PD (see discussion section 7). Namely in using an established theoretical framework to tap underlying psychological processes relevant across traditional PD diagnostic categories, without the reliance on patient self report and therefore self awareness. However, Kernberg argued against using classification systems which relied on observable behaviours, which could be misleading as one behaviour may have many causes (Kernberg 1996).

By departing from self report procedures, the PDCM relies on coders classifying observable phenomena during the video-taped AAIs. It is therefore possible that as

predicted by Kernberg, we are being misled by overt behaviours with may have multiple covert functions. Although the PDCM taps underlying psychological processes it still relies on overt behavioural markers e.g. boasting behaviour to indicate self over evaluation. It is possible that someone who repeatedly claims not to remember a childhood event, is being intentionally obstructive and possibly passive aggressive, but it could also indicate a genuine difficulty in recalling or even tiredness and lack of motivation. Often the coder is left to discern possible underlying functions using the participant's non-verbal behaviour and by taking the whole interview as a context to the behaviour. However, it is clear that some psychological processes have clearer behavioural markers than others and this may only be an issue for some scales. One way of addressing the faults of any measurement instrument is to use multiple forms of measurement, in order to minimise single source error. In addition to using the PDCM, the clinician could use a clinical interview or talk to the patient's family.

2.4 Future considerations

Outlined below are some thoughts about future use of the PDCM within both research and NHS settings.

2.4.1 The relevance of the interviewer/ coder personality profile

One issue that arose during supervision for the study was how far the coder (or indeed the interviewer's) own personality profile might influence their ability to identify and score personality features. In a sense the coder's own personality is a part of the measuring tool. Ones ability to recognise a pathological personality feature in operation depends on ones ability to classify it as deviating from the

normal range. Each coder's personality will vary on the personality dimensions within the PDCM and they will subsequently have their own personal views on what is 'normal' or deviating from normality, based on their own experience and their self awareness. It is possible for example, that a coder who often under evaluates themselves will view this trait as less severe in a interview participant or possible fail to notice it so often, compared with a coder who does not under evaluate themselves. In addition, the interviewer's personalities may influence the interview participant's responses during the AAI via subtle individual reactions or cues. It may therefore be advantageous for prospective coders and interviewers to have their personality profiles assessed using the PDCM prior to embarking on any series of coding, in order to promote their awareness of their own potential 'blind spots.' Whilst this might seem a timely and superfluous procedure, improving self awareness and understanding in order to promote better therapeutic practice is often the aim of many therapists who undergo their own personal therapy.

2.4.2 The clinical and research uses of the PDCM

The PDCM deviates from DSM based classification tools in that it avoids categorising PD into discreet groups and instead attends to the many pathological dimensions which are relevant for individuals with PD, regardless of their PD category. PD individuals will naturally vary on which dimensions are more relevant for their pathology and which are not. Further research on the PDCM will also reveal whether some dimensions represent core processes common to all individuals with PD, whilst other dimensions represent rarer or less commonly seen processes. It is also likely that individuals without PD may have elevated scores on some scales. The question becomes how to judge cut-off points which indicate that the individual's

profile signifies a PD diagnosis. It seems likely that obtaining standardised scores indicating the normal range on each scale is crucial for this endeavour. It remains to be seen how the PDCM will be used, if it will be a research tool for diagnosing PD (for which cut-off points may be helpful) or a clinician's tool for building a patient's personality profile to inform treatment and prognosis.

In line with this idea, it may be beneficial for clinicians who are exploring the attachment related difficulties of their PD patients to use the PDCM to provide them with details of the distinct patterns of defences used (in relation to the self and others) as well as the affect management strategies their patients are employing in accordance with their internal working models (as elicited by the AAI). This knowledge could greatly inform the clinicians formulation and provide much more detailed information than can be offered by the 'CC classification' (can not code) of the AAI which many psychiatric patients end up coded under and which arguably employs too broad a range of criteria to be clinically useful (Turton 2001).

2.4.3 The interaction between axis I conditions and the PDCM

During interviews with participants I became increasingly aware of the possibility that axis I conditions might be affecting interview performance. This issue of how 'states' and 'traits' coexist and interact was raised by Lenzenweger and Clarkin (2005). I interviewed a few students who were in the midst of taking their exams and I was aware that they presented as rather anxious, but was unclear if this was a transient mood state or one associated with their personality. Similarly, one PD participant had an additional diagnosis of bipolar disorder and although his presentation was fairly balanced on the day of the interview, his performance could

easily have been coloured by manic or depressive symptomology. Such symptoms are likely to impact on the scale scores, for example a participant with depressive symptoms is arguably more likely to self under evaluate. One possible way of addressing this is to administer a measure of mood prior to the AAI, such as the Beck Anxiety Scale (BAI) (Beck and Steer 1990) and the Beck Depression Scale (BDI) (Beck, Ward and Mendelson 1961). One could then assess the extent to which mood might be impacting upon the scores.

Part 3

3.1 Working with individuals with PD

Interviewing PD patients using the AAI was very different to interviewing participants from the control group. Quite often the procedure took much longer, necessitated partially by the initial need to build up rapport (which was easier and faster with the control group) as well as by the finding that many of the PD participants were preoccupied with grievances against their families in addition to being prone to wander off topic, resulting in long interview times. On a few occasions PD participants considered terminating the interview part way through and careful steps had to be taken to explore their feelings about being interviewed and re-engage them with the task. Issues of consent and confidentiality were highly relevant for the PD group. Being service users meant that they frequently had information shared about them amongst mental health professionals and therefore needed careful explanation about the boundaries of the study, to ensure that informed consent had been obtained. In addition, I found it very helpful to be working within the very

teams that some of these patients were recruited from. The AAI can be an emotionally arousing experience and it was helpful to know who the patients could contact should they require any extra support as a consequence of the interview.

3.2 Learning about the AAI and interview technique

Finally, I found that my interview technique with the AAI changed as I became more experienced with using it and more aware of the function of it. This was helped due to having to repeatedly watch myself on the video-tapes conducting the interviews and observing errors in how I was presenting myself and the questions. The more interviews I conducted the more I realised the importance of presenting oneself as neutral and as non-reactive as possible. I observed that participants were often looking for cues from the interviewer about how to respond and could be unintentionally led in certain directions by subtle communications from the interviewer. I found some of the AAI questions ambiguous and there was an initial temptation to offer the participant some clarification about what the question might be asking. During the course of the study I learnt that the participant's own interpretation of an ambiguous question was in fact laden with information about their attitude and feelings about the topic. I also realised that my temptation to clarify a question for a participant may have been more about alleviating my anxiety than theirs. These two discoveries have also been very helpful in my clinical work.

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Appendix

1. The other two research projects on the PDCM

The other Trainee Clinical Psychologist project

This focused on the development of the Affect and Cognition dimensions through integration of non-verbal information into the existing manual. Non-verbal aspects of the scales were developed through observation of a selection of videotaped AAIs in the sample and literature search on non-verbal behaviour. This study also explored reliability of the PDCM using the14 videotaped AAIs and conducted a content analysis on the non-verbal behaviour data collected from the reliability sample. The analysis generated suggestions for the improvement of the Cognition and Affect dimensions. Clinical and control groups were also compared on the measures of Cognition and Affect.

The PhD project

This project explored the development of the entire PDCM, including all of its composite scales. Of particular interest was the development and reformulation of the scale criteria and the use of the PDCM with a clinical population. This project also incorporated non-verbal behaviour into the remaining PDCM scales.

2. Qualitative data section

2.1 Self under evaluation dialogue exerts for the PD group

Number/ interviewer	time	level	SELF UNDER CLINICAL interview description
30 T	1.6.30	mod	Subject talks about wetting herself out of fear of her dads aggression and keeping the abuse from him for fear of what he would do to her mum and brother
30 T	1.16.00	sev	Subject reports self harm, hurting herself down below, tying things round her neck, drinking and slashing her wrist.
30 T	1.25.00	mod	Subject reports becoming terrified when her husband hit her and being afraid of everything and reported that even if her daughter hit her she would call up in a ball in the corner
30 T	1.43.00	mod	Subject complains of feeling disgusting, really bad and at fault. She feels her husband has contributed to her feeling this way.
30 J	1:08:43	mod	Talks about friends party over the road and how she could see everyone going in but wasn't allowed to go. 'and I was breaking my heart' (victim of agg)
30 J	1:14:44	mod	'When upset- I'd run upstairs and shut the door. Really cry to myself and do silly things to myself'
30 J	1:15:17	sev	'Emotionally? Try and hurt myself. Try and hurt myself down below so no one could touch me again- put something around my self and be how can I hang this? I don't know why I didn't, I really don't know why I didn't some days.'
30 J	1:16:38	sev	'I sliced my wrist once'
30 J	1:29:04	mod	'we'd get slapped and hit like that as well (by siblings)...it was like one circle all of the time where you'd wake up thinking which one is going to slap you today, and what are you going to do wrong'
30 J	1:37:46	mild	'I feel I've got no one but myself and that I've got to look after myself- be strong for myself'
30 J	01:43:36	mod erate	'Other traumatic experiences- yes with my husband, with him pushing me lower and lower, making me feel that I was disgusting. Making me feel really bad like its my fault what happened to me and my daughter.'
30 J	ALL	mod	being the victim of violence is thematic throughout the interview
30 J	1:43:00	mod	"low self esteem about myself", "I just feel like it is never going to stop"
30 J	01:15:0	sev	'Trying to hurt herself "down below" trying to hang herself "I really don't know why I didn't.."

30 J	0:53:10	mod	"that why I used to drink, go and drink a lot of whisky, just to know, knowing what was going to happen"
30 J	0:02:08	mild	'I can't get my head around it to be honest, it didn't make me feel very good-being the middle child as well- I put it down to being darker and in the 50s being mixed race-or black as they wanted to call it-wasn't acceptable, and that's the only conclusion I've come to.'
37 J	0:08:48	mild	talking about couple who volunteered to come and visit her and her brother in care- how should I put it, we filled in a gap in their life, because she couldn't have children
37 J	0:11:41	mod	'I always felt that I didn't fit in, I always felt that I was the black sheep of the family and even now I feel like I am different from all of them because they made me feel that way.'
37 J	0:13:15	mild	'It was made very clear to me that I was different by the words that she used and the word that he (step father) used, I have no time for him what-so-ever.'
37 J	0:14:45	mod	'I went there for Christmas one time and as usual my step father would get drunk and carry on and I felt that she was blaming me for the way that he was.'
37 J	0:39:53	mild	'I don't think that I've done a bad job (referring to raising her children) although I still question myself sometimes.'
37 J	0:42:43	mod	'He knew about my past (her children's father) and he used it against me and that taught me- don't trust other people.'
37 J	0:43:00	mod	'Set backs? Yes mentally I don't think that I achieved as much as I could have achieved because I didn't feel good enough, as clever as other people because I was made to feel that way.'
37 J	0:46:22	mod	'I can't wait for my time to come (talking about death) that's how I feel.'
37 J	1:05:00	mod	'I've learned that there are a lot of people out there not to be trusted. I've learned not to get too involved because if you get too deeply involved you end up getting hurt one way or another.'
60 J	0:14:38	mod	intrusive negative reference to self
60 J	0:15:56	mild	'He wasn't shy, whereas I was and if we bumped into someone in the street or at church and things he would say or the jokes he would crack would embarrass me because I was a timid character.'
60 J	0:22:11	mod	'Well I was reluctant to leave home, which I think was a character defect for various reasons.'
60 J	0:25:00	mod	'It did make me- I don't know that it was there fault- but selfish I suppose, and self-indulgent.'
60 J	0:30:47	mild	'He didn't take a great deal of you know, I remember being shown to him one day and he looked up and said is this Emmie's boy, you know mixed me up with a cousin.'

60 J	0:37:25	sev	'I was remorsful and still am that I wasn't a better son. Several years prior to his death I was a disaster. I had destroyed everything in my life, I'd been in trouble with the police and went to prison for a few weeks. I didn't work and I didn't go to see him. Partly because of selfishness and partly because I was ashamed of myself. So I was an unhappiness and a disaster to him.'
60 J	0:38:26	sev	'Effect? Not really it's a natural event in life to lose your parents. Other than the remorse and unhappiness that I wasn't a better son, that still troubles me.'
60 J	0:40:03	sev	'Mixed feelings. On the one hand I'm pleased that I did manage to maintain contact with him, on the other unhappiness that I was such a depressed vegetable and a failure for him for much of the time.'
60 J	0:42:00	sev	'It was only after my mother died that I became a bit of a disaster and made dad unhappy and a bit ashamed of me I suppose.'
60 J	0:42:42	mod	'With hindsight I can see that I matured late... I had disasters in my 20s when I had a muck up of life and was out of work for a bit.'
60 J	0:46:00	sev	'Worried about son? Only in so far as I've been a bit of a failure and a bit of a pathetic..and I feel bad about this I wished I'd been mentally better and material better for him.'
8 J	0:40:15	mod	'We used to be punished. If we hadn't done something to a high standard she would come behind us and ask us to watch. It was humiliating.'
8 J	1:04:52	sev	'I've always wanted to die as far as I can remember (from age 5 onwards).'
12 J	54	mild	'I feel like I am the odd one out, do you know what I mean.' Subject also describes not receiving enough love or encouragement compared to her older sister
12 J	57	mild	'I just felt like I was the one who was doing things wrong...'
11 J	0:16:57	mild	'I know it was more my fault because I was the eldest, so it was up to me not to do that and then my brothers and sisters wouldn't copy me.'
11 J	0:17:38	sev	Disappointed- no specific memories 'just being there I think. The thing is if I hadn't been born my parents probably wouldn't have stayed together, they was just going out when I was born. I was an accident, so really it stems back from there'
11 T	0:18:29	sev	'I know now that this is probably the reason why she was most angry with me.'
11 T	0:19:09	mod	'Talks about how his mum was always asking him to pay attention and he was not concentrating on what was going on- 'and I should have because I was the eldest'

11 T	0:19:57	sev	'A Burden? Yes, just having to look after me you know. I knew she had the others to look after and when I was 3 and my brother was the baby I should have been more looking after myself so she could look after the others- I felt like I should have been more independent.'
11 T	0:35:16	mod	'I don't know why, maybe I wasn't observing enough but I didn't notice.' (interviewer 'that's fine')
11 T	0:40:53	mod	Talks about being locked out in the garden by his mum when he was 7/8 years and crying because he wasn't sure how long he would be out there. 'and the boy next door was laughing at me'- 'so then I tried to pretend that I wasn't upset and went down the alley so that he couldn't see me.'
11 T	0:47:08	mod	'They knew (the girls who bullied him) what happened when men and women sleep together, one of them knew, and they kept laughing at me.'
11 T	0:48:31	sev	'I get on well with my children, but perhaps in years to come they will be talking about me, saying I wasn't this or I wasn't that.'
11 T	0:51:40	sev	'Childhood experiences effected adult personality? I think in a way it's all turned out bad. Not because of them but by me trying not to do what they did that upset me, I've spoiled my family's life because I've tried too hard.'
11 T	0:54:51	mod	'Negative effect? Yes I should have done A levels and gone to university but I left school-talks about how he should have done physics- I just thought the sooner I get to work that's one less mouth my parents have to feed.'
11 T	0:57:17	sev	'and I was the oldest and I thought I'm the most stupid and I shouldn't be, I should be setting an example.'
11 T	0:57:36	mod	'I remember my mum used to get very upset if I tore my trousers and I did that a lot falling over. She'd start telling me about how much they cost and I didn't do it on purpose but I felt very bad about it.'
11 T	1:14:56	sev	'I got a paper round and got some doctor martin boots. I used to put bleach in my bath thinking that my skin would go lighter so I could pretend that I was a white guy (12/13 years). One day I think I over done it with the bleach because I really did, I could feel parts of my skin burning.'
11 T	1:17:16	sev	'Cause I think some of them thought I had something wrong with me...and it didn't matter what they thought. Even the bigger kids stopped picking on me- its not so much that I'd win the fight but they knew I would fight.'
11 T	1:17:47	mod	'and when I thought about it I was bigger than most of them. So why had I been running home, getting all stressed out, especially the night before.'
11 T	1:18:01	sev	'and I just turned into some sort of monster and I'm not proud of it.'

11 T	1:22:00	sev	'I don't think I apologised for that either- I don't think I ever have. I probably should have.'
11 T	1:22:27	sev	'and then I thought if she can't hit me anymore, cause I thought hitting was punishment, that means I've probably got to act older.'
11 T	1:36:00	sev	'What you hope your children might have gained by their experiences of being parented by you- 'I don't know, that's all gone bad.'
11 J	1:37:07	sev	'I can't give them advice because I've mucked up so much I don't really want to give them advice no more.'
11 J	25	mild	'I know it sounds bad....'
11 J	51.3	sev	'I have spoiled my life and my family's life...'
11 T	55.3	sev	'Subject talks about his parents being incompatible for marriage and adds 'but I know it is me that made them have to do that.'
37 J	0:04:52	mod	'What we did me and my MP was actually change the law so I could get my care notes because you could only get them from 20 years ago, but I got them from 40 years ago. I was horrified to discover that my father had a home help...and I'm not sure how long I was in care, but I went to live with her and her son, and their son, he hated me.'
37 J	0:24:00	mod	'Teacher got hold of hair and took her to the front of the lines lifted her skirt and slapped her on the top of the leg. She was left with hand marks there for 'days and days and day, and I'm just giving you one instance of the abuse I had'. Talks about remembering everyone sniggering and laughing and that she went 'into a depression.'
37 J	0:24:41	sev	'Memories of foster mother? Yes I do, abusive, terrible and the son he hated me.'
49 J	0:11:04	sev	'It frightened the life out of me and all the girls at school laughed at me, we were in the cloakroom at the time. I felt terrible.'
49 J	0:38:57	mild	daddy used to spend more attention on Paul and then I used to have to look after Paul at school- mummy told me to look after him because he was still soiling his nappies- so I didn't really feel like anybody important
49 J	0:39:45	mod	'I don't think my mother wanted me.'
49 J	0:42:02	mod	'Yes daddy would threaten me every night. He would turn the lights out and come into my room like a ghost and I could hear my mum shouting les stop it.'

49 J	0:42:36	sev	'My step dad turned around to me and said, one day Susan I will get you locked up.'
49 J	0:48:22	mod	'I hate men and each man I chose..my husband, well he used to hit me and my common law husband he used to beat me anyway and he was a drunkard. I got away from him eventually I jumped out the window and went to the YMCA. I picked all the wrong men in my life, all the nice men disappeared..'
49 J	0:51:23	mod	'I was slow. I developed in all the wrong areas really. I developed the wrong way.'
49 J	1:10:07	mod	'I wasn't very clever (at school) in fact I was a real dunce
49 J	1:11:48	mod	'They say you pick up things from your parents- you are like your mother or father. Out of the two of them I'd have to say I was like my mother, but not in a nice way.'
4 A	0:46:50	sev	Subject talks about trying to kill himself, several times; also self-destructive behaviour like drinking.
36 A	0:00:01	mild	Subject talks about being called stupid by the whole family, "they put me down"
36 A	all	mod	Being abused and bullied is thematic to large parts of interview
36 A	0:28:30	mod	"everyone, all throughout my life took the piss out of me because my family rejected me"
36 A	0:37:30	sev	"I let everyone walk over me and I say sorry when I am wrong"
36 A	0:22:00	sev	Subject talks about putting herself down when she was upset, calling herself stupid, poking herself in the nose so the nose was bleeding, trying to cut her legs off, when she was 5 year
44 T	10	mod	'I was different to everyone else, I couldn't talk to people, I think I was insane even at that age…'
44 T	46	mild	'Maybe it was my fault, I was just born different…'
13 J	0:15:00	mild	'Oh I'm still running out of words (interviewer- it's alright)
29 J	0:11:20	mod	'Then she would start hitting me. Then if I yelled at her I'd get hit again.'
29 J	0:12:32	mod	'I was having a lot of unreasonable things forced down my throat. I was told all the time that I'm mad, I'm psychotic, I'm a liar.'
29 J	0:12:38	mod	'This progressed to the age of 12 which was incredibly frustrating to me, because once you are psychotic nothing you say is worth believing.'
29 J	0:13:17	sev	'This fighting could go on for an hour, she could go on about how mad I am, I'm the devil's child, and listening to it for an hour and trying to get a chance to say something back and being hit in-between. Sometimes I was totally wet by the time these episodes had finished

29 J	0:23:00		they worked as part of a team, mother and father together, or my mother. If my father was alone he wasn't interested enough to go looking for a problem. He'd be in the garage or something.'
29 J	0:24:54	sev	'One afternoon I actually lay in the road outside wanting to die, wanting to be ridden over. That's when I got it into my head that I wasn't going home and I stayed out all night. The police found me and tool me home and then my father beat me and did this long speech of words.'
29 J	0:34:37	sev	'When I was 14 I was sent to hospital for observation because I said I was going to kill myself.'
29 J	0:43:06	mod	'My mother and I had a very long list of things I had to deal with- of course there was an imbalance, my brother had almost nothing to do. I'm always happy to help, but then to be insulted for it and punished for doing it wrong.
29 J	0:44:22	sev	'When I left school I was a total write off. I was totally dead, I was ready to finish it.'
29 J	0:46:06	sev	'I had suicide attempts when I was 16, 18 and 21. The last time I was very nearly dead.'
29 J	1:14:20	mod	'I'm not a very confident person, I do get scared. I'm not very trusting of people generally.'
34 J	0:09:56	mod	'She'd (sister) get me at the end of the road and then she'd belittle me and shame me with all her friends and then I'd go home and be crying and they'd all be laughing and happy.'
34 J	0:31:38	sev	'I wasn't frightened or worried I was just full of shame.' (play ground incident)
34 J	0:32:00	mod	'Talking about failing 11+ and having to stand outside head mistresses room with a dunce's hat on all day.'
34 J	0:33:57	mod	'All they wanted was a cinderella, someone to do the cleaning.'
34 J	0:35:42	sev	'I would hoover under the bed and there would be a used condom, and I didn't know what to do with it- it was so abusive the whole lot, very very abusive- the shame and the powerlessness and the rage of what they've done to me and how I couldn't stand up for myself.'
51 J	0:22:22	sev	'Talks about brother being laid back and a good natured man- I wasn't I must admit I wasn't a very nice child. I was horrible to her, probably why she didn't like me. She idolised my brother, but she didn't like me.'
51 J	0:22:30	mod	Talks about how her and her mother didn't get on at all and used to argue all the time. 'I should have walked away but I always went back and said sorry, and then one day she said to me I don't want you to come back no more. I didn't see her again'- goes on to talk about how she got a phone call from her brother to say that she was dying.

51 J	0:24:00	mod	'She's say things to you and make you cry. She never came back and said oh I'm sorry I didn't mean it, she'd just let you cry in the corner. I didn't have a very nice childhood, I hated my childhood .'
51 J	0:26:11	sev	'That's the last thing I did'- goes on to explain that she didn't realise her mum was dying at the time but she wrote her a letter saying you never loved me. Her brother was cross about it 'but I couldn't help it Rob, she was always putting me down. She told me to go away from her door'. 'That's why I don't talk to him now. I haven't seen him since she died.'
51 J	0:26:48	mod	'Raymond this, Raymond that, why can't you be like Raymond, I'm not Raymond.'
51 J	00:34	mod	'She loved Mick- she thought better of Mick than me.'
51 J	0:40:23	mod	'I was devastated when my dad died- I hated it. But I don't even know where my mum's ashes are. When they scattered the ashes they didn't invite me.'
51 J	1:04:19	sev	'A lot has gone wrong in my life over the last few years and I have been blaming my mum- she made my life a misery when she was alive and I'm sure she's doing it now.'
51 J	1:05:03	mod	'Since she's died I think she's haunting me, making things go wrong in my life.'
51 J	1:11:06	mod	When she died- 'I felt like someone was punishing me then, look she's dead now, how do you feel about that then'
59 A	0:04:00	mod	Subject describing herself as a victim of other's aggression: hit by father, hit by priest
59 A	0:05:40	mod	Describing herself as victim of other physical aggression (feature a lot through interview)
59 A	0:09:50	mod	Looking for interviewer's reassurance when portraying herself as victim of aggression: 'do you know what I mean?'
47 T	1.23.00	mod	Subject talks about feeling worthless
6 T	11.3	sev	Subject talks about taking an overdose – 'I was 14 when I took an overdose.'
6T	26	mod	'When I was upset I would destroy something important to me, so as to hurt myself.'
6 T	34.3	mild	'They were probably glad to get rid of me for a little while to be honest.' (parents coping with separation)

6 T	38	mild	'I took it home to show my mum and she didn't even read it, I showed it to my dad and he didn't read it... I think that was the last time I made an effort in school...I did feel so rejected at the time that I made a conscious effort to, I thought right I am never gonna do it again....I sort of stopped trying to achieve then, you know'' (subject wrote a story at school which he was proud of, parents left him feeling 'rejected.')
6 T	43.3	mod	'She used to bully me...she used to scare the hell out of me my sister did.' Subject talks about this under question abusive.
6 T	52	mild	Subject reports visiting his aunt in hospital and saying to his aunt before she died 'I will see you dead soon.' This he really regretted and felt bad about as she died soon after.
6 T	55	sev	'I went on a bit of a self destruction mission taking loads of speed, ecstasy, cannabis and alcohol...that went on for a good couple of years...guilt, anger, loneliness, despair, yeah it was pretty severe....I just went on a self destruct mission with drink and drugs, I just went off the rails.' (subject reaction to his mothers suicide.)
21 T	0:59:00	mod	Talking about current relationship with mother- she put me on drugs at the age of 18 and took over my mothering skills. Explains how that made her feel worthless like a terrible mother when she used to feel that she was a perfect mother- I realise that she was back on drug, why would she hit me for the first time in 11 years?
21 T	1:01:07	mod	'When they took my daughter away that's when I became addicted- that was my way of self harming- another way I self harm was that I wouldn't eat.'
21 T	1:02:30	mod	'Bang my head on the wall, pull out my hair, bite myself- that was my self harm as a child I think.'
21 A	1:06:00	sev	Biting and cutting herself often when she was a child
21 A	1:01:10	sev	"to take crack cocaine was my way of self harming"
21 J	1.02.30	sev	'I used to rip clumps of hair out of my head and bite my arms, that was my form of self harm I think, I used to bite my fingers until they went blue.'
21 J	58.45	mod	'mum put me on drugs at the age of 18...'...'She got me all to herself, she hit me...'
21 J	1.01.20	mod	'she brainwashed me so much, when she was killing me and battering me and punching me I would bow, like so, you don't answer your mother back, you do you get a worse beating.'
26 J	0:09:40	sev	'Just anything, whatever I did it just wasn't right. I was really quite insignificant.'

26 J	0:35:00	sev	'Set back to development? Yes my whole experience of childhood, of violence at home, I create them, its in me now.'
26 J	0:32:13	mod	'I have to question everything, if someone is being really lovely or really good to me the first question is why? What does he/she want?'
26 J	0:32:28	mod	'I'm not used to people being kind towards me.'
26 J	0:29:27	mod	'If I answered back my mother would say- who do you think you are you don't have a father, you don't have anybody, you are a nobody.'
26 J	0:22:51	mod	specific example of emotionally upset- nun asking her to read when she knew that she would stutter when she was nervous, the other kids laughing and then being asked again to read the next day. 'I was so petrified of going into the classroom because I knew that there were times that this would happen- so what would I do? nothing, sit in the corner.'
26 J	0:15:00	mod	'When I was home (from convent) I wasn't favoured anyway, because they had other children. They had the new children whom they were more involved with, we were just like the orphans going left right and centre. The unwanted children, I think.'
26 A	0:26:34	mod	'Nothing I could have done/ what was more important was there life/ it is my life which is that, every day.'
26 A	0:11:10	mild	"my views were not counted"
26 A	0:08:00	mod	"I just can remember being so afraid of her"
26 A	0:09:58	mod	"I was really insignificant. This is what I felt"
26 A	0:15:31	mod	"We were just like the orphans, left, right and centre...the unwanted children"
26 A	0:30:00	mod	"My mother bullied me mentally, which is worse"
26 T	9.3	mild	'I was really quite insignificant to my mother, this is how I felt.'
26 T	15	mild	'I was not the favourite, they had new children, we were the unwanted children going back and forth, like orphans.'
26 T	45	mod	'I have been bullied from a young age and she is still doing the same things now (mother) and I cant allow this to happen, that is why I am here that is why I ran away.'
37 J	0:02:08	mild	'I can't get my head around it to be honest, it didn't make me feel very good, being the middle child as well, I put it down to being darker and in the 50s being mixed race-or black as they wanted to call it-wasn't acceptable, and that's the only conclusion I've come to.'
37 J	0:11:41	mod	'I always felt that I didn't fit in, I always felt that I was the black sheep of the family and even now I feel like I am different from all of them because they made me feel that way.'

37 J	0:13:15	mild	'It was made very clear to me that I was different by the words that she used and the word that he (step father) used, I have no time for him what-so-ever.'
37 A	0:02:10	mild	Being put into care because she was darker of skin colour
37 A	0:54:40	mild	Correcting herself: "bloody hell, it was not last year, it was this year"
37 A	0:11:40	mod	"I felt I didn't fit in there (family)" "I also was the black sheep of the family"
37 A	0:52:45	mod	stepfather: "he made it very clear that he didn't want me"
37 A	1:06:00	mod	talking about own illness, drug addiction and own anger
37 A	0:57:10	sev	"the older I get I wonder: 'what's the point going on'...at times it seems pointless"
37 A	0:46:30	sev	talking about death: "I can't wait till my time comes, that's how I feel"
37 T	43	mild	'I did not feel good enough, I did not feel clever enough as other people.....'
31 J	0:13:26	mod	'Even though I passed all the entrance exams (for grammar school) they turned me down because I was brought up by my grandmother and they were worried she wouldn't be able to pay the fees- that's where my life really started to fall apart-before that everything was about education- goes on to recount another incident.'
31 J	0:16:02	mild	'I can remember her always saying, you'll be sorry when I'm gone, and I am- I wasn't there for her when she needed me because I had been told to stay away from the family- they didn't want me.'
31 J	0:17:37	mod	'I can remember my mother always calling me fat when she was around- I mean I would call myself a little round kid. I was a size 14 in clothes by the time I was 12 years old. But even if I saw my mother today, by her eyes I'd be fat, but now I know she had an eating disorder.'
31 J	0:25:49	mild	'I can't forgive myself for that.'
31 J	0:26:14	mild	'So that made my mum call me thick and stupid and things like that.'
31 J	0:27:32	mod	'Felt rejected? Always when you grow up with the kids at school that have at least a mother or a father you get told- they didn't love you, they wouldn't have left you if they'd loved you. So I've always felt that, its something that's never gone away.'
31 J	0:28:46	mod	'My mother and father, I always felt that they deserted me- I got told again at 14 by my mother that she never wanted me- she wanted a boy, why couldn't I wear dresses, I was fat, I was ugly, I was no good.'

31 J	0:31:00	sev	Did she realise that she was rejecting you at the time? 'I think she did because when we have had contact since then, which was for about 6 months last year, before I took my overdose, she turned round then and she apologised for all of it.'
31 J	0:31:40	mod	'I told them I'd taken an overdose and that I'd be starting here and I've not had a phone call, a letter, nothing. I'm the nutter who 100 year ago would have been locked in the loony bin- they don't want to know, so I feel it all over again, the rejection.'
31 J	0:34:15	mod erate	'My mother hit me right in the face with a wooden clog when I was 14. I ended up with black eyes, bruised neck.
31 J	0:35:50	mod	'and like with this last relationship I end up doing everything for them and they want a mother. They want someone to cook, clean, care for them.'
31 J	0:37:53	mod	'and in some ways it makes me feel as though I'm not really female.'
31 J	0:38:02	mod	'When I had my son I was terrified of being like my mother, and I lost him. I put him in to voluntary care and they took parental rights off me...and that is all because of what happened.' (17 years old at the time)
31 J	0:38:34	mod	'I only had him for three months and they took him off me- and that's something you can't live with you blame yourself for it- what if, what if I'd had family around, someone I could have lent on when I needed it?'
31 J	0:38:49	mod	'and then I started remembering how my mum had treated me and I thought, what if I start picking him up and throwing him around, what if I hit him? So for his safety I put him in care.'
31 J	0:39:00	mod	'I never got him back. So in his eyes I've done to him what my mother did to me. I deserted him, so that's another life down the line that's ruined.'
31 J	0:39:51	mild	'Why did they behave as they did? My mother because she was ill- but she won't admit it.'
31 J	0:40:17	mod	'Recalls incident of seeing step father arguing with mother and telling her she was mad and butting in to stick up for mother- 'but perhaps if she had got help then....'
31 J	0:40:46	mild	'I think she was scared of the label, but that's something I refuse to be scared of- it is who I am, it's part of me.'
31 J	0:42:20	sev	'But also because I am the one who should be locked in the mental institution, locked in the attic or the cellar and forgotten about.'
31 J	0:46:20	mod	'Roughly between childhood and adolescence- anger, I was really angry- when did that start- probably when I was about 9/10 years old. I would just argue with her over nothing. Looking back now they were all silly little

			things...but I kicked her, fought her, called her allsorts of names...I was nasty, a nasty piece of work.'
31 J	0:48:15	sev	'I'm not capable of it so they don't need me, I'm surplus to requirements- they can forget about me conveniently now. It happens.'
31 J	0:50:51	mod	'You can only hope that the future is going to be better- but sometimes its hard because sometimes you don't see that far.'
31 J	0:50:58	mod	'Somebody says they are going to phone you on a particular day and they don't maybe they've got another appointment or something- for most people they'd say oh well they'll phone another day, but I'm like, what have I done they are never going to phone me again. and that's hard, I don't think that'll ever go away.'
31 J	0:51:53	mod	'For me personally I think it's too late. I don't think things will change.'
31 A	0:16:10	mild	"I am thinking about the things that I have done to her...that I wasn't there for her when she needed me...but the family didn't want me there" (talking about grandmother)
31 A	0:27:45	mild	Talks about having always felt rejected
31 A	0:39:10	mild	Giving up son for adoption: "I did to him what my mother did to me: I deserted him. So another life down the line was ruined"
31 A	0:46:50	mod	"I was nasty, a nasty piece of work"
31 A	0:31:27	mod	"When I needed the family, not necessarily her (mother), they have not contacted me since. (talks then about being sectioned after taking an overdose)...I did not have a letter, a phone call or anything. I am a nutter, that a 100 years ago would have been locked up in a looney bin. So I feel it all over again...the rejection...and I know it affects me in my relationship with other people...it's a big stumbling block... that how life goes."
31 A	0:48:18	mod	"I am surplus to requirements..they can forget about me conveniently now"
31 A	0:36:15	mod	Relationship with someone: "I am getting to think now that it ain't gonna happen.'
31 A	0:42:20	mod	"Because they know I am not strong enough. Also because I am the one who should be locked up in a mental home, in an institution, locked in the attic or in the cellar and forgotten about"
31 A	0:51:53	sev	"...I think for me its too late..."
31 A	0:31:10	sev	Talks about having taken an overdose
31 A	0:25:55	mild	Talks about being separated from grandmother, and not seeing her again: " and I can't forgive myself for that"
35 A	1:12:31	mod	'Everybody took what they wanted and nobody gave me anything.'

35 J	10:00	sev	'She wanted my sister and my brother and that's it.'
35 J	10:21	sev	'Unwanted, she said she tried everything (to abort the pregnancy) she made exercise you understand?'
35 J	18:26	very mild	Subject apologises for her English and her difficulty remembering things
35 J	26:31	?	'I'm nervous do you understand Anouschka?'
35 J	35:16:	sev	Talks about him holding her and dropping her on the floor and how her teeth get broken 'I am a small child, a small child'
35 J	37:14:	sev	When upset what would you do? 'Take the tablet, I want to die.'
35 J	38:11:	sev	'I take pills everyday until 13-14 years (from 11/12) and I wonder how I am still alive when I wake up.'
35 J	39:10	sev	'When he hit me I said to him you destroy me.'
35 J	43:13	mod	'Of course because my mother doesn't like me- goes on to talk about how mother would protect sister from father but not her.'
35 J	22.45	sev	Subject describes taking an overdose when she was 11 due to wishing to 'I want to die.....finish, sleep.' She spoke about 'being very afraid and wanting to escape and ugly life, reality and family.'
40 J	0:27:52	mod	'I don't think that I lived up to her conditions to get her love.'
40 J	0:28:22	mod	'I would always be anxious coming home from school thinking have I done something today that I could get into trouble for?'
40 J	0:28:24	mod	'Do you know I have never stood up to her- I've never told her. She would always shout me down and I think that that is part of my problem, I need to tell her what I think of her.'
40 J	0:35:50	mod	'I was never good enough- I wasn't my mother's favourite because I was never going to amount to anything and I wasn't my father's favourite because I thought he was an idiot and you could see it in my eyes.'
40 J	0:36:49	mod	'I feared greatly my dad (following discussion about him physically abusing older sister) because a) I didn't think I was good enough academically and b) I didn't want him to hit me.'
40 J	0:40:53	mod	'Looking back on it I suppose I must have been quite a hard child to raise really because I've always been solitary- If I have a problem I just deal with it by myself.'
40 J	0:43:30	mod	'I don't think that we really had a relationship (with mother). Talks about how she was competent at lots of household chores due to her upbringing in Barbados- offered to help mother at home in UK and she 'barked' at her 'get away'- reflects that this might just have been 'her way'

40 J	0:44:40		'My mother always used to say that I was rough and that sort of think so she always made me feel awkward'
40 J	0:49:41	mod	'Adulthood- I always worry that someone is going to hit me and common sense tells me that that's not going o happen, but I do worry about that.'
40 J	0:56:10	mod	'I think I've always been depressed since I was about 9 and it just got worse.'
40 J	0:59:02	sev	'Coming here (to London) is the worst thing that ever happened to me- I've never felt loved, I've never felt wanted.'
40 j	1:12:41	mod	'I would ask her the next day are you alright? And she would start having a go at me....so even my sympathy wasn't worth anything.'
40 J	1:20:23	sev	'Everything I do I destroy myself.'
40 J	1:21:00	sev	'Left me doubting myself- feeling I'm not good enough- no body takes me seriously.'
40 J	1:22:00	sev	'Damaged goods- referring to herself- interviewer drawn to reassure her.'
40 J	0:40:45	mild	(why she can not remember being held) " I must have been a quite difficult child to raise...because I was, not solitary, but because I always kept to myself"
40 A	1:24:20	mild	"I wasn't the best mom, there was room for improvement"
40 A	0:35:45	mild	Talks about being unimportant to her parents
40 A	0:28:35	mod	"I never stood up to her, and I guess that is part of my problem."
40 A	1:20:30	mod	"everything I do is kind of destroying myself"
40 A	1:20:30	sev	"I am not pretty, I have no saying, I allow other people to use me...."
40 T	25.3	mod	'The first time I tried to do something, it results in something bad...' (being hit by mother.)
40 T	28.3	mod	'I have never stood up to her, she always would shout me down and I think that's part of my problem.'
40 T	35.3	mild	'I was never good enough...I was never going to amount to anything.'
40 T	49.15	mod	When talking about how her mothers behaviour effects her now, client says 'I always thinking that someone is going to hit me..'
40 T	56.3	mild	'I might be the mother from hell....'
40 T	57.47	mod	'I don't trust men, I don't really like them very much...you cant trust them with your children.'
40 T	58.3	mild	'I have never felt loved, I have never felt wanted and I have just carried that through my whole life.'
40 T	1.17.30	mod	Subject describes being beaten by her mother for a whole week and not being able to convince mother that she was not lying, she told her father 'she has been hitting me all week.'

40 T	1.20.00	mod	'Basically my mother destroyed me.'
40 T	1.20.00	mod	'Its like everything I do, its like a want to destroy myself.'
40 T	1.20.15	mod	'its always left me doubting myself, its left me feeling not good enough, its all right for people to use me and take advantage.'
40 T	1.21.45	mod	'damaged goods…' subject makes a derogatory reference to herself
22 T	0:21:34	mild	'I just felt like I wasn't my mum's…a proper child's thought, I just don't belong to you two at all.'
22 J	0:46:31	mod	Recounts memory of her and her brother playing with the phone and her father becoming angry and going for her. 'I was like, Micheal was doing it too and he was like, I'm not interested in Micheal' recounts him chasing her up the stairs and in to her room and being her frightened.
22 J	1:00:25	mod	'I remember trying to get up on my mum's knee and my brother could do it because he was taller, and her laughing and saying you can't do it. I thought that was awful. And her picking my brother up a lot because he was lighter than me.'
22 J	1:00:33	mod	'I remember her saying, I can't pick you up you little fatty, and it was horrible.'
22 J	1:07:18	mild	Talking about close relationships- 'I don't really trust people and very little trust in the close relationships I have with people….I don't really expect them to last. I expect the kind of behaviour I'm used to I suppose.'
22 J	1:10:09	mild	'I do feel pretty pessimistic and I think that has come from a lack of confidence straight down the line. They weren't the kind of parents that praised you and as a result I don't go around praising myself.'
22 J	1:10:36	mod	'She taught me to be ashamed of myself and I really do feel ashamed of myself most of the time.'
22 J	1:18:02	mod	'Yes I was only a child but I wasn't allowed to grieve because there were more important people…sorry what was the question?'
22 A	1:00:10	mild	Remember feeling rejected "all the time: it was horrible" "remember being called 'little fatty'"
22 A	1:00:10	mild	Talks about her brother being easier child, more special to mother
22 A	1:13:55	mild	"This is really, really negative…should I focus more on the positive?"
22 A	1:10:50	mod	"I really do feel ashamed of myself most of the time"
22 A	1:12:30	mild	"I am a bit of a martyr"
22 a	0:42:00	mild	Feeling ignored by father "he wasn't interested"
22 t	5.3	mild	Subject talks about how her older brother 'did not really want me around…'

22 t	15.1	mild	'I remember my mum not wanting to pick me up…' 'I remember being upset about it.'
22 T	40.3	mild	'Sorry, I am taking so long…' subject apologises when thinking of adjectives.

2.2. Self under evaluation dialogue exerts for the control group

Number/ interviewer	Time	level	Interview exert
5j	0:20:18	mild	'After I had had tonsillitis a few times my mum would be like 'oh come on you don't need to do this' but I still reacted in quite a childish way I guess.'
5j	00:22:36	mild	'Having such a big family I think I felt rejected a lot of the time if someone was being paid more attention than me- describes time when sister left for uni and she was the centre of attention.'
5j	00:34:47	sev	'That was the period when I felt really low and would cut myself- because it was at that time that I started to think that I would like to have a father, and I was getting bullied (at school). It was just that whole period that was really crappy.'
5j	00:39:29	mild	'So often I was comparing myself to my older sisters that I kind of lost myself a long the way.'
18j	00:00:33	mod	'I was frightened of my father until I was about 8 or 9, to the degree that I used to lock myself in the cupboard if he was coming in.'
18j	00:19:26	mild	'It was mostly about his desire to have a son.'
18j	00:59	mod	'Feelings at the time? Devastated. I wanted to throw myself in after the coffin. In fact I nearly did, I was held back.'
20t	3	mild	'The earliest I can remember is 7, I am a bit behind.'
20t	30….	mod	Subject describes being rejected by almost everyone in her 1st school (children and teachers) and being unpopular in her 2nd, she described name calling and one physical attack which resulted in her becoming 'upset,' 'shy', fearful of it happening again in new school and 'hypersensitive'.
20t	40.15	mild	'My dad became a little more threatening and my mum became less patient, but now she think about it they had to put up with me for 12 years, so she was pretty good.'
20t	51	mild	Subject talks about feeling 'responsible' for the suicide of her school friend, also adds, 'I felt bad and felt it was slightly my fault…'
20t	1.6.00	mild	'I don't think I would be a very good mother…'
33t	7.30	mild	'I suppose it was more my fault…' Subject takes the blame when describing her early relationship with her mother as tempestuous

7j	00:05:36	mild	'What do you expect me to say?'
50j	00:09:42	mod	'I remember being at home with my mother and getting into arguments with her- not when my father was home, because he would blame me.'
50j	00:12:24	mod	'I didn't used to shout back because I was too scared so it was more him being angry at me.'
50j	00:13:00	mod	'If we went to family and friends and I was very quiet he would have a go at me. I was just a shy child.'
5oj	00:13:26	mod	'It was unfair the way he treated me because with children you have to expect them not to be perfect or to know what to do on the first day.'
50j	00:13:37	mild	'I always did well at school and was well behaved at home I wasn't noisy so you'd expect him not to be that angry or disappointed in me..so I think it was unfair that when he was tired or an a bad mood he would have an excuse to shout at me.'
50j	00:14:33	mild	(cousins) 'I used to get the feeling that if I did half as much as what they were doing I would be in so much trouble.'
50j	00:17:40	mild	'Usually it was because of them (upset) so they'd already be angry at me and I wouldn't be able to talk to them.'
50j	00:18:40	mod	Description of how she would hide in the bathroom to try to avoid her father when he was angry but that that would sometimes make him worse.
50j	00:18:55	mod	'Ill? Well what ever happened I was forced to go to school. Sometimes it was a little harsh because I might be pucking and they'd put me in the car and give me a little bowl to puck in.'
50j	00:21:05	mod	Talking about school trip- even if I didn't really have that many close friends
50j	00:21:22	mild	'Well they said they missed me- they do miss me when I'm away.'
50j	00:22:22	mod	'Fear- it would be a normal state of mind when I was at home. I felt like if I breathed wrong something bad would happen. So I was quite worried and scared most of the time.'
45a	00:23:05	mild	"I am the black sheep of the family"
45a	01:16:10	mild	"I am glad that I was not in my parents situation when they had to deal with me"
45a	00:47:00	mod	Having felt rejected all her life, and still "because I was rejected, now I play that part, no problem"
10t	48	sev	Subject talks about having temper tantrums as a child, clawing at his legs in order to hurt and 'punish' himself
10t	56	mod	Subject talks about children at school not wanting to be around him when he had measles his friends at school rejected him thinking he was 'nasty' and 'I got made fun of and stuff like that…'
10t	1.4.30	mod	Subject talks about being bullied by other children, 'wanting my mum' and being called 'goggle eyes.'

54t	2.15	mild	'I talked about a science project, which was about space or something, something stupid...'
54t	23	mild	Subject recalls feeling that she was annoying to her mum, 'for just being there' at times.
54t	38	mild	Subject reports that she does not like herself and often assumes that others do not like her either.
54t	42	mod	Subject wonders if her parents thought she was boring and would have preferred her if she had been more like her younger sister. Subject wonders if her mum did not like her or get her. She later adds that she felt her mother did not want her to return home after uni.
54t	51/ 53	mild	'I talked about a science project, which was about space or something, something stupid...'
41j	01:08:00	mod	Talking about how the people she works with in her laboratory pick on her and turn their backs on her.
41j	01:10:45	mod	'They tried to convince the professor that I don't deserve the prize- something like that!'
27a	00:41:00	mod	Talking about how she was worried to be given away again and about brother bullying her
27a	ALL	mod	Topic of being the victim of mothers/brothers aggression;
46a	00:30:15	mild	Excluded by siblings because "I was really annoying"
46a	00:08:10	mild	Describes herself as "quite spoilt", blaming herself for relationship quite tempestuous
46a	00:29:00	mild	"I was sort of the afterthought in the family" feeling rejected by her sister and her brother but not by parents
25t	4	mild	'I wasn't her favourite grandchild...'
25t	1.27	mild	Subject expresses guilt over death of her husband, 'I should have done more...'
3j	00:10:30	mild	'oh sorry I can't think of anything, sorry (when asked for specific example for 'trusting'
3j	00:18:39	mod	'He was annoyed I guess that he had made this big effort to drive me down there, so he was like 'oh you stupid girl', but at the time it was upsetting.'
3t	26.15	mild	Subject describes how parents would not be upset at being separated from her, 'I was the youngest child and they had been through it all before, I don't think they would have thought oh it's the first day at school....'
14j	00:02:36	very mild	'How do you mean? I don't know what to say.'
14j	00:05:20	very mild	'sorry, I can't...trails off.'
14j	00:12:36	very mild	'I'm really not sure what to say, I can't remember.'
14j	00:13:58	very mild	'That's all I can think of, I'm sorry.'
14j	00:14:11	mild	'is that ok? Sorry I'm rubbish'
14j	00:17:02	mild	'I'm trying to say that in a word, my vocab is so bad.'

14j	00:37:58	sev	'I took an overdose again at 15 because of the boyfriend- I was really upset.'
14a	00:16:50	mild	"my vocabulary is very bad"
14t	7.30	mild	'this sounds so lame…' subject makes derogatory comment about her descriptions of childhood memories with mum
14t	14.50	mod	Subject apologises repeatedly for not being able to think of more adjectives for her father and mutters under breath 'it's a bit rubbish' (felt to be directed at self not interviewer)
14t	33.17	mod	Subject asks the interviewer 'is that the right answer' after she has answered a question interviewer reassures that it is fine.
14t	36.5	mild	..'this sounds really stupid but…'
16t	8.45	mild	Subject talks about being a difficult child who drove her mother to desperation. She mentions a couple of times earlier as well, (point appears to be laboured somewhat) e.g. being stubborn, not easy and bad behaved.
17j	00:17:28	very mild	To interviewer: 'can I use strict?' …can I use angry
17j	00:32:34	very mild	Subject reported how mum would be 'fine' when separated from her and even 'she seemed to say she liked the time away, she seemed ok with it.'
17j	00:42:00	very mild	Effects on adult personality- 'with my mum- nobody would ever guess that she was like that. I think she has two personalities, sometimes she can be really jumpy and nice and friendly and big and everyone sees that side of her, so when I look at other people I think what you get is not always what you see.'
17t	9	mod	'Subject describes mums verbal aggression towards her 'she got really really angry with me..angry and shouting at me…' and subject describes how as a result she would feel 'scared and worried.'
17t	12.4	mod	Subject recalls her mother becoming very angry, lashing out, chasing her, shouting, not knowing when to stop and as a result subject would run away and 'cry and cry and cry'
17t	32.45	mild	Subject describes feeling rejected by dad when brother was born; 'I thought that he wouldn't think about me much now that he has a son…' subject recalled 'I would just really ask a lot of questions to see how dad really felt…'
19j	00:07:09	mild	My brother was always closer with my mum and my sister with my dad- just family dynamics
19t	17.15	mild	'Looking back he didn't seem that bothered really…' Subject describes her dad finding her after she had fallen down the stairs aged 4 yrs.
39a	00:34:20	mild	"I was very childish, when I was a child"

2.3 Self under evaluation thematic categories and frequencies for both groups

SELF UNDER VALUATION Thematic category / Sub-theme	**Frequency in the control group**	**Frequency in the clinical group**
Themes of aggression towards the self	11	55
Self punishment	1	1
Self criticism/ putting self down	5	24
Attacking the self physically (self harm)	4	16
Unforgiving of self	0	3
Thinking/ fantasising about death	0	11
Themes of harm and rejection by others	42	134
Helplessness	2	12
Paranoia - expectation of harm	2	18
Feeling unloved and rejected	8	34
Fearfulness and intimidation	6	19
Feeling low in value to others	5	14
Vulnerability	4	14
Being mistreated (forced, used, hurt)	5	20
Not being cared about/ thought about	4	0
Being a burden	3	0
Being disliked by peers	3	0
Serving others	0	3
Themes of failure	4	24
Not being good enough/ lacking	3	12
Expectation of failure	1	3
Doubting and questioning the self	0	4
Enlarging and generalising own failures	0	5
Themes of being different and alone	4	19
Being different/ not fitting in	1	10
Sense of aloneness, separation, isolation	3	9
Themes of the self being harmful to others	4	15
Self felt as being harmful to others	2	5
Self blame	2	10
Insecurities with interview performance	12	9
Critisising/ doubting own interview performance	5	4
Seeking reassurance in the interview	2	5
Apologising in interview	5	0
Themes of hopelessness and shame	0	23
Idea that the self contains a badness	0	2
Feeling shameful (for things done to them or done by them)	0	9
Hopelessness	0	12

2.4 Self over evaluation dialogue exerts for the PD group

Number/ interviewer	time	level	SELF OVER CLINICAL interview description
60 J	00:24:14	mild mod	'I was top of the class and then third so I did well in school, and physically I was bigger than most, although I never actually bullied anybody or fought anybody- but I suppose it gave me a sense of confidence that I was above average in both areas.'
8 J	00:39:04	mod	'I never got on with my sister we were always fighting, we never played the only game we played I remember she actually took my head and hit it against the wall. She was very jealous of me.'
8 J	00:39:29	mild	'I was very very close to my mum when I was little. I was always holding on to her skirt. My sister was always very jealous of that because I was always getting her attention.'
8 J	01:11:36	mild	'My mum was really upset (when she left her to go to school) apparently she was very upset, I can't remember that because probably I was too upset to realise that.'
8 J	01:20:38	mild	'Everybody knows that she was very proud of me and my sister. She would die for us.' (mum)
11 J	00:53:15	?	'I've not met anyone else who has actually ever worked that hard.'
49 J	00:17:23	mild	'I thought mummy was always jealous of my boyfriends'
49 J	00:40:00	mild	'Because looking back on it I was a threat to her femininity because mummy had been ill so therefore there was a lot that she couldn't do as woman for herself and daddy was still young and he had taken to drinking more.'
49 J	01:04:47	mod	(mother's death) 'at the time I was living with my common law husband, so he helped me through a lot and I cleared all the clothes up and took them down to the charity shop because my stepfather couldn't do it. In fact I was a rock- the only one who could take it all in hand really.'
36 A	00:13:30	mild	Talks about her achievements at school "I knew all the answers"
44 T	9.15	mod	Subject goes on to replace the interview question about his early relationship with his parents with an episode on his bike when he was two. He states that it is more important to cover this and will go on to address the other question later.
13 J	00:41:02	sev	'People have told me that I sound more like Alice Cooper, because I've got more of a growl than he has.'
13 J	00:44:22	mild	'Talking about childhood illness and how he faked well to get back to school...I've never been to the doctor so much they were really concerned- every two days they'd come in and take my blood pressure.'
13 J	00:45:00	mild	'My mum made sure that that happened.'

13 J	00:46:16	sev	'I've always been a freedom fighter you know.'
13 J	00:46:37	mod	'Little did the teachers know that this illness that was building up in my head would one day threaten my life. People didn't understand that I was having panic attacks'
13 J	00:47:27	mod	'Obviously because I was having panic attacks I did put up a fight. That's the naivety about some schools that I don't really like...they should have been able to tell (about panic attacks) if they were as good with kids as they are.'
13 J	00:48:38	mod	'I was actually frightened for my life that's why I laugh at that stuff now. It fascinates me that people can be so naïve about a potential mental disorder.'
13 J	00:49:22	mod	'I'm way over it now (dad leaving) because I've actually lost two emotion senses due to my illness. It's actually numbed me.'
13 J	00:50:22	mild	'It's the pressure of time. Like going on one of my runs. I've done one mile, I've got another 7 to go- you put that in to months.'
13 j	00:51:49	mod	'When I was actually in hospital when I was 16 I was in a very bad way. I had a very major case of impulse bulimia. That means you love doing it you just want to do it. I've got a recovery part of it now. My mum was obviously very traumatised by the way I turned out. Everyone was just burned out, they couldn't handle it really. I was actually very disappointed, I thought that was unfair of them really because they don't have to look. I have to look I have to feel, I have to be there the whole time.'
13 j	00:52:56	?	'They could take a break. They had about a months break from it. She didn't want me to come home. I come home and felt so unwelcome there. They just said stay in your room. 'Forgive me for being ill' so I thought sod it I'm going to move out. After that the relationship improved because she had that space.'
13 J	00:53:30	mod	'I don't think hospital was actually the answer- goes on to describe advice by psychiatrist at the time.'
13 J	00:54:34	mod	'My mums a lot more sensitive than me. Not a lot of things bother me that much..I'm not light hearted I'm very hard hearted, and I'm not faint hearted either.'
13 J	00:55:15	mod	'I could deal with you know...if one of the animals died it was me that had to bury it. No body else could hack it. That kind of explains why they couldn't deal with what I had to deal with. Basically I felt like I was wasting my time with living at my mum's.'
13 J	00:55:59	mild	'I decided to move out and nurse myself back to health.'
13 J	00:29:04	mild	giving photos of family to the interviewer to look at
13 J	00:32:12	mild	'He's only 5ft 5 and so he can feel a bit insecure. Last time he saw me and my brother we were already half a foot taller than him and he felt a bit intimidated by that.

13 J	00:38:37	mil	'I actually started marshal arts at a young age. I was 12 when I started...recently I was telling him that I had got another grade and all the training it took and he was like 'why are you telling me this I've been there, done it' he's like a kid.'
13 J	00:59:10	mild	'Then there'd be a struggle and I'd put up a fight. That's when I started kung-fu.'
13 J	01:05:17	mild	'It's hard to really say what my true personality is. I finished childhood with an eating disorder and started adulthood with an eating disorder- and that colours a lot things of your personality. All you care about is your rituals.'
13 J	01:06:00	mod	'What I've been doing with the years is finding out what I really want to do- healing oneself you know. That's why I went back to reading Bruce Lee because that's what he used to have to do for himself.'
13 j	01:06:58	sev	'I am very wise in comparison to some kids I know.'
13 J	01:07:17	sev	Talks about how a lot of people he went to school with became young parents and boys that went to prison. 'When I see how these kids turned out I think I'm actually quite sensible.'
13 J	01:08:06	mod	'All of these things I've learned either from my mum or from marshal arts philosophy.'
13 J	01:10:13	mod	'Even now she takes me and Jo (grandmother does) on an adult holiday. She knows we don't like going on a holiday with kids, its depressing.'
13 J	01:11:08	sev	'My uncle Mick he was actually tragically run over by a lorry in London.'
13 J	01:11:59	sev	Talking about going to a medium who contacted his uncle. 'No one knew of my eating disorder, only my brother knew'
13 J	01:13:22	mild	'My mum she was obviously in tears over it you know.' (talking about his eating disorder)
13 J	01:13:44	mod	'I've always been a believer in the paranormal so it wasn't really upsetting for me. To be honest I was already in the process of loosing my emotions anyway.'
13 J	01:14:56	sev	'I've always been one of those people who finds is easier to get my head around death than other people.'
13 j	01:15:42	mild	'That's the thing about me I'll just go in to like a static shock, like I'm trying to process it you know.'
13 j	01:17:13	sev	'All the family know that he was probably my guardian angel when I was ill.'
13 J	01:19:19	mild	'And I'll thank him when I see him. It does reassure you that you'll see him again cause I've studied the paranormal- goes on to explain that he knows how ghosts form.'
13 J	01:20:47	mod	'I've lost the cat that I have had since I was 2 years old very recently- because I've got no emotions I just buried him without feeling a thing.'

J 13	01:23:32	mild	'In comparison to being ill nothing in the past really compares to that. That's why its hard for me to remember.'
29 J	00:48:22	mild	'I did go to the top person that I could find.'
51 J	00:41:02	mild	'He used to take me every where- he wouldn't take my brother he'd take me.'
24 A	00:51:30	mild	"yes I had two other interesting experiences"
24 A	00:16:45	mild	"I was quite capable"
24 A	0:10:45	mod	To interviewer: "I believe the other (example) was even more interesting slightly outside the parameter of being normal here...so you can edit it out, just put it in your, you, your memory of delights of human behaviour, human experience..uhm..like the occasional jewels, the little sparkling, gems...of human existence, human experience"
21 A	00:20:25	mod	"I was very intelligent, I knew everything....I believe in special powers"
21 A	00:26:20	mild	"all my cousins were jealous of me living with her...but I am the fortunate one"
21 A	00:22:00	mild	Talks about being her grandmother's favourite
21 A	00:48:50	mod	Not being able to argue with woman: "because my vocabulary would be too much for her"
21 A	00:57:00	mod	"I used to make bottles from the age of five...I knew what I was doing...from a very early age" "..I know so much now"" I am fed up with the world putting me down, I have a lot of good stuff inside of me...I write a new poetry (quotes poem)"
21 A	01:14:00	mod	"that is what I believe and what I believe, works"
21 A	01:03:00	mod	"I am such an old woman in my head, I am so full of wisdom...potentially I am a millionaire"
21 A	00:27:40	mod	"my little sister is not racist, and she is not racist because I am teaching her"
21 A	01:29:30	mod	"I felt supernatural"; "I got hit by a car and could have died, but I didn't die" - making a point for her strenght
21 T	14.15	mild	'There was not much focus on my brother, it was all on me, my mum looked after my brother and my grandmother looked after me..."
21 T	26	mod	Subject talks about cousins being jealous of her and wandering if she could be as gifted and good as her grandmother, 'maybe I am the next one of her? Am I the next Eileen?'
21 T	31	mod	'I never did nothing wrong, as far as my granny was concerned I was an angel, I never did nothing wrong...' Subject goes on to talk about how she was treated in a more special way than other relatives.
21 T	39.37	mild	'I am the oldest sibling that can read or right, I have qualifications, I have a number of things my siblings don't have...they say little Eileen did it'

21 T	58.3	mild	Subject talks about writing a book one day of all her memories, and how bad memories 'wont break me,' and how she always bounces back from negative experiences.
21 t	1.25.15	mild	'I felt so strong one day, so strong, like supernatural…'
21 T	1.28.50	mod	'I am fortunate I am here to do something with this life and in this world...'…'I am very determined, I impress myself, if you love yourself you can do anything.'
21 T	48.3	sev	Mum: subject talks about being more intelligent than her mother and having a better vocabulary. Grandmother: 'she was my queen, she was the food to my soul…'
21 T	12.15	mild	'Granny thought the sun shone out of my bum, she thought I could do nothing wrong, that butter wouldn't melt in my mouth..'
21 T	1,03.15	mild	When asked about what she had gained from childhood: "I am full of wisdom, big women ask me for advise….potentially I am a millionaire, with what I have been through I think I am in line with a professional and I should help people.'
35 A	00:19:10	mild	"I am very young, very cute [then]"
35 A	00:06:00	mod	(talking about sister) "because she is jealous of me, because I am prettier than her (….) I have human sense, I am very good heart, because I can the attract people (…) nicer hair, nicer make-up, nice clothes, (…) she is very complicated, different personality"
35 A	00:15:50	mild	"I have beautiful hair, I always had beautiful hair, even now, look, I am 46"
35 T	5.3	mild	'She jealous of me, 'I am prettier than her and ….I can attract the people, nice clothes, nice hair nice make up.' Subject compares herself to her sister.
35 T	1.25.00	mild	Subject speaks to interviewer about how strange all this must seem to her and how she must understand that her family's background is in Cairo which is very different to London.
35 J	09:02	mild	Talking about mother encouraging her to buy expensive clothes- I buy expensive clothes because I was born like that
35 J	10:44	mild	I showed Bess, my key worker the picture. In the picture I am very nice, very elegant, but it was not like in the picture.

2.5. Self over evaluation dialogue exerts for the control group

Number / interviewer	time	level	SELF OVER NON CLINICAL interview description
10 T	5	mild	'I always surprise people with my earliest earliest memory….'

10 T	15	mild	'I had a fiery temper, the incredible hulk would have a hard time controlling me'
10 T	1.1.30	mod	'As far as I was concerned they (parents) were pretty much my servants, clean me, feed me, do what I say, that was pretty much it!' laughs. Subject describes how he felt as a young child.
10 T	1.2.30	mod	'Even at a young age I knew I could make friends that easily, it wasn't that hard…'
10 T	1.12.00	mild	'Quite frankly Limford Christie would have had some trouble trying to catch up with me…' 'I left the dog in my dust…'
10 T	1.27.00	mild	Subject likens himself to superman in the movie and talks about 'I know what's going on I know more about things than people on the street…'
10 T	1.34.30	sev	'I have had some experiences which most people might consider traumatic, but they bounced off my back quite easily…' He then goes on to say how lept into the air and somersaulted to avoid being hit by a car as a child. Lots of boasting about own ability.
10 T	1.44.30	mod	'I have a very idiosyncratic approach to life, just in case anyone is watching this that doesn't know what that means, it means I have my own approach…' 'I have a very philosophical, practical, pragmatic and very fluid approach to life …I am a very spiritual person…I shape myself like a bonsai tree into something beautiful…'
10 T	1.49.45	mild	Subject refers to himself as his nephews 'special' uncle.
10 T	1.50.00	sev	'I think I would be a very good parent….I have this running joke with my friend that if I have kids they would eventually take over the world….due me shaping them with my personality…'
1 A	00:40:25	mild	(grandfather) "and I was the only one to be allowed to sit with him"
1 A	00:42:00	mild	"I did the cutest things"
1 A	00:19:40	mild	Talking about what a special child she was, because she was the first daughter born for 24 years into the family.
1 A	00:23:30	mild	"By the time I was 13 I read Thomas Hardy, Dickens.."
1 A	00:45:20	mild	"So me and my older brother are very focused and directional. My younger brother has no direction what so ever"
1 A	00:53:15	mild	"Well, the interesting thing is that I think I had a very high level of independence from an early age because my first memory is a nanny and a dog"
1 A	ALL	mod	Mildly critical with interviewer, correcting interviewer, somewhat annoyed
1 A	00:30:45	mod	"I was really flattered that people came to my father's funeral, as I realised he had a greater impact then I realised"
1 A	00:32:45	mod	Talks about having to take care of cousins children because mother just abandoned them.

1 A	00:34:20	mod	"there are things in my life that are too small to dwell on them, because I have space in my brain only for a certain number of things and unfortunately in the last few years my brain space has been filled up by other things"
1 A	00:35:50	mod	Bossy with interviewer: "you put down religious and spiritual together!"
1 A	00:30:20	mod	Does not answer question interviewer had asked: "well that is what I said before" then not really answering question.
1 A	00:21:10	mod	Bossy towards interviewer: "well you can take it down as one and then we can explore it as two (adjectives)!" then: you need to put them as two different words!"
1 A	00:23:30	mod	Taking over interviewer's task by not sticking to question: ties up the first three adjectives
1 A	00:09:40	mild	Talking about mother smacking her when she was a child "and after some time it didn't have any impact on me, I just thought 'smack me if you like'"
1 A	00:07:20	mild	"That is another interesting element.." talking about relationship with mother
45 A	00:02:30	mild	"I was my dad's favourite child. I know that!"
45 A	00:04:20	mild	"And I also was my grandmother's favourite child"
45 A	00:28:50	mild	"I was my father's favourite child"
45 A	00:50:00	mild	"many things I can do"
45 A	01:06:10	mild	Pointing out that late cousin left her something, but not to brothers and sisters
45 A	00:53:30	mod	"I was taller then him, bigger then him, I was not frightful from my father" when talking about not feeling threatened by father when being a child
56 T	4.45	mild	Subject talks about how his mother looked after him more than his other brothers and how she gave him special attention.
46	00:26:50	mild	"I was really good at languages at school
7 J	00:02:00	mild	'I was kind of special- goes on to explain that she went to primary school and secondary school much earlier than other children.'
7 J	00:20:35	mild	'Lots of children participated in it (writing competition) and I won the first prize. I was 4, but because I competed with children who were 7,8,9, people were surprised.'
42 J	00:04:42	mod	'Lord everything she did was for me, not everything she did, but it gave her pleasure to make me happy so if I wanted anything I got it.'
9 J	00:05:29	mild	'I was the focus of the family. They spent a long time with me- explains that he was injured as a child and had to have 9 surgeries.'
18 J	00:15:47	mild	'My father was jealous of me because he was passionate about my mother and he was jealous of- anything that took her time or concentration away from him.'
18 J	00:16:24	mild	'He couldn't read books- and I was great reader, my mother was a great read.

41 J	01:11:01	mild	'In the end I was very strong because I thought I have nothing to lose and I wanted to show my capacity- I was not shy, I was not scared I was very myself.'
50 J	00:40:14	mild	'Something positive? I guess I've become quite a depressive person. But in a way that's quite good because I do tend to think a lot more- why someone is doing something....maybe coming up with deeper thoughts than most people who talk about boys and fashion.'
2 J	36	?	'I was easy as a kid, straightforward and as a teenager so they did not really have a reason to punish me. (exaggeration as earlier admitted to being punished, also later comments about brother being harder than her).
3 J	00:11:48	mild	'It was ok for me because I was always near the top end.'(being told to line up in order of achievement)
16 A	00:03:25	mild	"I was there first born so of course I was something special"
16j	00:16:29	very mild	'If I fell, for him it was always a big drama, like oh my god the child has hurt herself.'
16j	00:28:13	very mild	'I think my dad was at least a little bit upset because he had to realise that his little girl wasn't so little any more- but he managed to put on a brave face I think.'
39 J	00:08:05	mild	'Gives specific memory when prompted-I was quite bright and doing quite well so there was not much there and he wasn't appreciating that I was doing quite well (teacher at school). Mum didn't really need to but went and spoke to my tutor about it.'
39 J	00:16:07	very mild	'Although I remember being quite confident in it- I was always quite able I think, but even so finding it a bit tough.'
39 T	7.4	mild	Subject talks about a teacher at school who did not like him, subject talks about being confused about this as he was 'bright and doing well' and the teacher had failed to 'appreciate' his abilities.

2.6. Self over evaluation thematic categories and frequencies for both groups

SELF OVER VALUATION	**Frequency in control group**	**frequency in clinical group**
Thematic category / Sub-theme		
Being special and valued	19	18
Being the favourite	2	3
Being special and of value	10	6
Being needed	1	1

41 J	01:11:01	mild	'In the end I was very strong because I thought I have nothing to lose and I wanted to show my capacity- I was not shy, I was not scared I was very myself.'
50 J	00:40:14	mild	'Something positive? I guess I've become quite a depressive person. But in a way that's quite good because I do tend to think a lot more- why someone is doing something....maybe coming up with deeper thoughts than most people who talk about boys and fashion.'
2 J	36	?	'I was easy as a kid, straightforward and as a teenager so they did not really have a reason to punish me. (exaggeration as earlier admitted to being punished, also later comments about brother being harder than her).
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Thematic category / Sub-theme		
Being special and valued	19	18
Being the favourite	2	3
Being special and of value	10	6
Being needed	1	1

Being likeable and attractive to others	1	0
Assuming interviewer is interest in you	3	4
Receiving special treatment from others	0	1
Assuming others are preoccupied with you	2	7
Being superior and strong	16	45
Being more capable than others	2	1
Others being jealous	1	7
Being powerful and strong	3	9
Linking self with powerful others	1	2
Claiming superior abilities and intellect	5	15
Having superhero powers	4	4
Own high status and achievement	0	3
Being more sexually attractive or beautiful	0	4
Praising the self	11	8
Having self confidence	2	2
Complimenting self	9	6
Denigration and idolisation	6	8
Insulting or criticising others	2	4
Being served by others	2	0
Others failing to appreciate your talents	2	0
Demanding the best from others	0	2
Idolising others and being idolised	0	2
Emotional resilience and fearlessness	5	18
Fearlessness	2	4
Not needing others	1	3
Claiming to be unaffected by stressful events	2	8
Being emotionless	0	3
Instructing and controlling others	3	6
Being critical of the interviewer	1	1
Instructing the interviewer and taking control	1	3
Controlling others	1	0
Guiding/ teaching others	0	2

2.7. Passive aggression interview exerts for the PD group

Number and intervie wer	time	level	Interview exert
37 J	0:08:48	mod	Talking about couple who volunteered to come and visit her and her brother in care- 'how should I put it, we filled in a gap in their life, because she couldn't

			have children.' Said bitterly.
37 J	00:30:35	mod	'She always used to tell me off about my eating- you're so fussy, you don't eat anything and I thought well, there's reasons behind it.'
37 J	00:44:35	mild	Refers to the couple that used to take her home at weekends as 'pen friends'...an auntie and an uncle who take you home to show you a normal life
30 A	01:44:00	mod	Describing how husband was being abusive even though she had a 'breakdown', she seems unaware of the impact of her own doing, e.g. throwing daughter out of the house when she was coming home drunk
8J	00:53:16	mild	'I can't really say when I was a child particular example, I just know she was.' (following from earlier easy recounting of events on the subject of mother)
8J	00:53:28	mild	'yes she was definitely controlling but I can't giev particular examples.'
8J	00:54:44	mild	Gives general answers for all adjectives and doesn't come up with specifics when pushed despite easily recalling violent incidents earlier in the interview 'I don't want to remember' (laughs)
8J	00:51:40	mild	'In particular with my dad, she was the mother of her two daughters, she was the one who was there....she was over-baring with us, she was the one.'
8J	00:56:00	mod	'The only examples are the ones that are later, and the ones I can cope with now. I don't really want to go too much there, I could probably dig.'
8J	01:31:02	mild	'I had to have a massive argument (with mum) I had to stop speaking to her for 6 months because she wouldn't respect me as an adult- now its ok.'
8J	01:33:30	mod	'After fight with brother in law- my mum just looked at me and said 'I'm very glad that you are making progress in your development' in just such a patronising way and I just looked at her and said 'thanks, I'm very glad you are making progress to' (sarcastic)- goes on to talk about how her mum preaches and is judgemental.
34 J	00:16:32	mod	Looks at watch-second time in interview
34J	00:18:00	mod	Lonely- 'all the time' any specific time? 'No it was all lonely all of it, very lonely' 2nd prompt 'no it was all lonely all of it' (without pausing to think)
34J	00:18:55	mod	Gives one line answers with no specific examples for all of father's adjective. Does not pause to think about responses
34J	00:20:51	mod	When you were upset as a child what would you do? 'I'd get very depressed' and when you were upset emotionally what would you do? 'get very depressed' lip smack and slow head nod on second answer stares straight at interviewer when she says 'no I just remember being very depressed' emphasis on 'no' - seems to indicate frustration
36a	00:27:20	mod	At first says she can't remember how she felt when she

			felt rejected which is contradictory to earlier parts of the interview; however, when interviewer moves on and asks next question, subject interrupts.
36a	00:30:10	mild	Subjects interrupts interviewer and resumes talking as if interviewer wasn't present
36a	00:36:45	mild	Subject again leans back in chair, looks disinterested, then asks if she can have a break, as she feels really embarrassed, upset (subject doesn't seem upset, rather bored)
36a	8	mod	'I beg to differ anouschka…' subject makes it clear he wants to address memories around the age of two rather than between 5-12.
44 T	10	mod	When asked for adjectives about his relationship with his father, subject rolls his eyes, shakes his head and says 'there was none Anouschka, there was none, I can't think of anything…' Rolls eyes, shakes head, looks down
11T	1.36.00	mod	Subject talks about wanting to turn off the central heating for a while so his children 'can see how cold it can really get, so that when it goes back on they can appreciate it.'
13J	00:12:47	mod	I say to him 'what's the point in phone calls we've got nothing to talk about we've done nothing' and if he wants to get stressed out about it well, he knows what to do, come down and see us and then we'll have things to talk about on the phone. You just run out of things to talk about and then start waffling.
29J	00:31:29	mod	Long pause looking down. Interviewer tried to prompt. Puts finger up 'I just need a minute'
51J	00:26:11	mod	'That's the last thing I did- goes on to explain that she didn't realise her mum was dying at the time but she wrote her a letter saying you never loved me. Her brother was cross about it 'but I couldn't help it Rob, she was always putting me down.She told me to go away from her door'. That's why I don't talk to him now. I haven't seen him since she died.'
24a	00:06:00	mild	Q: when you were emotionally upset as a child, what would you do? "this was untypical of me when I was young…I took up a battery from my toys and threw it at my mother…I don't know if hit her or not..."
24a	00:14:00	mild	Interviewer repeatedly clarifying question
6T	1.19.00	mod	'I remember I had this friends Tony, and I kissed his girlfriend (smirks) and I remember he waited outside my house for days and days and I would go out because he was gonna beat me up.' Smirks, smiles, touches face
21j	00:09:30	mild	'Everything I asked for on my birthday she got her own daughter and I said 'Sandy I'm not being rude or anything but how come Jo got what I wanted on my

			birthday?' and she said, are you telling me young lady how to raise my daughter.'
21t	21	mild	Phone rings, subject asks for camera to stop whilst she answers it and again in second part of interview
35a	01.25.45	mod	"Does this interview affect me later" Interviewer: "don't know??" "because you should think" interviewer suggest if subject wants to stop - subject becomes very concerned and paranoid about interview and confidentiality
35a	00:54:40	mild	"I don't know what you mean.." 'sorry I don't remember the question?'
35a	00:06:40	mod	Subject says that she wants to say anything until the interviewer has asked a question, then interrupts interviewer midway the next question
35a	00:10:39	mod	Despite interviewer's effort, to explain that at this point she only wants 5 words or adjectives, and subject's assurance that they understand what is asked from her, subject repeatedly diverts from this task by going into detailed accounts
35a	00:14:30	mod	Not answering question, but diverting by talking in great detail about other things unrelated to task; interviewer has to explain repeatedly task
35a	00:43:00	mod	Can not understand what 'rejection' means even though subject has used that word before
35a	00:05:40	sev	"I can not talk about everything here, you understand, because I have secret with my doctor"
35a	all	mod	Subject not answering questions but talking about other things
35a	01:28:00	mod	Suggest that interview should be "cut" because of subject's English
35a	00:25:00	mod	Subjects interrupts, cuts off interviewer, somewhat annoyed with interviewer
35T	5	mild	'I can't talk everything you understand anouschka, because I have secrets.' Subject spoke of not wanting to talk about sister in interview.
35 T	58	mod	When subject becomes tearful she asks interviewer if she too is upset 'I make you upset anuschka, your reaction.... your face!' Smiling and pointing at interviewer (this is felt to be a little mocking or undermining possibly?)
35t	1.13.15	?	The subject describes marked(unacknowledged) provocations and angry or rejecting reactions, which are bewildering and probably hurtful to other without being acknowledged by the subject.
35t	all	?	The subject's may be obstructing the interview to the point of diverting the interviewer from his or her task
35t	1.25.10	sev	Subject begins to question the interviewer about the nature of the interview e.g. will this have a bad effect on her, who will watch the tape etc. Interviewer asks if

			subject would like to stop. Subject points into camera, gets consent from out of bag, agitated, tense
40a	00:38:00	mild	"Dragging her feet" when asked whether she was ill as a child: "not that I can't remember" looking repeatedly away from interviewer, and out of the window
22 a	00:27:45	mild	Describing how she complaint about haircut..mother responding over the top - can see now that she probably pushed her so far
31j	00:31:40	mild	'I told them I'd taken an overdose and that I'd be starting here and I've not had a phone call, a letter, nothing. I'm the nutter who 100 year ago would have been locked in the loony bin- they don't want to know, so I feel it all over again, the rejection, crying intensifies.'
31 j	00:47:48	mild	'Current relationship? Non-existent- as I said last year I told the whole family and I haven't had one letter or one phone call since I posted the letters.'

2.8. Passive aggression interview exerts for the control group

Number interviewer Video time	Scoring level	Interview exert
5 A 00:14:40	mild	Having a sweet picnic with sibling "and my mother turned livid. That was quite fun", causing annoyance and irritation
33 T 27	mild	Subject talks about walking out of the family home during a row between her parents, without telling them and them needing to call the police as they were worried. She described feeling food that she could get out of the home when she wanted.
54 T 20	mild	Subject consistently reports that she is unable to think of any specific memories about either parent's. Unclear the reasons behind this, could be non-attachment but the interview is stunted and awkward and there is an absence of apologetic language or body language by the subject, 'again, I cant think of anything specific' (said many times)
54 T 34.45	mild	When asked about separations, subject recalls when she went to nursery school 'which I vaguely remember' when asked how she responded, she laughs and says 'I do not remember, I don't not remember at all.'
54 T 40	mild	When asked about being frightened as a child, subject refers to how most children feel a little this way 'no one has a story book childhood' and then claims not remember anything specific. Being unduly hesitant or circumstantial during the interview, self-effacing or indecisive.
1 A 00:08:05/1	mod	Even after interviewer probes subject not answering question as if she hasn't understood question
1A	severe	Adjectives: "do they have to be five"

00:22:00/1		
1 A 00:53:00/1	mod	Not answering interviewer's question: "which parent did you feel closest"
1 A 00:21:50/1	mod	Unduly hesitant when choosing adjective, changing her mind backwards and forwards
45 A 00:54:40	mild	When talking about being threatened by mother to be send away to boarding school
45 A 00:07:50	mod	Doesn't reply or look up when asked by interviewer whether she would like "strict" as an adjective
45 A 00:14:15	mild-mod	Although subject has at length talked about relationship using words/adjective, interviewer has to prompt repeatedly to elicit specific adjectives
45 A 00:48:00	mod	Going off on a completely unrelated topic
45 A 00:54:45	mod	Completely wandering off topic, hereby not answering question
45 A 00:42:45	mod	Cuts interviewer off
7 J 00:58:43	mild	Abusive- describes incident with classmate (age 4)- claims not to remember what he did, but it made her really unhappy, unduly hesitant or circumstantial
42 J 00:18:32	mild	Seems unwilling to give examples, very brief, slightly dismissive or irritable in some of her responses, obstructing interview
42 J 00:21: 00	mild	Towards mother and towards that time when I went to california (9) with a friend and her parents, and I told my mum when I got back that I felt like I had no parents. Being a therapist she found that very interesting
41 J 01:12:04	mild	Describing how she didn't understand why they didn't like her, goes on to say that her laboratory results were not good.
2 J 23	mod	Description of being emotionally upset by brother, subject c/o being blackmailed by him, which she claimed was 'really mean' , when in fact she had blackmailed him first. Her role in interaction not acknowledged, blame given to brother. Laughter smirking
14 J 17.20	mild	'Um, um, I really want to say fat!' Subject is trying thinking of adjectives for relationship with step father. Giggling.
14 T 39.00	mod	Subject describes being found by mum after she had taken an overdose due to being unhappy at school and her mum needing to call an ambulance no mention of effect on mum of her behaviour
19 T 19.3	mild	Subject gives minimal responses to questions, e.g. no, ok, fine, fine, (no elaboration) neutral expression, quiet voice, very still posture
19 T 49.3	mild	Subject offers only a little information at a time and often needs prompting by the interviewer for elaboration. Neutral face.
19 T	mod	Subject spoke of being injured by her sister, the school

43		were concerned and subject recalled telling them a 'different story' which did not match up with her sisters confession, and therefore resulted in an investigation into her family. Subject unsure why she gave a different story to school and also claimed to be upset by their investigation. Neutral face, some smiling.

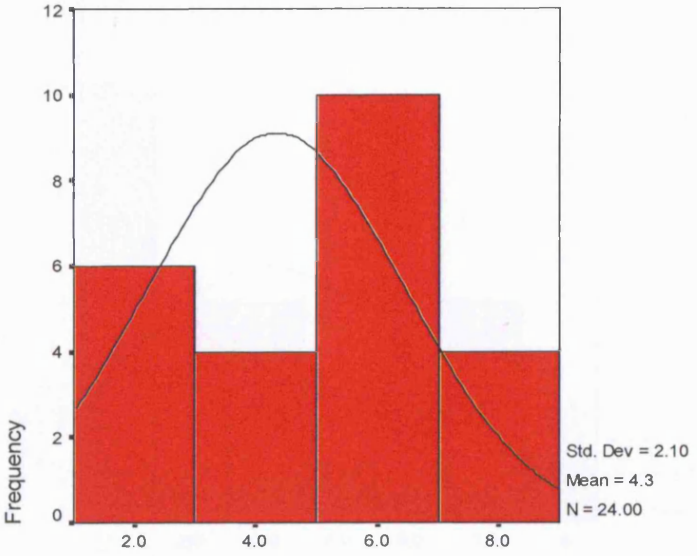
2.9 Passive aggression themes with frequency counts for each three coders (A, J, T)

Passive aggression themes	**Control group frequency**	**Clinical group frequency**
Unacknowledged anger towards someone in the narrative	A0 J1 T0	A1 J5 T1
Obstructing interview process	A7 J2 T3	A14 J8 T3
Behaviour which upsets or provokes anger in another (acknowledged and unacknowledged)	A1 J1 T5	A4 J5 T2
Unacknowledged anger towards interviewer (clinical only)	A0 J0 T0	A1 J2 T3
Behaviour which elicits increased effort in the interviewer e.g. interviewer required to repeatedly prompt, clarify and reiterate.	A1 J0 T1	A3 J1 T0

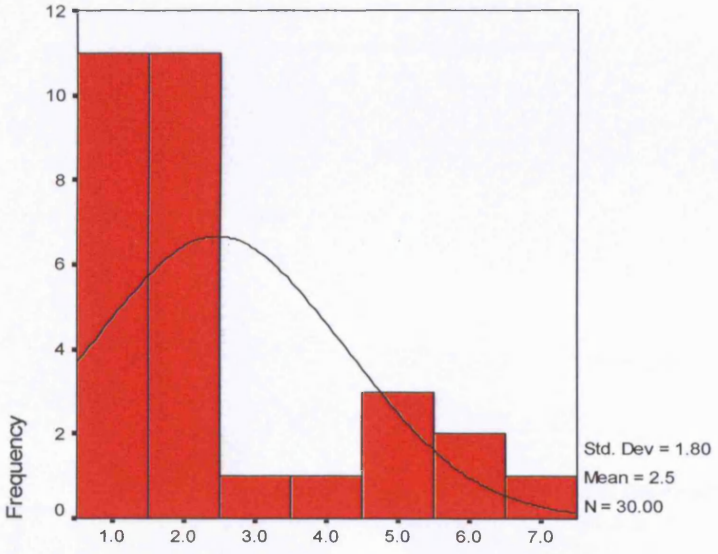
Totals: A32 (43%), J25(33%), T18 (24%) = 75

3. Quantitative data section

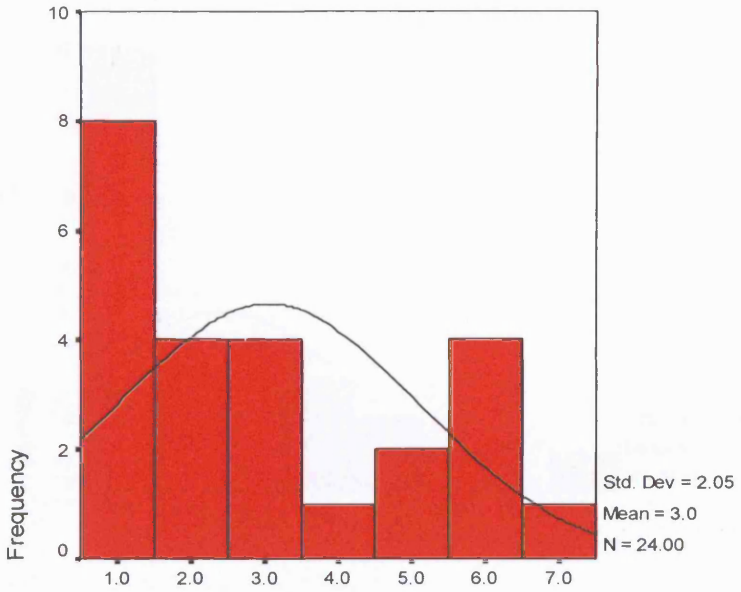
3.1 Histogram indicating the distribution of **external aggression** for the PD group



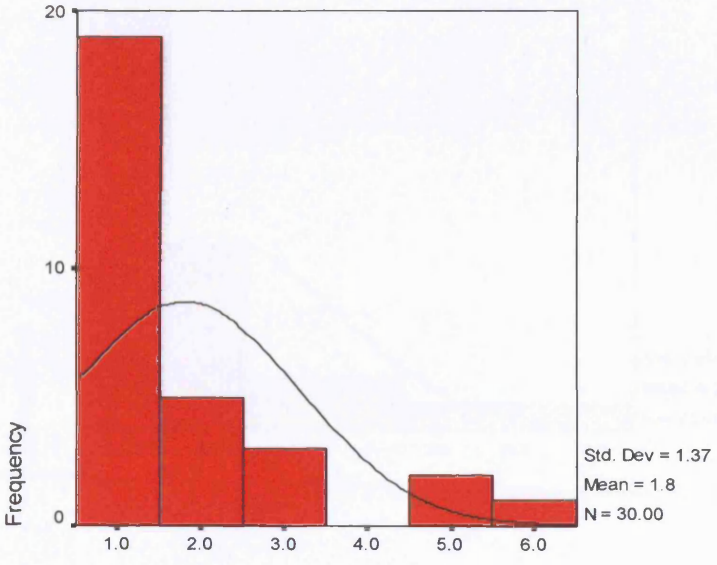
3.2 Histogram indicating the distribution of **external aggression** for the control group



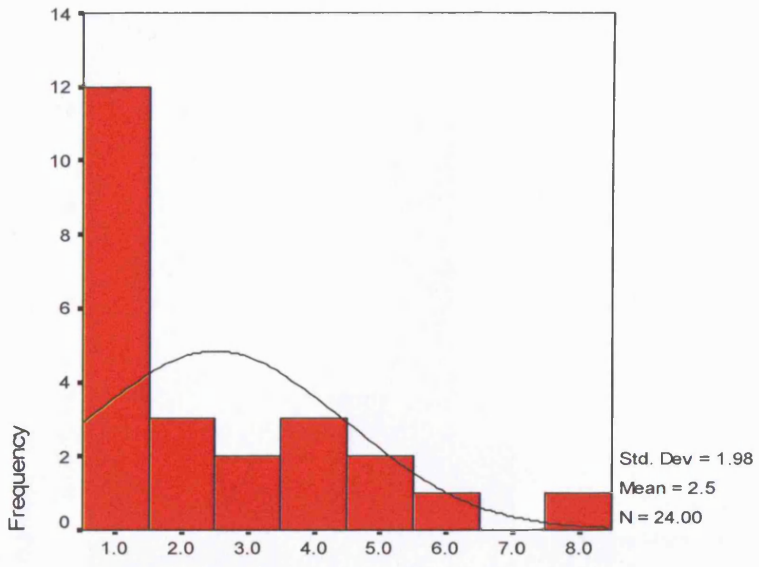
3.3 Histogram indicating the distribution of **passive aggression** for the PD group



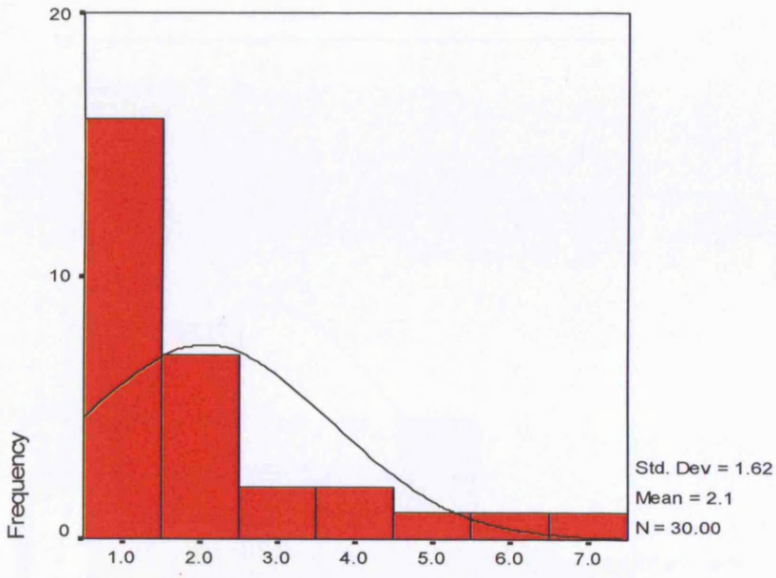
3.4 Histogram indicating the distribution of **passive aggression** for the control group



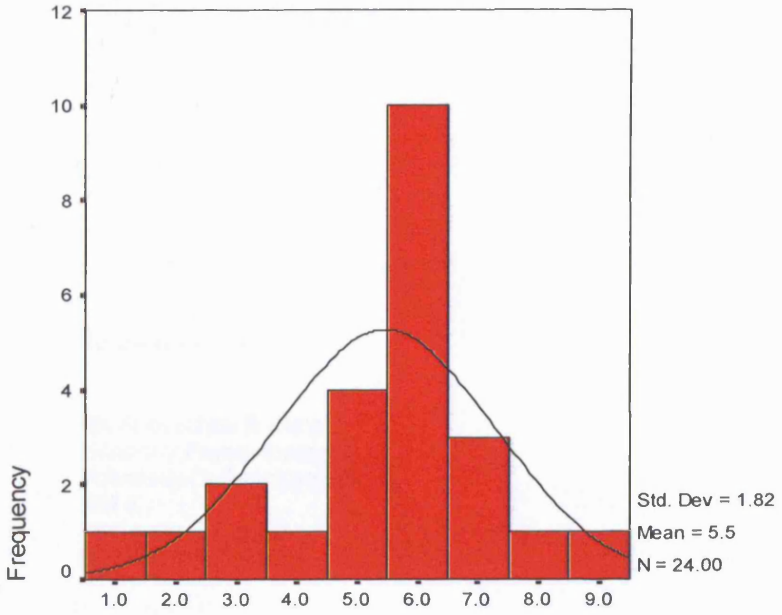
3.5 Histogram indicating the distribution for self over evaluation for the PD group



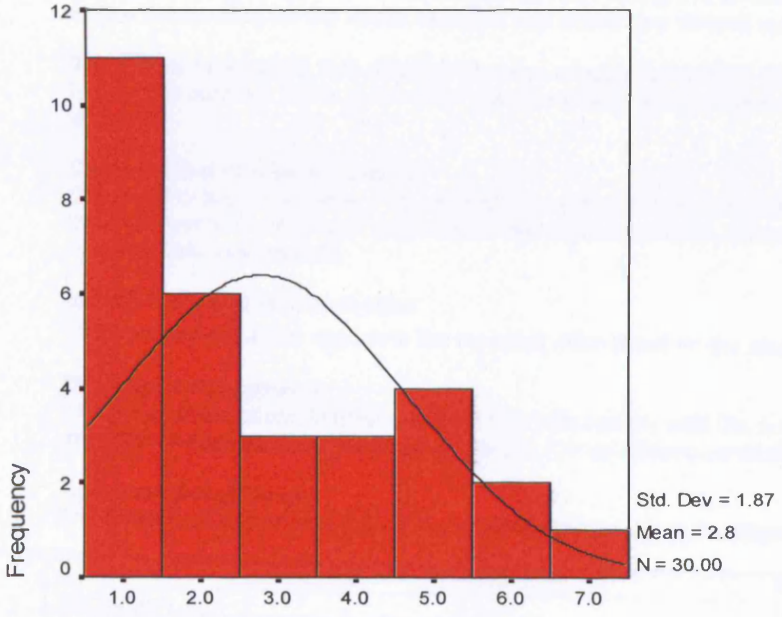
3.6 Histogram indicating the distribution for self over evaluation for the control group



3.7 Histogram indicating the distribution for self under evaluation for the PD group



3.8 Histogram indicating the distribution for self under evaluation for the control group



4. Ethics approval letters

4.1 St Marys REC approval letter

St Mary's Research Ethics Committee

26 January 2006

Ms Anouschka Buettner
Honorary Psychotherapist
University College London

Dear Ms Buettner

Full title of study: **The relationship between current personality functioning and memories of early attachment relationships**

REC reference number: **05/Q0403/134**

Thank you for your letter of 19 January 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 26 January 2006. A list of the members who were present at the meeting is attached.

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.

Ethical review of research sites
The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

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

Document	*Version*	*Date*
Application	5.0	08 September 2005
Application	various	
Investigator CV	n/a	
Protocol	1	08 September 2005
Letter from Sponsor	n/a	08 September 2005
Interview Schedules/Topic Guides	n/a	
Advertisement	1	08 September 2005
Letter of invitation to participant	1	08 September 2005

An advisory committee to North West London Strategic Health Authority

Participant Information Sheet	1	08 September 2005
Participant Information Sheet	2 UCL heading	19 January 2006
Participant Information Sheet	2 CNWL Trust heading	19 January 2006
Participant Consent Form		08 September 2005
Response to Request for Further Information	Covering email	19 January 2006
Other	Data Protection Form UCL	
Other	cv of supervisor	

Research governance approval
The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q0403/134	**Please quote this number on all correspondence**

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

Yours sincerely

Chairman

Email:

Enclosures: *Standard approval conditions*
Site approval form

Copy to:

[R&D Department for NHS care organisation at lead site]

4.2. St Mary's REC letter indicating approved site amendments

NHS
National Research Ethics Service

St Mary's REC

08 May 2007

Ms Anouschka Buettner

Dear Ms Buettner

Full title of study: **The relationship between current personality functioning and memories of early attachment relationships**
REC reference number: **05/Q0403/134**

The REC gave a favourable ethical opinion to this study on 26 January 2006.

Further notification(s) have been received from local site assessor(s) following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site(s). I attach an updated version of the site approval form, listing all sites with a favourable ethical opinion to conduct the research.

R&D approval

The Chief Investigator or sponsor should inform the local Principal Investigator at each site of the favourable opinion by sending a copy of this letter and the attached form. The research should not commence at any NHS site until approval from the R&D office for the relevant NHS care organisation has been confirmed.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q0403/134	**Please quote this number on all correspondence**

Yours sincerely

Committee Co-ordinator

Email:

Enclosure: *Site approval form*
Cc

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

St Mary's REC

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	05/Q0403/134	**Issue number:**	2	**Date of issue:**	08 May 2007
Chief Investigator:	Ms Anouschka Buettner				
Full title of study:	The relationship between current personality functioning and memories of early attachment relationships				

This study was given a favourable ethical opinion by St Mary's REC on 26 January 2006. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	*Post*	*Research site*	*Site assessor*	*Date of favourable opinion for this site*	*Notes* [1]
Ms A Buettner		CNWL Mental Health Trust	St Mary's REC	26/01/2006	
Ms Tanya Lee	Trainee Clinical Psychologist	North Essex Mental Health Partnership Trust	Essex 1 Research Ethics Committee	08/05/2007	

Approved by the Chair on behalf of the REC:

(Signature of ~~Chair~~/Co-ordinator)

(delete as applicable)

(Name)

[1] *The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension or termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded*

An advisory committee to London Strategic Health Authority

4.3. Local R and D letter approving recruitment from new site in Essex.

Essex County Council

North Essex NHS
Mental Health Partnership
NHS Trust

Our ref: ST

Trust Headquarters
Stapleford House

21 November 2006

Dear Ms Buettner

Re: Trust Research Application Number : BA 06 24

I am writing to you as the named Chief Investigator on this study although my contact has been with Tanya Lee. Unfortunately this Trust's R&D Committee meeting on the 9 November had to be cancelled and this has caused a delay in coming back to you with the result of the review. I am pleased to advise you that your application has been approved. As I am sure you are aware the Trust now has to meet rigorous standards set by the Department of Health for research governance. Consequently, your research must be carried out subject to the following conditions: -

- Permission to proceed is granted by a Research Ethics Committee and I understand that a favourable ethical opinion has already been granted and that Tanya will be sending me a copy of this.

- Honorary contracts are in place. I understand that Tanya is expecting to receive an honorary contract with this Trust and that she will send to me a copy of this.

- This Trust's logo must be correct on any documentation e.g. the participant information sheet and consent form and amendments to the submitted documents are required. I will send this Trust's logo to Tanya Lee. Please send online copies of the amended documents.

- A 'Brief Information Sheet for Participants' was submitted together with the main participant information sheet and the former refers to interviews taking place at *********and is incorrect. My understanding is that the interviews will take place either at********** or **********. Accordingly this should be altered in the brief information sheet

although it is not clear why it is necessary to have this document at all. Please send online copies of the amended document.

- The research must be carried out in strict accordance with the protocol submitted and any changes to that protocol must be approved by the R&D Committee and receive a favourable ethics opinion from a Research Ethics Committee before the research is undertaken or continues.

- A financial or any other agreement relating to your research that is binding upon the Trust must be notified to me and thereafter approved and signed by the Chief Executive of the Trust.

- You must report any adverse events relating to this research to me as soon as practicable. I can be contacted by telephone on . In my absence, incidents should be reported to the Medical Director, Dr who can be contacted by telephone via his PA on . In addition, you must complete one of the Trust's adverse incident forms and follow the requirements as set out in the Trust's adverse incident reporting policy. A copy of the adverse incident form must be submitted to **me** as soon as possible.

- In cases where the research will take place over a period of more than 12 months, you are required to send to me a short progress report on your research dealing with recruitment, any adverse incidents and interim findings as appropriate. You will be notified when the report is due.

- Any research terminated prematurely must be notified to me immediately.

- The results of your completed study must be sent to me within 3 months of completion of the study so that the Research and Development Committee can consider it. In addition, please supply a summary on a single page of A4 paper of the conclusions of the study that would be suitable for dissemination.

The R&D Committee, on behalf of the Trust, will revoke or suspend its approval to any research that does not comply with these conditions, is in breach of LREC approval or where there is any misconduct or fraud.

I wish you every success with your research and to receiving a copy of the ethics committee approval, copy of Tanya Lee's honorary contract with the Trust and amended documents in due course.

Yours sincerely

Sarah Thurlow
Research and Development Manager

5. PD participant information sheet

Central and North West London NHS

Mental Health NHS Trust

Participant Information Sheet:
Memories of Childhood and Personality Functioning

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve.
Please take time to read the following information carefully and discuss with others if you wish.
If anything is not clear, or if you would like more information, please ask the researcher (see contact details below).
Thank you for taking the time to read this!

What is the study about?
This study is looking at the way people remember their childhood experiences, in particular their early relationships with their parents.
We would like to understand, how memories of childhood experiences and relationships are related to current personality functioning.
The research will take around a year to complete in total, although each individual participant will only be asked to attend one interview session.

Why have I been chosen?
We would like to interview people who have been referred to ********** (delete as appropriate) as they are currently experiencing difficulties in their personal and social life. Therefore we asked the psychotherapist or keyworker conducting your assessment or treatment to pass on information about the study to anyone who thought they might like to take part. In total we hope to interview around 30 people for this study.

Do I have to take part?
It is entirely up to you whether or not to take part.
If you do decide to take part you will be asked to sign a consent form.
If you decide to take part you are still free to withdraw at any time, without giving a reason.
A decision to withdraw, or a decision to take part, will not have any effect on the support or care you receive from any service.

What will happen if I take part?
If you decide to take part, you will be offered a time to meet with a researcher who will conduct the interviews. The interviews will take place in a room at ********** (delete as appropriate).

The interview is likely to take between 2 and 3 hours to complete, and consists of two parts: an interview about your current personal and social life, lasting about 30 to 45 minutes to an hour and an interview about your early childhood memories,

lasting between 60 to 90 minutes. There will be a break of at least 15min in between the two interviews.
Before completing the interview, you will be also given a chance to ask any questions about the research, and you will be asked whether you agree to take part and to sign a form of consent.
The interview will be completed by an Trainee Clinical Psychologist at the ********** Service.

Both interviews will be **videotaped**, so that the researcher can look at them later and write out transcripts of them. We decided to use videotape as opposed to interview protocols, as we wanted to make sure that we are getting a complete and realistic picture.

As we appreciate your participation, we are able to offer you £ 15.00 to reimburse your time and travel expenses.

What are the possible disadvantages and risks of taking part?
Taking part in this research will involve interviews, which covers topics that some people might find difficult to discuss. If you decide to take part, but find the interview upsetting, you are free to answer the relevant question or to change your mind and stop at any time. If as a result of the interview, you feel you need some support to come to terms with some of the things you have discussed, the interviewer will help to arrange this.

What are the possible benefits of taking part?
The information we get from the study may help to understand how memories of early childhood relationships and experiences are related to the personal functioning and social relationships in later life. We hope that a better understanding will help us to provide a more better support for people with difficulties in these areas of their life.
Some people have found that the interviews are interesting or even beneficial for them.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you can discuss this with the clinical supervisor, whose contact details are given below.

What will happen to any information about me?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you - any forms, videotapes or transcripts - will have your name or any personal details removed at the earliest stage so you cannot be identified from them. All data will be stored in accordance with Data Protection Act, and only accessible to the researcher immediately involved in this study.

All material will be disposed off securely once the research has been completed, according to UCL retention schedules and appraisal guidelines.
Before disposal, the videotapes will be electronically cleared and cleaned. This will be recorded in a Video Tape Log, noting the date and time of the disposal.
The videotaped interviews will not be used for commercial purposes.
Nobody will be informed that you have taken part unless you ask the researcher to do this.

In the rare circumstance that there be serious concern about your wellbeing or that of another, the issue will be raised with you. We will discuss with you the actions that might be appropriate to safe-guard those concerned.

What will happen to the results of the research study?
The results of this research will be written up as part of the researcher's PhD theses in Psychology .They are also likely to be written up for publication in scientific journals. If you would like to be sent a summary of the results, or a copy of any papers that are published as a result of this study, please let the researcher know this and it will be arranged.All results will be made anonymous when they are written up - it will not be possible for anyone reading the research to identify you.

Further Information
If you would like any further information about the study, or discuss any questions or concerns, or **decided that you would like to take part in this study, please contact the researcher:**

Researcher:
Ms Tanya Lee
Trainee Clinical Psychologist

Clinical Supervisor:
Dr Mary target

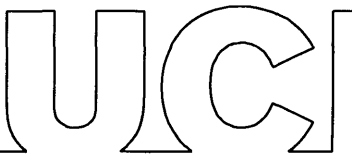
Thank you for taking the time to read this information. If you decide to take part, you will be given copies of the consent form to keep.

This study has been approved by St. Mary's Research Ethics Committee 05/Q0403/134

6. Control participant information sheet

SUB-DEPARTMENT OF CLINICAL HEALTH PSYCHOLOGY
UNIVERSITY COLLEGE LONDON

Participant Information Sheet:
Memories of Childhood and Personality Functioning



You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss with others if you wish. If anything is not clear, of if you would like more information, please ask the researcher. Thank you for taking the time to read this!

What is the study about?
This study is looking at the way people remember their childhood experiences, in particular their early relationships with their parents. We would like to understand, how memories of childhood experiences and relationships are related to current personality functioning.The research will take around a year to complete in total, although each individual participant will only be asked to attend one interview session.

Why have I been chosen?
We would like to interview you as part of a group that will be compared to a similar group of NHS patients, referred for mental health problems. Therefore we contacted GPs to pass on information about this study to anyone who might be interested in participating. In total we hope to interview around 30 people.

Do I have to take part?
It is entirely up to you whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time, without giving a reason.

What will happen if I take part?
If you decide to take part, you will be offered a time to meet with a researcher who will interview you. The interviews will take place in a room in the Psychology Department, University College London.

The interview is likely to take between 2 and 3 hours to complete, and consists of two parts: an interview about your current personal and social life, lasting about 30 to 60 minutes to an hour and an interview about your early childhood memories, lasting between 60 to 90 minutes. There will be a break of at least 15 min following the first interview. Before completing the interview, you will be also given a chance to ask any questions about the research, and you will be asked whether you agree to take part and to sign a form of consent. The interview will be completed by a Trainee Clinical Psychologist.

Both interviews will be **videotaped**, so that researcher can look at them later. We decided to use videotape as opposed to interview protocols, as we wanted to make sure that we are getting a complete and realistic picture.
As we appreciate your participation, we are able to offer you £15.00 to reimburse your time and travel expenses.

What are the possible disadvantages and risks of taking part?
Taking part in this research will involve interviews, which covers topics that some people might find difficult to discuss. If you decide to take part, but find the interview upsetting, you are free to answer the relevant question or to change your mind and stop at any time. If as a result of the interview, you feel you need some support to come to terms with some of the things you have discussed, the interviewer will help to arrange this.

What are the possible benefits of taking part?
The information we get from the study may help to understand how memories of early childhood relationships and experiences are related to the personal functioning and social relationships in later life. We hope that a better understanding will help us to provide a more better support for people with difficulties in these areas of their life.
Some people have found that the interviews are interesting or even beneficial for them.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you can discuss this with the research supervisor, whose contact details are given below.

What will happen to any information about me?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you - any forms, videotapes or transcripts - will have your name or any personal details removed at the earliest stage so you cannot be identified from them. All data will be stored in accordance with Data Protection Act, and only accessible to the researcher immediately involved in this study.

All material will be disposed off securely once the research has been completed, accoding to UCL retention schedules and appraisal guidelines.
Before disposal, the videotapes will be electronically cleared and cleaned. This will be recorded in a Video Tape Log, noting the date and time of the disposal.

Nobody will be informed that you have taken part unless you ask the researcher to do this.

What will happen to the results of the research study?
The results of this research will be written up as part of the researcher's Doctorate in Clinical Psychology. They are also likely to be written up for publication in scientific journals. If you would like to be sent a summary of the results, or a copy of any papers that are published as a result of this study, please let the researcher know this

and it will be arranged. All results will be made anonymous when they are written up - it will not be possible for anyone reading the research to identify you.

Further Information
If you would like any further information about the study, or discuss any questions or concerns, or decide to take part in the research, please contact one of the two researchers:

Researchers:
Tanya Lee and Joanna Pearson
Trainees in Clinical Psychology

Anouschka Buettner
PhD researcher

Phone:
Email:

Scientific Supervisor:
Dr. Mary Target, Senior Lecturer
Sub-department of Clinical Health Psychology

Email:
Phone:

Thank you for taking the time to read this information. If you decide to take part, you will be given copies of the consent form to keep.

This study has been approved by St.Mary's Research Ethics Committee - Ref No: 05/Q0403/134

7. PD participant invitation

Central and North West London NHS
Mental Health NHS Trust

(patient's address)

(date)

Dear (patient's name),

I would like to inform you about a research project that is currently conducted at **********(delete as appropriate) in conjunction with University College London.

I was wondering if you would be interested in participating in the project.

Please find enclosed a brief description of what the study is about and, more importantly, what your participation involves for you.

If you would like further information or would like to discuss any questions, please feel free to contact me at any time either by phone or by email (see contact details below).

Alternately, you can use the enclosed feedback form and envelope.

Yours sincerely,

Tanya Lee

CONTACT: Tanya Lee, Researcher
PHONE:
Email:

8. PD participant feedback form

Research study:
Memories of Childhood and Personality Functioning

- ☐ **I would be interested in participating in the study and would like to be contacted by a researcher**

- ☐ **I would be interested to receive further information about the study**

Name:

_____

Address:_____

_

Email: _____

Contact phone number

_____

This study has been approved by St. Mary's Research Ethics Committee 05/Q0403/134

9. Confirmation of appointment (PD group)

North Essex Mental Health Trust NHS

{Address}

Dear

Thank you for participating in our study!

I am looking forward to see at ********** **(delete as appropriate)**

on _____

For your information, I have enclosed a more detailed description of what the study is about.

Yours sincerely,

Tanya Lee
Researcher

Phone:
Email:

10. Informed consent form (both groups)

RESEARCH PARTICIPANT CONSENT FORM
RESEARCH STUDY:
"Memories of Childhood and Personality Functioning"

Please take your time and read the Participant Information Sheet carefully.

Please tick the boxes prior to signing this form.

I have been explained to the project orally ❑

I had the opportunity to ask quesitions and to discuss the study ❑

I have read the participant information sheet ❑

I did receive enough information ❑

I do understand that I am free to withdraw from the study at any stage and that a withdrawal will not have any effect on the support or care you receive from any services ❑

I do agree to be videotaped for the purpose of this study ❑

I do agree with the publication of the results of the study in an appropriate outlets ❑

I do understand that my personal details will not be identifiable and that data will be protected according to the Data Protection Act ❑

I understand that all files and recordings will be kept securely by Parkside Clinic and University College London ❑

Date..... Signature.....

I have explained the interview and recording procedure to the participant and confirm that they have given consent. I have explained that, if they prefer not to give such a consent, the Trust will still endeavour to provide them with the highest quality service.

Signed by researcher.....

11. Participant personal details (both groups)

PARTICIPANT CODE:

_____

(to be filled in by researcher)

PLEASE USE CAPITAL LETTERS WHEN FILLING IN THE FORM

Mr/Mrs/Miss/Ms/Dr *(please delete as appropriate)* **First Name:**	**Surname:**
Postcode:	
Date of Birth:	**Age:**
Nationality:	**Ethnic Background:**
Present Occupation:	
Education: GCSE/O'Level, A'Level/post 16, Degree, Higher degree, Other (please specify): *(please underline)*	
Are you single, married or cohabiting, separated, divorces, widowed? *(please underline)*	
Children: *(Gender & Dates of Birth)*	

Finally, where did you hear about this study?

12. Control group advert

Sub-Department of Clinical Health Psychology

Participants wanted!

We are looking for people prepared to talk about their childhood experiences and how these relate to their current lives.

This will involve a one-off videotaped interview and questionnaire for which you will be paid £15. Participants need to be between 18 and 65 years old.

For more information please contact Tanya Lee and Joanna Pearson on:

Tel:
Email:

13. The Personality Disorder Coding Manual (PDCM)

Dimensions and their subscales

DIMENSIONS	SCALES & SUB-SCALES
AFFECT	DOWN
	UP
	LABILITY
AGGRESSION	EXTERNAL
	PASSIVE
COGNITION	DISTURBANCE OF THINKING
RELATEDNESS	ANXIOUS DEPENDENCY
	HOSTILE GRIEVANCE
	[A] LACK OF ATTACHMENT
	[B] OVER-EXTENDED ATTACHMENT
	OSCILLATION
	LACK OF CONCERN
SELF	OVER-EVALUATION
	UNDER-EVALUATION
	LACK OF STRUCTURE
SELF & OBJECT	LACK OF INTEGRATION [A] EXAGGERATED
	LACK OF INTEGRATION [B] INCOHERENT
	AFFECT TONE
SEXUALISATION	EROTISATION

AFFECT:

DOWN REGULATION
UP-REGULATION

DESCRIPTION OF SCALE

The interview inevitably elicits experiences which may be expected to arouse strong affect, both positive and negative. For example, questions about experiences of rejection, separation and illness may elicit descriptions of either loving interactions with attachment figures or extremely distressing experiences. These scales assess the way the subject deals with those experiences either by reducing or heightening the emotional arousal associated to them.

CODING INSTRUCTION

The rater should carefully review the emotional state accompanying the reports. It is the subject's current affective response and implied evaluation of the event that should be coded, and not how he/she responded at the time (e.g. if S distances self from reported reaction in past, then current reaction is what is rated). Only when this is not possible to discern, should the rater assume that the past response continues.

The rater should be alert that the significance of the event should not be defined on the basis of response.

Coding affect using video data

CATEGORIES OF AFFECT
Visual and voice aspects of care affect groups are described below with examples of low and high level expressions of each.

NEUTRAL AFFECT
Neutral affect, or lack of strong affective response may be shown through a lack of facial tension and a lack of indicators of other affective states alongside neutral voice tone with regular pitch and rhythm and smooth steady body movements with no strong gestures.

POSITIVE AFFECT: INTEREST/WARMTH-EXCITED INTEREST
Low level- interest/ warmth:
Physical cues- increased volume and tempo of speech alongside warmth in tone of voice (affection demonstrated when talking about memories). Facial signs of attentiveness may be present such as focused gaze and good eye-contact. There may be some smiles although less broad with lower intensity than high-level expressions.

High level- warmth/excitement
Physical cues- high level of positive energy will be demonstrated through rapid fluctuations in pitch, volume and rate of speech giving an overall impression of buoyancy. Speech may be accompanied by excited hand gestures and gesticulations that may fluctuate rapidly. Facial indicators will include indicators of excited happiness such as smiling, crows feet wrinkles around the eyes, raised cheeks and a wrinkle from the nose to the outer edges of the lips.

ANXIOUS-FEARFUL
Low-level- tension

The person may have difficulty expressing what they want to say. They may be hesitant with unfinished sentences and thoughts-For example saying 'uh', 'ah' repeatedly. Facial indicators of anxiety include a raised and straightened brow conveying worry or apprehension, lip biting and touching of the face. Body indictors include fidgeting or frequent shifting of body position, pressing against self- eg. Rubbing/wringing hands together, wiggling legs, or a sense of restlessness or mild agitation.

High level- fearful
Body and vocal signs of tension such as fidgeting will remain but may be accompanied by fearful facial expressions. These include frequent eye movements, raised and straightened brow conveying worry or apprehension alongside other facial indicators of fear. Open and tense eyes with the upper eyelid raised and the lower lid tense. The lips maybe either open and tense or drawn back and tense. In extreme cases the individual may convey the message 'I'd rather not be here right now' through turning the body outwards or looking away from the interviewer perhaps alongside automanipulation.

SADNESS-EMOTIONAL DISTRESS
Low-level-
Facial expressions indicating sadness include the brows drawn together in the centre, down cast eyes and drooping around the corners of the mouth. The voice tone may be lowered and slower in pace with some pauses.

High level-
Facial indicators of emotional distress are the same as sad facial expressions although with greater intensity of expression and facial tension. The lips may quiver and there will be crying or tears. The voice may be wavering or sound as though the individual is crying or too choked up to speak.

FRUSTRATION-ANGER
Low level-
Facial indicators of frustration or irritation include tightening of the mouth and pressing the lips together, and frowning or and angry brow without other indicators of anger. There may be a slight bobble of the head whilst speaking and the voice may be stuttering with changes in rhythm and the way certain words are stressed.

High level- anger
Facial cues for anger include the brows lowered and drawn together with vertical lines appearing between the brows. Lower and upper eyelids are tense and the upper lid maybe lowered by the action of the brows. The eyes maybe staring or bulging slightly and the lips maybe tense and pressed firmly together or open in a tense squared position. The nostrils may be flared. Lip presses, involuntary twitches or jerks, tightened jaw, clenched teeth may also be seen. Voice tone will be raised or lowered out of the normal range with changes in the way words are stressed.

EMBARRASSMENT/SHAME
Low Level- embarrassment
Facial indicators of embarrassment include downward gaze, or shifting gaze, particularly with glances to the left. There might be embarrassed smiles, which can be distinguished from amused or enjoyment smiles by their weaker intensity and the participant's attempts to control the smile.

High Level- Shame
Facial indicators for higher level shame remain the same as for embarrassment but downward gazes will be for longer and eye contact will be avoided. The person may have a hunched posture or appear tense. Voice tone may be lowered and harder to hear. The person may blush or become tearful.

MICRO-EXPRESSIONS IN THE FACE
Normal facial expressions of affect may only last for a few seconds. However, micro-expressions, lasting a fraction of a second may also occur. Although difficult to detect, these expressions may give an indication of the emotions that the person is masking or attempting to neutralise.

AFFECT:

DOWN-REGULATION

This scale aims to assess the extend to which the subject tends towards reducing emotional arousal, in particular in relation to stressful experiences

DESCRIPTION OF SCALE

This scale assesses the degree to which there is a tendency in the narrative to reduce affect. As a result, positive and negative affects, are muted.

Severe down-regulation is only expected in relation to negative experiences.

At the extreme end of this scale, the response is the explicit claim to be unaffected by a traumatic event.

INSTRUCTION FOR CODING

It is important to distinguish down-regulation as a defensive mechanism from the process of working-through.

It would be expected that traumatic events and losses would be processed and worked through to an extent with time.
Working-through is evidenced by a narrative ideally containing:
acknowledgement of distress and pain experienced at the time,
description of changes in feelings between the childhood emotional response and the current feelings, and
explanation of why current responses are less intense than hitherto. Unfortunately, many narratives that indicate such a process do not adequately describe the changes, and how they have come about; however if an explanation for the changes in affect is made plausible then the subject should be given the benefit of some doubt.

When these elements are present, the current reduced emotional arousal should not be considered as down-regulation.

This includes some allowance for the time passed since the event (e.g. discussion of the death of a grandparent s expected to have a less intense impact obvious to the observer once years have passed, but some acknowledgement of continuing grief is expected.

VIDEO CODING

The affect is muted or incongruent when talking about distressing experiences. For example their maybe an absence of affect expressions/ neutral facial expressions whilst discussing a distressing/stressful experience. More extreme responses may include laughing or smiling when discussing extreme or high-level stressful events. In particular, pay attention to micro-

expressions that may convey the emotion that the individual is masking or attempting to neutralise. Eg. Wincing, fleeting sad, angry, fearful or shameful expressions.

CODING LEVEL: DOWN-REGULATION

MILD

Mild denial of the impact of events.

Affect is muted and flat.

Responses are reduced.

MODERATE

Explicitly denying or claiming to be unaffected by an otherwise stressful event

Examples:
"My father died unexpectedly, and I was quite sad about it for a while'
"Those kinds of beatings went on every day, and it did not affect me much in the end."

SEVERE

Emphasising the positive aspect of stressful event, seemingly unaffected.

Affect is down-regulated to a point where there seems to be a complete absense of affect

Examples:
"Seeing my mother trying to kill herself taught me how to become self-reliant. It made me grow up quickly. I think I am able to be totally objective about it."

AFFECT:

UP-REGULATION

This scale aims to assess the extend to which the subject tends towards heightening emotional arousal, in particular in relation to stressful experiences.

DESCRIPTION OF SCALE

This scale assesses the degree to which there is a tendency in the narrative to amplify affect These affect displays can range from intense but congruent emotional arousal to a more exaggerated response to a certain event. In addition, the amplified affect may even be incongruous with the event manifested (See INSTRUCTION FOR CODING).

At the extreme end of this scale, the affect elicited by the interview is so intense that the individual can no longer regulate it normally.

INSTRUCTION FOR CODING

The severity of the event has to be evaluated in relation to the affective response (e.g. an experience of chronic abuse would be expected to be accompanied by quite extreme feelings). So, e.g. abuse experienced in childhood which still evokes overwhelming affect would be rated as mild up-regulation and not as severe up-regulation.

When the experience of being overwhelmed may be understandable, particularly if the event was recent, this response should not be coded as severe up-regulation.

UP-REGULATION vs. INNAPROPRIATE AFFECT TONE OF OBJECT RELATIONS:
Where the amplified affect displayed is not only exaggerated but also incongruous with the event described, coding on both scales may be necessary (MODERATE and SEVERE level).
However, incongruous affect is only coded as "Inappropriate Affect Tone" when it is in response to an object or attachment relationship.

VIDEO CODING

Look for negative affect laden facial and vocal expressions as outlined above as well as body cues indicating anxiety/tension or excitement

CODING LEVEL: UP-REGULATION

MILD

Response somewhat intense and amplified but affect is congruent with event.

A tendency to display or relate intense affect in response to events which is understandable in terms of its direction but somewhat exaggerated in terms of its degree. *(e.g., claiming prolonged distress in relation to mild criticism)*

MODERATE

Response bizarre, exaggerated affect, hard to understand.

Affect is exaggerated to a point where it is hard to understand the connection with the event and/or the affect is incongruous with the event manifested.

SEVERE

Overwhelmed and disorganised by affect.

Affect is so intense that it clearly overwhelms the subject currently or in the past, related in a manner that indicates that a similar reaction would take place if the event were to occur currently
(e.g. unable to cope, breaks down in interview).

AFFECT:

LABILITY

This scale aims to assess the readiness with which different emotions oscillate in the course of the interview

DESCRIPTION OF SCALE

Lability of affect concerns a difficulty in modulating affective states during the interview, which is independent of a general tendency to up or down regulate the emotional state. Some vulnerable people are unable to tolerate the intense affect that can be elicited by the interview, and seem to be alarmed by it presumably because they cannot modulate it.

At the extreme end of the scale, this results in a marked fluctuation of intense affect. These changes are rapid and seem out of proportion and therefore difficult to relate to the content of the narrative.

INSTRUCTION FOR CODING

The interview has to be read as whole and episodes of the interview have to be taken in combination in order to make this rating.

Appropriate affect in relation to specific contents is not to be considered an indication of lability even if there are a number of episodes where affect is intense, as long as these expressions of feeling are in line with the narrative being told.

Where normal variation becomes rateable as lability is where such emotional episodes quickly trigger other affects or when the onset and offset of affect appears rapid or dramatic (e.g., anxiety may trigger anger, which in its turn may ellicit sadness or manic denial or false joy).

VIDEO CODING

Look for rapid changes in affect facial expressions, posture, movements or vocal expressions eg. Raising, lowering or changing the pace of the voice.

CODING LEVEL: LABILITY

MILD

There is a somewhat sudden and unexpected change in the emotional expression.
There is either a rapid change in the intensity of emotional expression, which is congruent with the event.
e.g. subject suddenly starts to cry

Or

There is a somewhat sudden change but mild in the direction of the emotional expression, but this change remains within expectable boundaries.

On the mild level the subject's affective state remains stable.

MODERATE

There is a sudden change in the intensity and the direction of the emotional expression which is unexpected and somewhat incongruent with the event described.

A sudden change of the emotional state may be justified by the events described. Nevertheless the general impression created is of a heightened state of arousal and consequent instability

SEVERE

There is an extreme and rapid change of different affects in relation to the same set of events or parts of the narrative, which is completely unrelated to the narrative and incongruent with the event described.

These opposing affects (happy-sad, anxious-calm, angry-loving) change very rapidly even in relation to the same person or situation

AGGRESSION:

EXTERNAL AGGRESSION

This scale aims to asses the extent to which an individual's internal working model of relationships is infused with externally directed aggression

DESCRIPTION OF SCALE

Externally directed aggression can be displayed in form of verbal aggression, descriptions of angry or aggressive behaviour, through the use of aggressive language or current anger with the interviewer marked by derogation, criticism, sarcastic remarks.

At the extreme end of the scale, the subject may describe violence to other or may talk or even behave in an overtly aggressive way, without apparent conflict or even with enjoyment.

INSTRUCTION FOR CODING

The extent to which an individual's internal working model of relationships is infused with externally directed aggression can be identified in the subject's

- LANGUAGE in the context of attachment relationships;
- DESCRIPTIONS OF ATTACHMENT FIGURES AND ATTACHMENT-RELATED EPISODES
- ATTITUDE TOWARDS THE INTERVIEW OR THE INTERVIEWER

VIDEO CODING guidance

Signs of tension in context of angry verbal content e.g. difficulty speaking, fidgeting, plucking at clothes, rubbing face, biting nails, shifting posture, involuntary twitches, tight muscles or posture, tight jaw, raised or lowered voice beyond normal range, short sighs. Look for any threatening behaviour towards the interviewer e.g. pointing gestures, leaning in, forming a fist or facial grimace.

Look for paralinguistic signs of aggression e.g. Tutting, snorts

CODING LEVEL: EXTERNAL AGGRESSION

MILD

IN THE NARRATIV:
On this level, the use of aggressive language Is mild.
Angry recounting of episodes.

Reports of interactions in which the subject was verbally aggressive.

In the descriptions of episodes and attachment figure, which do not include aggression, the language used is unnecessarily harsh and would appear to be mildly insulting, should the person described have heard it.

The subject refers an episode of his past in which he used a verbally aggressive language.
e.g." I was reading a psychological book a few years ago and I said to my wife Shit, that's dad".

IN THE INTERVIEW:
The subject might show mild annoyance on this level,
Exclamations, which are not directly related to the content of the narrative..
e.g. "Oh shit, I thought you wanted five adjectives that describe her!"

MODERATE

IN THE NARRATIV:
On this level, the use of aggressive language is strong and extreme.

However, the subjects descriptions of aggressive acts remain in the realm of the imagined. They are not carried our intended in reality.

Insulting descriptions with use of strong language.

Description of extreme verbal aggression and/or threatening behaviour with others.

Imagining other's extreme verbally aggressive language.
e.g. "My parents may have said to each other under their breath The little fucker's gone, thank God".

When the subject wishes to kill somebody, but it is clear that he will not put into action.
e.g. "I I could have killed her""

IN THE INTERVIEW:

On this level, the subject shows clear signs of anger with the interviewer or the interview process.
However, the anger remains within acceptable boundaries.
e.g. the subject might argue with the interviewer or makes derogatory remarks about the interview

SEVERE

IN THE NARRATIV:
On this level, the subject either describes to have carried out aggressive acts or states the clear intention to carry out aggressive acts.

Descriptions of violence to others involving injury and realistic risk of harm.
When the subject plans to kill somebody.
e.g. "If I see my girlfriend, I will kill her"

IN THE INTERVIEW:
The subject shows marked anger with the interview and the interview process.
On this level, the subject has difficulties in keeping his anger under control that may lead to a disruption or at the extrem to a termination of the interview.

E.g. the subject makes abusive remarks, threats or menacing gestures in the interview that are more or less directed at the interviewer.

AGGRESSION:

PASSIVE AGGRESSION

This scale aims to assess the extend to which an individual's internal working model of relationships is infused with passive aggression

DESCRIPTION OF SCALE

Passive aggression refers to the subject's destructive impulses that become manifest indirectly through acts of omission or commission which cause inconvenience and irritation, on in the extreme even harm, but without the subject acknowledging an intention.
The subject or others may experience disasters, which are presented as having been without an agent. There may be a forceful assertion of lack of responsibility, and helplessness in relation to repeated traumas - if it is suggested that the subject might have contributed at all, there may be an extremely angry reaction.
On the other hand, passive aggression may be shown as a lack of co-operation with the interview process which is not obviously justified by the subject's current emotional state.

At the extreme end of the scale, the interview process itself is significantly disrupted by the subject without that being acknowledged or apparently conscious.

Avoidance of eye contact or too much eye contact, smirks or smiles whilst being uncooperative with the interview process

INSTRUCTION FOR CODING

Passive aggression can become obvious in the interview in three ways:

- LANGUAGE in the context of attachment relationships, which may be unduly hesitant or circumstantial
- DESCRIPTIONS OF EPISODES AND/OR ATTACHMENT FIGURES, which include unacknowledged aggressive behaviour;
- ATTITUDE TOWARDS OR LACK OF CO-OPERATION WITH THE INTERVIEW PROCESS OR THE INTERVIEWER, which is not obviously justified by the subject's current emotional state (e.g., the subject may not answer the question but talking about other things). Instances where the subject seems to be uncooperative by not answering questions, claiming a 'lack of memory' need to be carefully evaluated: the rater needs to make a decision whether this is a lack of cooperation (i.e. passive aggression) or part of a defensive dismissive strategy, which would not be coded as passive aggression; PLEASE LOOK FOR NON-VERBAL SIGNS TO MAKE THIS DECISION.

VIDEO CODING guidance

Look for any constrained anger such as the 'unfelt' smile or contempt signs e.g. rolling eyes, sarcasm or hostile humour. Also obstructive behaviors such as answering mobile or break request.

CODING LEVEL: PASSIVE AGGRESSION

MILD

IN THE NARRATIV:
Descriptions of occasions in which the subject omitted to do something, thus causing some annoyance or irritation.

IN THE INTERVIEW:
Being unduly hesitant or circumstantial during the interview, self-effacing or indecisive.

MODERATE

IN THE NARRATIV:
Description of unacknowledged resistance or omission which clearly caused annoyance and irritation.

Description of provocations whereby the subject does not admit to having felt angry at the time, and is puzzled by the response of those around them.

IN THE INTERVIEW:
The relationship to the interviewer may be undermined by repeated implied rejection of the interviewer's efforts.
(e.g. eliciting reassurance but ignoring it and continuing to criticise own performance)

The subject's may be obstructing the interview to the point of diverting the interviewer from his or her task. *(e.g. subject may not answer question but talking about other things)*

SEVERE

IN THE NARRATIV:
The subject describes marked(unacknowledged) provocations and angry or rejecting reactions, which are bewildering and probably hurtful to other without being acknowledged by the subject.

IN THE INTERVIEW:
There is evidence of a clearly negativistic attitude within the interview itself, which is not acknowledged by the subject.
(e.g. by blocking, irrelevant intrusions, sullen resistance to aspects of the demands of the interview).

This might lead to a severe disruption, so that the interviewer might have to end the interview.

COGNITION:

DISTURBANCE OF THINKING

This scale aims to assess indications of disturbances of thinking, such as confused or bizarre statements, overly detailed descriptions, perseverance of one particular theme as well as sudden changes of state and discontinuities of a subjective state

DESCRIPTION OF SCALE

Disturbance of thinking can be observed in form of:

(a) confused or bizarre statements
Statements which are strikingly paradoxical and bizarre. Statements that do not make sense either in the context of the interview or in general, so that it is difficult to see any connection to the question just asked or the topic discussed; i at the extreme end of the scale, almost all of the interview seems rather bizarre and confused

(b) overly detailed descriptions
Descriptions which are excessively elaborated or include irrelevant detail; at the extreme end of the scale the subject seems to be lost in his own narrative and unable to stop (to stick to the constraints of the interview).

(c) perseverance of a particular theme
Perseverance of a particular theme refers to the repeated intrusion of one or more particular themes; in moderate cases the topic is not only intrusive but deviate from the question.
At the extreme end, the topic is completely irrelevant to the interview.

(d) Dissociation
Dissociation corresponds to a sudden shift in state. This may include instances where the subject may appear entirely unaware of what he has described shortly before. For example, the person is halfway through describing an episode, pause, then start to talk about something quite different; if reminded by the interviewer, they may seem confused. They may describe 'going blank' following a period in which they seemed very anxious or distressed, and involved with the narrative.

At the extreme end of the scale the subject becomes disoriented and confused and may no longer be aware of the context of the interview

INSTRUCTION FOR CODING

ad a) if the subject way of recollecting seems somewhat bizarre, these incidences need to be distinguished from source memory error, which is not a cognitive disturbance and hence not coded on this scale.

Likewise, a subject being able to reflect on the odd quality of their statement is not coded here.

E.g: (subject talking about having stayed in hospital as a child) " I remember being in hospital....I can see the bed. Strange, I can see myself lying in the bed from the outside. That is strange! I shouldn't be able to see myself from the outside! That is bizarre..."

VIDEO CODING

When coding disturbance of thinking from video data signs of dissociation might include visual signs of increasing affect followed by a sudden shift to a neutral affective state (see coding affect for video data P.). Look for sudden changes in the rate or tone of the voice or pauses and hesitation which give the impression that the individual is confused. In more extreme cases the voice tone might suddenly sound 'haunting' or inappropriate. Also look for blank looks or confused/ puzzled or disorientated facial expressions as shown through a raised brow, or a lowered frowning brow and eye squint, or shifting eye gaze. In more extreme cases the person may appear to be absent from what is occurring in the room, briefly or for a more prolonged period and may require prompting from the interviewer to continue. The individual may appear to 'freeze'. Eyes might be half shut or with a fixed stare and seemingly unblinking. In extreme cases the individual may appear to have a 'flashback' experience and may appear to be responding to stimuli unseen in the room.

CODING LEVEL: DISTURBANCE OF THINKING

MILD

(a) statements are somewhat confused or bizarre; however, the rater might still be able to make some sense of what is being said.
Slips that go unnoticed
e.g. "I held on to my mother dress, and she was always cuddling her. But it was for more for herself"

(b) an episode is described with more detail than it is appropriate or expected; however, the subject is able to focus somehow on the main aspects of the episode being told and is able to offer a conclusive remark for a particular episode.

(c) there is some intrusion of one or more particular topics, which cause a deviation from the question being asked; however, this deviation does not come across as particularly marked and there is some relation between the question made by the interview and the topic discussed by the subject.

MODERATE

(a) statements are clearly confused, paradoxical or bizarre; they do not seem to make much sense even in the context of the episode; however, the general idea being conveyed may still be hinted.

(b) descriptions are excessively elaborated or include irrelevant detail; the subject may seem to have lost the thread of his reasoning and seems to have difficulties in concluding the answer.

(c) there is a clear intrusion of one particular topic, which appears somewhat unrelated to the question being asked; however, the subject might still be able to establish a reasonable connection between his account and the question asked by the interviewer.

SEVERE

(a) the statement seems completely bizarre, paradoxical, or incomprehensible; the rater is clueless about what the patient is trying to say.

(b) the patient describes an episode with such detail that the answer becomes excessively long and irrelevant; the subject seems to be lost in his own narrative and seems unable to stop.

(c) the intrusion of one particular topic is very obvious in the sense that the narrative content seems completely unrelated to the question being asked by the interviewer; the interviewer may even try to ask the question again in order to bring the subject back to the topic.

RELATEDNESS:

HOSTILE GRIEVANCES

The aim of this scale is to asses to which extend the subject holds hostile grievance towards the attachment figure, which seems not justified

DESCRIPTION OF SCALE

The aim of the of this scale is to assess the extent to which an individual believes he deserved to receive more from his primary care givers as well as assessing his level of anger and complaint. There is a general sense of resentment and of having missed out in life.

We assume that unjustifiable grievances reflect the use of primitive defence mechanisms to some extent.

Blame for one's difficulties is located elsewhere and the individual does not recognise any responsibility on his/her part for the failures or difficulties.

The need seems to be to hold a grievance through bitterness and by focusing on events in the past that have caused psychological damage.

On the extreme end of the scale, the subject conveys a persistent sense of neglect and abandonment regarding his attachment relationships, which seems exaggerated and is largely not supported by evidence. There is no recognition of responsibility or participation.

INSTRUCTION FOR CODING

Although it is important to differentiate between justifiable complaints and unjustifiable ones, it is the general level of complaint that is rated here.

Therefore, subjects with consistent grievances are not given the benefit of the doubt but coded here, even if there seems some justification for their complaints.

Only if the subjects complaints are substantiated and to a significant degree, e.g. if a caregiver has clearly been neglectful and there is consistent evidence for this throughout the interview, the complaint is likely to be justifiable.

CODING LEVEL: HOSTILE GRIEVANCES

MILD

The subject complains about some aspects of his attachment figure or upbringing.

However he or she is able to reflect on it, e.g. he or she says why they think their parents did the things that they did.

The subject relates his or her complain to reality as well as to any misperception. (e.g. the patient realises that even if he felt rejected he may not have been). He or she explains how feelings of rejection have arisen.

The subject expresses some criticism, however, on the mild level, anger is not present. There is only mild blame for one's difficulties.

MODERATE

The subject clearly complains about aspects of his attachment figure or upbringing.

The subject's ability to reflect on it, if at all, is very limited. Examples of neglect are easily recalled

On the moderate level, the anger is pervasive but also moderate.

SEVERE

The subject seems to be completely absorbed in his complains about aspects of his attachment figure or upbringing.

On the severe level, the anger is invasive and marked.

The subject recalls many examples of being let down, neglected and abandoned, but these are not compelling to the reader.

The subject reports of having felt like that since early childhood.

The five adjectives chosen of both parental figures may link to neglect and abandonment or extremely negative aspects without any balance,

There is evidence that the individual's expectations should now be *met (i.e. if they need something it should be provided). When they are not met, the blame is located elsewhere*

RELATEDNESS:
IN-APPROPRIATE ATTACHMENT

This scale concerns the in-appropriateness of attachment relationships which can be expressed in two different ways:

Either as:

NON-ATTACHMENT

or as

OVER-EXTENDED/ GENERALISED ATTACHMENT

INSTRUCTION FOR CODING

These two strategies are not necessarily mutually exclusive but can occur simultaneously. Therefore in-apropriate attachment is coded separately by the following two sub-scales, Lack of Emotional Investment and Over-Investment of Attachment

RELATEDNESS:

IN-APPROPRIATE ATTACHMENT
NON-ATTACHMENT

This scale aims to asses the lack of emotional investment in attachment figures

DESCRIPTION OF SCALE

This subscale concerns - at least at the surface level of the narrative - the inability to describe the relationship with the caregiver as an attachment relationship.

Instead, there is an apparent neutrality which is inappropriate to the attachment context.

At the milder end of the scale, there may be lukewarm attachment to one or more figures, but a stronger relationship with at least one available caregiver.

At the extreme end of the subscale, all primary attachment figures will be emotionally unimportant, or there will appear to have been no relationship.

For example, the caregiver is described as a friend or as an acquaintance, in unemotional terms, and is not apparently seen either as a secure base or as a source of protection or understanding.

However, the descriptions do not indicate hostile relatedness, masochistic submissiveness or any other intense pattern of relationship.

CODING LEVEL: NON-ATTACHMENT

MILD

The subject speaks about experiences that would usually evoke strong attachment responses (e.g. separation, illness or death of attachment figures) with some emotional detachment.

Episodes of contact with the attachment figure are described with some elaboration but in bland terms.

There may be recourse to clichés or stereotyped descriptions of activities.

In general on this level, descriptions of primary caregivers are flat and are somewhat lacking in emotional investment; the used terms could equally apply to less important relationships.

MODERATE

The subject may explicitly state the lack of a relationship with an attachment figure, or state that they did not need the attachment figure.

There is a lack of elaboration and depth to descriptions of episodes, which suggests that memories of contact with that attachment figure are impoverished, they have little current emotional impact and are not remembered as having been formative at the time.

However, on the moderate level, there are signs elsewhere in the interview that the relationship with the parent had importance in some ways or at some times.

SEVERE

The subject may explicitly state that there was no relationship with the attachment figure, or that they did not have an attachment figure.

Events with a caregiver are described in highly impersonal terms, as routine, expected delivery of care.

Events which would normally evoke anxiety about loss of the attachment figure (such as prolonged separation) are described without current feeling, or memory of earlier distress.

On this level, there appears to be a complete dismissal of the importance of the relationship with this caregiver in the subject's development, whether explicit or implied by the descriptions given.
There is no indication elsewhere in the interview that the subject might have ever valued this relationship beyond the material benefits which it may have brought *(e.g. "She provided my meals, and did all the things that mothers are supposed to do").*

RELATEDNESS:

IN-APPROPRIATE ATTACHMENT
OVER EXTENDED/ GENERALISED ATTACHMENT

This scale aims to assess an over-investment or generalization of
Attachment in ordinary relationships

DESCRIPTION OF SCALE

This subscale concerns the tendency to develop feelings of attachment towards otherwise non-significant others.

Figures that the subject has only met occasionally are treated as attachment figures and considered as a source of security (e.g., hairdresser).

There is an apparent over-investment, which is inappropriate to the relationship context.

At the extreme end of the subscale, virtually all ordinary relationships are regarded as emotionally important. For example, a faint acquaintance is described in highly emotional terms, and it is seen as a secure base and as a source of protection or understanding.

CODING LEVEL: OVER EXTENDED/ GENERALISED ATTACHMENT

MILD

The subject speaks about experiences that would usually not evoke an attachment responses with some emotional investment which would be appropriate for attachment relationships.

Episodes of contact with acquaintances or figures that the subject only met occasionally are described in emotional terms appropriate for more intense relationships.

Descriptions of people that would normally be considered non-significant indicate emotional investment; they use terms that could equally apply to far more important relationships

MODERATE

The subject may explicitly state the importance of an otherwise ordinary relationship as if referring to an attachment relationship, or state that the need for that person as he or she were an attachment figure.

There is a vividness and depth to the description of episodes, which suggest that memories of ordinary relationships have current emotional impact and are remembered as having been very personal at the time.

However, there are signs elsewhere in the interview that there are faint relationships which remain within a more ordinary framework.

SEVERE

Events with otherwise non-significant figures are described in highly emotional terms, involving a special quality of care.

Events which would not normally evoke anxiety (such as separation from acquaintances) are described with strong feeling, or memory of distress.

There appears to be a complete engagement in the relationship with otherwise non-significant people and this relationship is considered as having importance in the subject's development, whether explicit or implied by the descriptions given.

There is no indication elsewhere in the interview that the subject might have had a relationship which was not over-valued and burdened with expectations.

RELATEDNESS:

ANXIOUS DEPENDENCY

The aim of this scale is to assess subjects who describe a continuing childish dependent relationship with one or more caregivers

DESCRIPTION OF SCALE

Anxious dependency describes a continuing need for the attachment figure, to give advice or support, and there may be a dread of disapproval, due to fear of loss of love.

The hallmark of this pattern of relating is inappropriate closeness, with often undue intimacy, and the sense that the subject feels he or she would not be viable without the closeness to the parent.

There may be resentment at the perceived intrusiveness of the parent and lack of privacy, however, this is felt to be inevitable, and beyond the subject's power to change

At the extreme end of the scale, the relationship is likely to be infused with anxiety about loss of the attachment figure which can lead to a concrete fear of his or her death. The anxious dependency between subject and attachment figure is often mutual.

CODING LEVEL: ANXIOUS DEPENDENCY

MILD

The subject worries about the parents' reactions, wanting approval and wanting to maintain closeness. The subject's self-esteem may be dependent on this.

Descriptions of fear of separation, or lack of ordinarily increasing independence in childhood.

There may be signs of reliance on parental encouragement, or presence at an age when this has become uncommon.

The current adult relationship with attachment figures may be described as like the childhood relationship, though there may be some reversal of caregiving roles.

However, on the mild level, these descriptions are balanced by others in which there have been attempts by the child or the adult to overcome the dependence.

MODERATE

One or both parents are experienced as intrusive (e.g. commenting on what the subject needs to do, or has not done).

Pervasive need for advice or support.

There is explicit fear of the absence or death of the parent.

The parents are not remembered as having promoted independence, or are portrayed as having undermined confidence and self-sufficiency *(e.g. by needing the child to stay at home to help the parent, or overprotective concern with dangers in the outside world).*

SEVERE

The subject states that he could not manage without the caregivers' support, and is evidently frightened of a situation when this might not be available.

There may be a striking lack of questioning of a clearly pathological relationship (e.g. the subject describes family having been very different from all peers in childhood but sees this as appropriate given the circumstances).

The dependence of caregiver on offspring is mutual and often difficult to disentangle (e.g. who is ill and looking after whom).
e.g." How would I be able to cope, if anything happens to them, I didn't know, I'd probably commit suicide"

RELATEDNESS:

OSCILLATION

The aim of the of this scale is to assess the extent to which an individual oscillates between a desire for or actual closeness
and a need to withdraw to a safer distance

DESCRIPTION OF THE SCALE/ INSTRUCTION FOR CODING

Oscillation describes an inability to find an appropriate emotional distance which does not lead to anxiety.

Hereby, closeness leads to a feeling of suffocation and being trapped, whereas greater distance leads to fears of being alone and of being abandoned.

Each anxiety is likely to mount over time, until it becomes unbearable and will then lead to a change in mood and intimacy (at the milder end), or severance (or resumption) of the relationship at the moderate-severe end.

This can lead to difficulties in modulating the perception of intimacy, so that a new relationship is felt to be immediately very close and special, and later as intolerable and dangerous.

At the milder end, there is sustained attachment to the same person, which can withstand the oscillations.At the extreme end of the scale, relationships are likely to be severely disrupted by the changes in dominant anxieties and reactions to them, so that there are either shifts in primary attachment figures and / or in the closeness of each relationship.

CODING LEVEL: OSCILLATION
PLEASE NOTE: TO BE CODED FOR THE INTERVIEW AS A WHOLE

MILD

Close relationships are described as showing some fluctuation between attachment behaviour - showing features of strong positive affect, self-disclosure, spending a lot of time together and minimisation of problems in the relationship, followed by withdrawal of emotional investment, negative affect, lack of confiding.

This change cannot be properly accounted for by the subject, it seems to reflect an internal cycle rather than external changes.

MODERATE

The shifts between attachment behaviour and withdrawal of emotional investment are more rapid and even less linked to understandable external triggers.

These shifts are more pronounced, from intense positive relating to violent dislike or denigration of the former attachment figure.

Most attachment relationships are likely to be affected by this pattern over time. Alternatively, there may be phases where the subject completely disengages from the relationship.

Some subjects may swing between closeness to one attachment figure, closely followed by intimacy with the other and the rejection of the first *(e.g. mother loved and father hated then father cherished and mother despised).*

SEVERE

The subject's descriptions include evidence of major disruptions of important relationships through dramatic swings, from intense intimacy and dependence to hatred or paranoid anxiety and a need to take a distance or destroy the relationship.

Here, oscillation is rapid and within the same relationship. The subject can be neither intimate nor distant for a significant period.

All attachment relationships are likely to be destroyed by this pattern over time.

There may be dramatic gestures, such as suicidal attempts or serious self-harm, thinly veiled as attempts at regulating the distance within the relationship.

RELATEDNESS:

LACK OF CONCERN TOWARDS THE OTHER (EMPATHY)

This scale aims to assess the subject's lack of awareness of others as separate and independent beings, with feelings, needs and rights

DESCRIPTION OF THE SCALE

Lack of concern towards the others involves a relative absence of conscious feelings of guilt, which could be part of a more general lack of emotional responsiveness. There may be a range of indications: callousness, selfishness, cruelty, lack of concern about the potential impact on the other person of one's actions, enjoyment of the other's suffering.

Even if the impact of the subject's actions on the other is noticed, it is not felt to be important in comparison with the subject's own needs. In some cases there may be awareness of the other's feelings, but these are then manipulated or exploited rather than responded to with concern

At the extreme end of scale, the subject either clearly enjoys the other's suffering or even deliberately causes it.

INSTRUCTION FOR CODING

Moderate lack of concern includes exploiting the vulnerability or the suffering of others which may be part of a more general opportunism. This is not inhibited by an awareness of their suffering and may even be accompanied by accounts of harsh treatment suffered by the subject, which may be portrayed as excusing his or her own callousness – the rater must not

be tempted to overlook the lack of concern shown by the subject and should be coded as moderate

CODING LEVEL: LACK OF CONCERN

MILD

The subject does not show emotional responses congruent to a description of others' distress or vulnerability (e.g. there is limited sadness when discussing how a loss affected others, or guilt when describing having hurt somebody).

There is a tendency to emphasise - more than expected from the questions - the subject's own needs considerably more than those of attachment figures or others in the family.

There may be an inappropriately dismissing remark about somebody else's suffering, perhaps intended to be humorous. The subject may alternatively come across as unsympathetic to others' feelings.

MODERATE

There is a marked incongruent response (e.g. laughter when describing the illness of an attachment figure),

The explicit denial of concern or guilt, or a description of an interaction with the attachment figure when such a reaction was shown.

A description that contains an account of exploiting the vulnerability or suffering of others, but this does not yet reach a level of cruelty – it does not intensify the suffering of the person concerned.

The subject may come across as intentionally causing suffering, though of a mild sort *(e.g. a subject who describes having deliberately increased his mother's distress at separation, by hiding when the parents came to collect their children).*

SEVERE

There is either clear enjoyment of suffering, or deliberate causing of suffering with no concern, or exploitation of suffering which would increase the distress, adding insult to injury. For example, there may be deliberate cruelty to animals causing significant pain or lasting harm.

Any account of causing severe injury or death, without accompanying guilt or disturbing affect, would also be considered a severe sign.
e.g. "I pride myself in reducing my father to tears"

PLEASE NOTE FOR CODING ON THIS LEVEL:
A description is more likely to be a severe indicator if it appears still to be felt in the present. Such descriptions are also likely to chill or jar on the reader, it is hard to have any empathy for the subject's reaction.

In the context of a situation involving life and death or catastrophic injury, then even a mildly callous reaction (which does not exacerbate the distress or injury) would be seen as a severe indicator.

SELF:
LACK OF SELF STRUCTURE/ COHERENCE

Extent to which the self is deliberately excluded from the narrative.

DESCRIPTION OF SCALE

Lack of Self-Structure/Coherence applies to individuals who experience the exclusion of the self as 'natural' and there appears to be little call for its restoration.
The self has withdrawn from relationships and cannot define itself in the absence of these.

At the extreme end of the scale, there is an absence where the person ought to be. The self is not prominent in these interviews in either an over or undervalued context. A sense of painful emptiness may result.

INSTRUCTION FOR CODING

LACK OF SELF-STRUCTURE VS. UNDER-VALUATION:
In more moderate cases there is an implicit under-valuation and there might be a profound dependence on others' views of the self. However, there is no pull on the part of the interviewee for reassurance as it would be characteristic for Under-Valuation

CODING LEVEL: LACK OF SELF STRUCTURE

MILD

On this level the subject tends to focus on other persons mentioned in the interview rather than themselves.

Even when subjects are directly asked about their own reaction the focus quickly shifts to other people in the narrative and the episode is recounted from the other person's perspective.

The subject is puzzled, hesitant and may have difficulty in producing a convincing response, when asked directly what they have learned over-all from their childhood experiences.

There may be slips of the tongue – confusing the self with other persons - but these are monitored or corrected.

MODERATE

On this level, there is confusion in the narrative about the self. The self does not emerge as a person independent of other people.

In the narratives the identity of the subject and object may become mixed or apparently interchangeable. This may be marked with slips of the tongue, which go unnoticed.

If asked for evaluations of issues the subject may appear to have no views.

They might experience great difficulty in finding adjectives or answers to direct questions about the reasons for the behaviour of others.

SEVERE

On this level, there is an absence of meaningful material in the narrative.
In general, the interview may be very short.
The subject may appear genuinely to have little to say in response to the questions. They may be quite distressed or frustrated by their inability to respond appropriately and ask for the interview to be terminated.
The subject indicates a total alienation from their own history and may recount events as if they were recounting someone else's experience.

As consequence they may be inappropriately factual, resistant to the line of questioning, claim ignorance or claim lack of memory for their late childhood and adolescence as well

SELF:

OVER-VALUATION

This scale aims to assess unrealistic over-valuation of the self

DESCRIPTION OF SCALE

Over-valuation of the self' applies to individuals which may present themselves as stronger, more robust, more central to other people's concerns, more successful, more powerful than is justified.
Occasionally, these characteristics may be shown in relation to the interviewer, where the subject assumes they are more interesting or important to the interviewer than is likely to be the case (e.g. subjects may feel that they are of special importance in a study, or that their material is of particular interest).

At the extreme end of scale, the subject takes it entirely for granted that he or she is of special importance. It is clear that for the subject, he or she is the only person who really exists or matters.

VIDEO CODING guidance

Look for any haughty behaviour, or high eye contact, close proximity and excessive talking time (evidence of dominance and control). Also look for behaviour which is the opposite to shame/ failure e.g. head held high, open posture, lengthy eye gaze, clear unbroken speech.

CODING LEVEL: OVER-VALUATION
MILD

IN THE NARRATIV:
the subject makes a somewhat unnecessary, positive reference to oneself, which strikes the rater as somewhat irrelevant.
A statement of one's own importance or abilities which may well be true, but are immodest or uncalled for.These references to the self are not counter-balanced by acknowledgement of one's shortcomings.

Narratives may contain a reference to their central importance within the family and/or other attachment relationships *(e.g., interpreting the parents' behaviour as more centred on the child than is really likely; expecting that the subject's own children feel and will always feel very close to him or her).*

The tendency to attribute other people's behaviour excessively to concern about oneself.

While there may be occasional references to the value of others, they are often less clearly acknowledged than the reader feels may be appropriate.
IN INTERVIEW:
Conveying that the interviewer probably has a special interest in something the subject is saying -but in quite a plausible way, if the subject is talking about an unusual attachment experience.

MODERATE
IN THE NARRATIV:

Intrusive positive references to oneself, which may have some factual basis but are certainly noticeable or irritating to the rater (e.g., intrusive positive reference in showing a magazine containing an article praising the subject).

The subject's claim to specialness are unrealistic, and inappropriate to the interview setting – even if there are real achievements, the claims for these are excessive and there are undisguised attempts at self-promotion
(e.g., the subject may keep describing experiences in unnecessary detail because he or she believes that they are especially interesting to the interviewer, more significant than things which happen in other people's lives.).

Self-aggrandisement is coupled with unwarranted criticism of others and the denial of their importance or value to the subject for their development.

There may be mention of other people's good qualities, but these are also likely to be exaggerated (idealised) and there is an implicit claim that the subject has ownership of the other's achievements or attributes.

IN INTERVIEW:
Interview questions may be criticised and replaced by the subject's preferred openings.

The subject may state that he or she is of special importance to the interviewer in a way that is not plausible.
E.g. He or she may state baldly that the interviewer must want to hear more about his life, or may be dissapointet that the interview is ending.

SEVERE

IN THE NARRATIV:
There are completely unsubstantiated claims to importance, and achievements, and any failures are likely to be contemptuously attributed to others' incompetence or envy.

Others are denigrated or dismissed, but if focussed on in positive terms, are strongly idealised and often seen as creations of the subject. In fact, on occasions, there may be a highly idealised figure, who is held up as an icon.

Undisguised boasting and use of the interview for the purpose of self-promotion.

The subject may describe himself as the only important child in his family, and more valuable than other people in his adult life (not that he was or is treated more favourably, but a sense of automatic entitlement to special treatment).

For example, the subject may state that the death of a sibling did not matter to the parents because he was still there, or that the parents behaved as they did because their only thought was for him and his welfare, all through his childhood, and that this is still their only important concern.

On this level, over-evaluation is the dominant theme in the interview.

IN INTERVIEW:
Condescension towards everybody, including the interviewer. The subject may convey to the interviewer that he or she is lucky to have the chance to talk to him, that his time and comments are immensely valuable.
The interviewer may be put under definite pressure to agree that the subject is special, better than other people or more interesting than the usual interviewee and the subject may become obviously irritated if this confirmation is not given.

Subject constantly forces the interview back to discussion of the self.

The subject frequently volunteers irrelevant information to emphasise his power, influence or importance, aggressively intruding this into the interview when the interviewer tries to bring the subject back to the topic which is being discussed.

The interview questions may be ignored as the subject pursues his or her own self-aggrandisement.

The subject may be irritated by the interviewer's focus on other people. Reference to other people's point of view or needs is resented, or the subject answers any question referring to another person with exclusive reference to himself, and he explains everything in terms of his own importance.

SELF:
UNDER-VALUATION

This scale aims to assess unrealistic under-valuation of the self.

DESCRIPTION OF SCALE

Under-valuation of the self' applies to individuals who see little role for the self, or importance of the self in the world or for other people.
The subject's account is marked by self-abasement and derogatory remarks in relation to the self and/or the depiction of the self as the victim of aggression.
The subject may externalise own feelings or self-worthlessness and may see others as an extension of his/her self-image. As a result he may express paranoid feelings concerning criticism, mocking or hostility, or expressions about personal inadequacy.

Occasionally, these characteristics may be shown in relation to the interviewer, where the subject assumes they are less interesting or important to the interviewer than is likely to be the case (e.g. subjects may feel that the interviewer finds things the subject is saying boring or disappointing.

At the extreme end of scale there is an apparently complete absence of any sense of achievement or positive attributes, and this continually intrudes into the interview. The subject's low sense of self is unremitting and pervasive in the context of all attachment relationships.
Subject's feeling of guilt is overwhelming and persecuting, yet seeming in his eyes justified.

The subject may be so convinced of their worthlessness that the interviewer is assumed to be in agreement with the completely bleak picture that is painted.
There may be an implicit call for reassurance from the interviewer, and with increasing severity this becomes compelling. However, if gratified by the interviewer, offering positive feedback of some sort, it leads only to renewed self-denigration

VIDEO CODING guidance

Look for any failure related emotion (embarrassment or shame) marked by: gaze aversion, gaze and head downward and rigid, slouching, forward leaning posture or blushing. Look for any embarrassment marked by nervous silly smile, shifty eyes, speech disturbances and face touches or blushing.

Check to see if any contempt or anger towards the self is present: Person may show signs of tension e.g. difficulty speaking, fidgeting, plucking at clothes, rubbing face,

biting nails, shifting posture, involuntary twitches, tight muscles or posture, tight jaw, raised or lowered voice beyond normal range, short sighs.

There may also be constrained anger towards self e.g. stuttering, short burst sighs and self directed sarcasm (noted in voice tone), hostile humour and rolling eyes. Also may show mild self-harming behaviours e.g. slapping, knocking or repeated scratching of self during interview.

CODING LEVEL: UNDER-VALUATION

MILD

A statement of one's own insignificance or deficiencies seems over-modest.

A description of a negative aspect of the self is not counterbalanced by an acknowledgement of one's strength.

The subject may refer to his or her low importance within the family and/ or other attachment relationships.
(e.g., describing the parents as rightly underinvolved with the child; expecting that the subject's own children or current attachment figures feel distant from him or her).

Others may be presented as more valuable or important than the reader feels is appropriate, and may be too readily excused for their failures towards the subject

The subject makes a derogatory remark about himself in relation to others, hereby blaming himself in the narrative.

The language used to describe the self may be unnecessarily condemnatory.

IN THE INTERVIEW:
The subject may show some over-sensitivity to the questions or to the interviewer.

The subject makes an unnecessary, negative reference to oneself which strikes the rater as somewhat irrelevant (*e.g., conveying that the interviewer probably finds things the subject is saying boring or disappointing)*

The interview may show a number of examples of over-sensitivity to the questions or to the interviewer.

MODERATE

The subjet makes an intrusive negative reference to oneself, which may have some factual basis but are noticeable to the rater (e.g., the subject may keep describing experiences in unnecessary detail because he or she believes that they are clear evidence of limitations or failures; the subject may state that he is particularly uninteresting or a spectacular failure).

The subject depicts himself as victim of others aggression.

There is a suggestion that no efforts of either the subject or anyone else would be likely to help him or her, because of the subject's inadequacies. There may however be a marked sense of shame about these inadequacies, often about having let others down, and a sense of humiliation in the interview

Incidences of self-harm are hinted at but are not acted out.

IN THE INTERVIEW:

The subject claim to unworthiness is unwarranted, and may be inappropriate to the interview setting. *(e.g., he may state that the interviewer is wasting her time by talking to him or her)*. This self-depreciation may be coupled with unwarranted emphasis on the qualities of others.

There are implicit calls for reassurance, either about the narrative or about the subject's performance and compliance in the interview. There might be some pressure on the interviewer to reassure or compliment the subject, but if this is offered then the subject will quickly trump the interviewer's effort to find evidence of something positive.

The subject misinterprets the interviewers comments as mocking or critical.

The interviewer may be seen as being unsympathetic

SEVERE

The subject's remark indicates that there is an overt preoccupation with the subject's worthlessness, the picture is of no redeeming qualities past or future.
(e.g., the subject insists relentlessly that he or she is useless, uninteresting, worthless, and so on. the subject feels that he or she has let everybody down and failed all expectations anybody might have had of him).

Even when there is a more positive aspect about the self presented (and perhaps taken up by the interviewer as a way of offering reassurance), it is immediately turned round so that the whole interview becomes further evidence of the badness and worthlessness of the self

The subject believes that everyone shares his or her own hyper-critical views.

Self-blame for the aggressive acts of others is frequent with excessive and inappropriate guilt.

There may be explicit wishes to be punished further or to punish themselves, or to die, for imagined misdeeds.

Subject may even report acts of self-harm.

IN THE INTERVIEW:
The subject at this level no longer presses for reassurance, instead there is implied pressure for agreement, the subject does not have a conception that the interviewer might have a different perspective

The interviewer may be put under definite pressure to agree that the subject is bad, worthless, worse than other people or less interesting than the usual interviewee

At this level, the self-deprecation is unremitting and is pervasive in the context of all attachment relationships and throughout the interview.

The interviewer is seen as sharing the critical attitude of the attachment figures

SELF & OBJECT REPRESENTATION:
LACK OF INTEGRATION OF OBJECT REPRESENTATION

Then main feature of these scales is a distortion of an otherwise coherent or consistent object representation in the narrative.

DESCRIPTION OF SCALES

Normally, important figures are represented in complex, multifaceted ways with the subject taking appropriate responsibility for the bi-directional, transactional character of the relationship A lack of integration of object representation can either be exaggerated and oversimplified [A] or contradictive and incoherent [B] and is therefore coded on two subscales:

[A] EXAGGERATED AND OVERSIMPLIFIED OBJECT REPRESENTATION

and

[B] INCONGRUOS AND INCOHERENT OBJECT REPRESENTATION

INSTRUCTION FOR CODING
The subject's description may contain one or all the following indicators:

[A] The attachment figure is represented in a way which appears to the reader as an exaggerated and oversimplified aspect of a more complex relationship.
or

[B] The description of the attachment figure is contradictory and the relationship appears rapidly to shift in the interview (prototypically from one extreme to another), without the subject explicitly recognising it.

SELF and OBJECT REPRESENTATIONS:

LACK OF INTEGRATED OBJECT REPRESENTATION

[A] EXAGGERATED AND OVERSIMPLIFIED OBJECT REPRESENTATION

This scale aims to assess a lack of balance and complexity with which past and current attachment figures are represented in the subject's mind.

DESCRIPTION OF SCALE

The main feature of this scale is a distortion of an otherwise balanced and complex object representation in the narrative. Normally, important figures are represented in complex and multifaceted ways with the subject talking appropriate responsibility for the bi-directional, transactional character of the relationship. When this balanced representation is not present, the description of the attachment figure is exaggerated and oversimplified in either negative or positive terms rather then being complex and multifaceted (splitting).

At the extreme end of the scale, there is a significant split in the representation of the attachment figure who is described in exaggerated and unsupported negative or positive terms

INSTRUCTION FOR CODING
The attachment figure is represented in a way which appears to the reader/ viewer as an exaggerated and oversimplified aspect of a more complex relationship
CODING LEVEL: EXAGGERATED AND OVERSIMPLIFIED OBJECT REPRESENTATION

MILD

The reader gets the impression that an account of an incident is distorted so that some unrealistic blame or credit is attributed to the other.

MODERATE

Marked exaggeration of a description of a relationship, or of an aspect of a relationship.

Relationships are characterised by a single quality which appears to the reader a very limited and highly selective account.

SEVERE

The attachment figure is seen as having only one overriding characteristic.

All problems within the relationship are blamed on the attachment figure

A highly dysfunctional relationship is described in glowing terms, the attachment figure may be exonerated from any responsibility for difficulties.

SELF and OBJECT REPRESENTATIONS:

LACK OF INTEGRATED OBJECT REPRESENTATION

[B] INCONGROUS AND INCOHERENT OBJECT REPRESENTATION

This scale aims to asses a lack of coherence and consistency with which past and current attachment figures are represented in the subject's mind

DESCRIPTION OF SCALE

Then main feature of this scale is a distortion of an otherwise coherent or consistent object representation in the narrative. Normally, important figures are represented in complex, multifaceted ways, hereby remaining a coherent and homogeneous person.

At the extreme end of the scale, there is a marked oscillation between different characteristics which are extreme, and thus appear confused and confusing

INSTRUCTION FOR CODING

The description of the attachment figure is contradictory and the relationship appears rapidly to shift in the interview (prototypically from one extreme to another), without the subject explicitly recognising it.

CODING LEVEL: INCONGROUS AND INCOHERENT OBJECT REPRESENTATION

MILD

At some point during the interview, the subject depicts an important relationship in contradictory ways without explicitly recognising this.

MODERATE

Different characterizations of a relationship rapidly follow each other without understandable explanation.

SEVERE

The subject's descriptions are extreme and shifting and appear confused and confusing

The attachment figure is depicted with two or more irreconcilable personalities.

SELF & OBJECT REPRESENTATION:

INAPPROPRIATE AFFECT TONE

The aim of this scale is to provide an overall rating of the inappropriateness of feelings toward important attachment figures.

DESCRIPTION OF SCALE

This scale aims to assess the inappropriateness of affect in relation to the representation of important attachment figures.
Excessive inappropriate negative, positive or flat affect is thought to lead to a distortion of, or detachment from, attachment figures in the mind of the individual.

By contrast, if appropriate positive or negative feelings predominate, this may allow attachments to others to function constructively giving an internal sense of safety. The presence of more benign and balanced affects suggests working through has taken place and an individual is less likely to be overwhelmed by peremptory wishes and desires.

At the extreme end of the scale: insert later

INSTRUCTION FOR CODING:

The rater is instructed to look for discrepancies between the experience and the response of the subject and the type of the affect expected in the circumstance under consideration. The aim is to identify the dominant affect tone emerging from the split.
Moderating Factors:
The rater should consider two classes of possible moderating factors, which lead to an adjustment of the rating by one category in the direction of increased appropriateness. (e.g. from moderate to mild):

a) LISENSING
i.e., interiewee might 'license' the discrepancy between experience and response.
Phases such as: "I realise that it must sound funny to you that I still love him, even though he was so cruel to me" or "It is silly for me to be sad" or "I was really angry but I know that she was a very good mother in other circumstances" etc.
'Licensing' the response by acknowledging the discrepancy should lead the rater to adjust the intensity of the response in the direction of increased appropriateness by one level.
b) LEGITIMISATION
Other than the expression of awareness or insight, the subject might moderate the discrepancy by contrasting past experience with the present perception of the event, where only the past perception shows inappropriateness.
For example, "When he did not turn up, I did not feel hurt at the time. Now I see it as quite neglectful and I feel quite angry with him".
In this example, there was inappropriate lack of affect concerning a minor experience; this is 'legitimised' by the subject's current awareness of the appropriateness of anger in that circumstance. Legitimisation would lead the rater to adjust the experience rating by one category in the direction of increased appropriateness.

Neither legitimisation nor licensing can be considered as increasing the inappropriateness of the response. We assume that in most cases such shifts are part of a process of working through.

CODING LEVEL: INAPPROPROPRIATE AFFECT TONE

MILD

At this level the affect expressed is not marked, but is either more than you would expect, or is mild, but not in the direction one would expect from the subject matter.

It may be that signs of inappropriate affect tone are in the moderate range, but if the discrepancies are recognised by the interviewee and an attempt is made to deal with them, then this would be rated here.

Mild signs of negative inappropriate affective tone will include, for example, expressions of anxiety, fear, uncertainty, sadness, disappointment, anger, resentment or suspicion of others, which is somewhat inappropriate regarding the described episode.

Mild signs of positive inappropriate affective tone will include, for example, expressions of neutrality and acceptance towards a caregiver who appears to have been neglectful.

MODERATE

At this level affect tone must be inappropriate not only in its quantity but also in its quality. The inappropriate affect is marked but not overwhelming to the subject.

Signs of inappropriate affect tone in the moderate range are not recognised by the interviewee and there is no attempt to deal with them.

Moderate signs of negative inappropriate affective tone will include, for example, expressions of moderate anxiety, fear, uncertainty, sadness, disappointment, anger, resentment or suspicion of others, which is inappropriate regarding the described episode.

Moderate signs of positive inappropriate affective tone will include, for example, expressions of warmth, gratitude, and appreciation towards a caregiver who appears to have been neglectful.

SEVERE

At this level the signs for inappropriate affect tone are extreme in their quantity and quality.

In addition to the extreme expression of inappropriate tone both in quantity and quality, one of the following aspects must be present:

Marked signs of negative inappropriate affective tone will include, for example, expressions of extreme anxiety, fear, uncertainty, sadness, disappointment, anger, resentment or suspicion of others, which is completely inappropriate regarding the described episode.

Marked signs of positive inappropriate affective tone will include, for example, expressions of warmth, gratitude, and appreciation towards a caregiver who clearly has been extremely neglectful or even abusive.

In general on this level, .affects are more severe (*e.g., fear of parent; idealisation*) and there is a paradox discrepancy between experiences and affective responses.
The individual is likely to be overwhelmed.

SEXUALISATION:
EROTISATION

Extent to which the attachment system has been infused by sexual feelings

DESCRIPTION OF SCALE
Sexual and attachment behaviour - although linked - are fundamentally distinct from each other (Bowlby, 1969, 1982, pp. 230). The activation of the two systems varies independently from each other and is directed towards a different class of objects.
As attachment behaviour persists into adulthood, adult (sexual) relationships can be infused by attachment behaviour. E.g. one might treat a sexual partner as though the partner was a parent, and the partner may reciproate by adopting a parental attitude in return.
By contrast, attachment relationships infused with sexual feelings presents a corruption of the domain and a violation of the function of attachment behaviour (incest barrier).

This scale aims to assess sexual ideas and feelings emerging within the attachment context (see Instruction for Coding). At a moderate level, attachment needs are inevitably associated with sexual feelings. At the extreme end of the scale attachment relationships were or still are confused with sexual relationships. The attachment need serves a perverted sexual aim.

INSTRUCTION FOR CODING
Indicators of sexualisation of attachment relationships can be found in any relationship with attachment figures:

- relationship with parents and other caregivers (past and present)
- relationship with teachers, minders etc in childhood
- relationship with own children

Please note: Sexualised ('flirtatious) behaviour towards the interviewer is not coded by this scale.

CODING LEVEL: EROTISATION

MILD

At this level, there is an atmosphere of sexuality which is hinted at without clear accounts of sexualised incidents or approaches.

E.g. the subject may describe having felt that her father had a very special relationship with her as his 'little princess', which excluded the mother.

There may be a romanticised, exclusive or vaguely sexual description of the relationship with an attachment figure or child.

The subject describes an atmosphere of sexuality which is hinted at without clear accounts of sexualised incidents or approaches.

The subject may recall events having been inaccurately interpreted as sexual by an attachment figure.
(e.g. the teenage girl comes home late, father accuses her of being a whore, about to get pregnant).

MODERATE

On this level, there is some indication that the attachment system has been hijacked to a sexual end. This may be most evident in the narrative account of the parent-child relationship that includes some degree of seduction.

The current relationship with the parent or chld may also have a highly inappropriate sexual focus.

On this level there is no clear evidence that sexual abuse conderning an attachment relationship has actually taken place.

However there may be descriptions of sexual abuse outside the context of attachment relationships.

Alternately, the subject might describe incidences outside the context of attachment relationships that have been interpreted as sexual and abusive.

There might be an atmosphere of these relationships being infused with sexual feelings, and of boundaries being blurred.

Examples:
The subject reports that being shown love and affection was conditional on offering physical comforting to the parent, even though this was experienced as sexual by the child.
The boy is invited to admire the mother's physical attractiveness (her body shape, her hairstyle or her underwear).

An adult man living with his mother reports the mother insisting on having a contact number whenever he is out with a woman, ringing him and insisting on knowing where he is and what he is doing.

SEVERE

On this level there may be either clear indication that sexual abuse has taken place within the context of an attachment relationship.

There may be descriptions of repeated, actual parental sexual abuse towards the child, so that the whole atmosphere of the family and of subsequent attachment relationships is infused with sexual feelings, and boundaries are blurred.

Attachment behaviour such as protectiveness or the wish to be close to another person are consistently described in overtly sexual terms.
(e.g. expressions of affection from either parent are remembered by the subject as sexual invitations, and there is no expectation of intimacy being possible without erotic expression).

Boundaries of sexuality itself becoming blurred and thus perverted (producing any variety of perverse sexuality, e.g sadistic, fetishistic, etc or children and adults being seen as interchangeable partners).

14. PDCM score sheet

SUBJECT:		CODER:	Tanya
DIMENSIONS	**SCALES & SUB-SCALES**	**COMMENTS**	**SCORES**
AFFECT	DOWN		
	UP		
	LABILITY		
AGGRESSION	EXTERNAL		
	PASSIVE		
COGNITION	DISTURBANCE OF THINKING		
RELATEDNESS	ANXIOUS DEPENDENCY		
	HOSTILE GRIEVANCE		
	[A] LACK OF ATTACHMENT		
	[B] OVER-EXTENDED ATTACHMENT		
	OSCILLATION		
	LACK OF CONCERN		
SELF	OVER-EVALUATION		
	UNDER-EVALUATION		
	LACK OF STRUCTURE		
SELF & OBJECT	LACK OF INTEGRATION [A] EXAGGERATED		
	LACK OF INTEGRATION [B] INCOHERENT		
	AFFECT TONE		
SEXUALISATION	EROTISATION		