SCHIZOPHRENIA: ADOLESCENT DEVELOPMENT AND SELF- CONSTRUCTION

by

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A thesis submitted to the Faculty of Science
of The University of Birmingham
for the degree of
DOCTOR OF PHILOSOPHY

School of Psychology
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The University of Birmingham
August 1998

Synopsis

The thesis starts with a review of the various branches of schizophrenia research, concluding that there is no evidence that biological differences should take precedence over psychological differences in people with schizophrenia, and that the opposite argument is as compelling. The purpose of the opening section is to critically evaluate and make explicit these key paradigm assumptions, and in doing so lay the framework for the rest of the thesis. The literature on normal adolescent development is then reviewed and a theory about late-adolescent onset schizophrenia put forward. The first empirical study demonstrates that levels of mild psychotic-like 'symptoms' in normal teenagers were intimately linked to levels of psychological development. The second study shows that people with a diagnosis of schizophrenia showed on average a level of psychological development much more akin to young teenagers than normal adult controls.

From the two studies it is speculated that psychosis-sufferers become stuck at that point in development where normal psychotic-like symptoms are most prevalent. Unlike 'normal' adolescents, psychosis-sufferers fail to resolve this phase. The second part of the thesis focuses on the psychological mechanisms whereby this may come about and elaborates a theory of self-construction, threat and defence, within the context of the established literature on the Self. An empirical study reconstructs key episodes from schizophrenia sufferer's lives. It was found that clients experience a dilemma between self-actualisation goals and affiliative goals, and that the pressure of this dichotomy could explain the development over time of many of the symptoms of schizophrenia. Finally, hypotheses derived from the empirical self-construction chapter are tested in another empirical study, and the thesis as a whole is discussed.

Acknowledgements

Heartfelt and enormous thanks to my supervisor, **Peter Trower** for his immense help towards this thesis. I also want to thank Peter for his emotional support and friendship over the 4 years, which has similarly could not have been better!

Thanks also to **Dr. Ian Mitchell** for enormous help, not just in the first chapter, and the others he advised with, but also his knowledge of great Liverpool teams past.

Thanks to **Anjula Gupta**, **Amtul Hashemi** and **Chris Jones** for the many interesting and supportive chats. Also to **Peter Mitchell** for advice and insights.

Special thanks to the **School of Psychology** for 3 years of funding; also **South Birmingham Mental Health Trust** (especially **Alan Meaden**) - for financial support in a crisis.

At a personal level, thanks to **Lourdinyesh Santos, Christos Giachritsis**, **Rhodri Cusack, Nina Sekhon, Amanda Pennell, Nik Hargaden** and the **6th floor people**. Also **Psycho FC** and the **Thursday night footballers**.

Posthumous respect to **Jim Hughes**.

Thanks to **Garth Harrop**, **Patricia Harrop** and **Sarah Harrop**.

Finally, thanks to **Anjula Gupta** for <u>everything</u>

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Chapter 2[Ψ]

2. Why does schizophrenia develop at late adolescence?

Schizophrenia is one of the most researched, yet least understood problems. One of the cardinal features of schizophrenia has been neglected- that schizophrenia typically emerges at late adolescence. Around 25% of normal teenagers report finding adolescence distressing. Certain characteristics typical of adolescence are reviewed such as argumentativeness, grandiosity, egocentrism and magical ideation, and it is demonstrated that they bear a distinct resemblance to phenomena seen in psychosis. For most adolescents, such phenomena pass with successful psychological development. It is proposed that psychosis in late adolescence is a consequence of severe disruption in this normally difficult psychological maturational process, and explanations are offered as to why and how this comes about. It is suggested that problems either in individuating from parents or in bonding to peers or both may lead to crucial self-construction difficulties, and that psychosis emerges out of this 'blocked adolescence'. This approach allows professional services to side with both parents and clients simultaneously, and is normalising and stigma-free.

[Ψ] *An abridged version of this chapter has been accepted for publication in* ***Clinical Psychology Review*** *(early 2000).*

2.1.1 Introduction

By any standards, schizophrenia is a major problem, both in terms of the degree of suffering (it is one of the most severe and debilitating of the mental disorders), prevalence (affecting roughly 1% of people; Sartorius, 1986) and cost (between 0.3 and 0.7 per cent of GNP of Western countries; McGuire, 1991). Despite enormous research effort, schizophrenia remains largely one of the great unsolved mysteries, and this has led many researchers to criticise the very concept and definition of schizophrenia (Bentall, Jackson and Pilgrim, 1988; Boyle, 1990; see appendix A). At the very least it seems likely that the category of schizophrenia actually refers to "the broad range of disorders that have at some time been given the name "schizophrenia" (Wing, 1988, p326), i.e. a heterogenous category, containing a number of 'schizophrenias' (Crow, 1980). Accordingly, it seems unlikely that that there will ever be one all-encompassing theory of schizophrenia. Given this diversity, it is not surprising that there are a large number of theories, of which few if any have survived empirical evaluation. In the continuing search for alternative theories, this paper offers another theory to be used eclectically with the established literature. The new theory is based on the one facet of schizophrenia that has been consistently overlooked. It has been said that there are three inescapable clinical facts about schizophrenia (Weinberger, 1987)

1) Neuroleptic drugs have a therapeutic benefit.

2) Stress is involved in onset and relapse.

3) Late adolescence or early adulthood is the time when schizophrenia usually becomes clinically apparent.

Research has been mainly targeted at the first two facts, (neuroleptics and stress) while the adolescence angle has been neglected. This is a big omission given the evidence that in the majority of cases, schizophrenia arises in late adolescence: a World Health

Organisation sponsored study in 9 countries found that 50.9% of their cases were aged between 15 and 25 (Sartorius, 1986; Jablensky and Cole, 1997)). 82.5% of participants were between 15 and 35. Most of these subjects were within 12 months of first showing psychotic symptoms (86%). All other studies have shown the same results; e.g. Häfner et al (1993b) found that 62% of males and 47% of females had symptoms before 25.

A psychological-developmental theory is put forward that argues that early psychosis is a consequence of blocked psychological maturation during adolescence. This argument will be developed in two stages. First, evidence is considered of the link between schizophrenia and normal adolescent development by reviewing the parallels between, on the one hand, difficult periods and associated needs in normal teenagers and on the other, psychological disturbances that characterise the majority of young schizophrenia sufferers. Second, the issue of **why** normal adolescents might become blocked in their psychological development is examined, and finally **how** these blocks might lead to the precipitation of symptoms is explored.

The last time psychological accounts of schizophrenia were attempted was in the 1960's, and so it is important to stress that a new psychological theory does not imply a return to the theories of "schizophrenogenic mothers" and pathological families of three decades ago. This theory is more scientifically valid by the criteria of philosophy of science (Harré and Secord, 1972), and also does not blame family members; instead what happens is described as an unfortunate consequence of normal adolescent development. The beauty of the paradigm is that it supports both parents and child.

2.2 Comparison of Normal Adolescent Developmental 'Turbulence' and Psychotic Disturbance

In this section, the adolescence literature is selectively reviewed. Because the literature is so vast, the review is not comprehensive; instead one predominantly clinical framework is adhered to, and this no account is taken of other controversies in the adolescence literature such as cultural or historical variation. Although this is a useful framework, the thesis does not depend on it, in that it is uncontentious a 13 year-old's view of the world is different to a 19 year-old's. After setting out the general framework that adolescence research uses, first empirical data is considered that supports the existence of the phenomena. The theoretical explanation of the phenomena is examined where appropriate, and finally the relevance to psychosis is examined.

2.2.1 The two basic psychological needs of adolescence

1) **Autonomy and individuation from the family**. A major theme of the adolescence literature is that an adolescent needs to emerge from under the parents as a person in their own right. An individual needs to have their own control over issues such as when to go out, who to hang out with, what to eat, etc. Individuation from parents and others occurs at adolescence- in essence the teenagers says "I am of you, but I am not the same as you".

2) **Forging peer relationships**. There is a need to be able to relate to peers in a way that can replace the lost attachment to the parents. For example, it has been postulated (Dunphy, 1972; Brown, 1986) that teenagers progress through same-sex gangs, to mixed sex gangs, to the formation of "romantic dyads". The empirical evidence suggests that although there is much variation between individuals and between genders, it can be generalised that peer

relationships (heterosexual or homosexual) become far more important and usually in the larger part replace parental attachments (Berndt, 1979).

2.2.2 Adolescent phenomenon 1: "Storm and stress"

There is probably more stress during adolescence than in any other stage in the life-cycle. For example, Siddique and D'arcy (1984) found that 28% of their sample reported high levels of psychological distress. Interestingly, a large number of teenagers did not report unbearable stress, and current thinking is that the intolerability of stress has been over-estimated (Youniss and Smollar, 1985). Thus for a significant majority adolescence is very distressing. Coleman (1979) speculated that whether or not adolescents experienced distress related to how free they were to "budget" their problems. Ideally, they would only take on as many problems as they could focus on at any one time. An individual experiences distress when more major life events are forced on the adolescent than they can cope with at once (called the "focal theory"; Coleman, 1979). Distress is also thought to be related to how much the family supports the individual through this difficult time. Studies have shown that the number of life transitions occurring is inversely related to school performance and self-esteem (Simmons and Blyth, 1987).

2.2.2.1 Stress and psychosis

Given the implications of the focal theory, a first hypothesis regarding schizophrenia is:

Schizophrenia arises because too many life events arrive at the same time for the adolescent to be able to handle them. Or *Adolescents who develop psychosis have very poor skills to be*

able to manage themselves and their traumas. This is close to traditional theories in the psychosis literature that say stressful life events bring on schizophrenia (in genetically vulnerable people) (Norman and Malla, 1993; Neuchterlein and Dawson, 1984). Some studies have estimated that as many as 70% of people who experience psychosis had stressful life events in the preceding 3 weeks (Brown and Birley, 1968).

2.2.3 Adolescent phenomenon 2: Conflict between adolescents and parents

Behavioural development in adolescence is characterised by there being much conflict between teenagers and their parents; this can be seen as a natural consequence of the need to individuate. This common stereotype of conflict between adolescents and their parents, and this has been borne out by research (Coleman, 1974; Rutter et al, 1976; Montemayor and Hansom, 1985). Conflict is less likely to be over "big" issues such as politics or religion; instead it is over issues of rule-breaking and non-compliance to parental requests. For example, Smetana (1989) asked normal family members to recount their versions of family disputes and justify the stances they took. The adolescents were likely to be arguing because they saw the issue as something that should now be under their personal jurisdiction (for example "cleaning one's room" for them would have been a matter of personal choice). Parents argued because they thought that the issue was something parents should have authority over. In effect, the conflicts arise because adolescents are constantly gaining ground, negotiating their way from 'subordinate' to 'self-ordinate' beings. This is difficult for parents, who are unsure about relinquishing the protection they give their child. "The parental task is to accept as best they can the adolescent's call for greater freedom" (Coleman and Hendry, 1990, p.84). They are also having to come to terms with another major role for themselves, that of middle-aged people with grown up children.

2.2.3.1 Conflict and psychosis

Data on how much conflict there is in families of people with a psychosis is difficult to collect. An interpretation of the mass of family work (E.g. Wynne and Singer, 1963; Leff and Vaughn, 1985; Birchwood and Tarrier, 1992) is that there is much variation, from families with no dischord at all, to those with much. Our own data suggests that many are highly anxious about dischord; clients are significantly more likely ($p<0.01$) than student controls to endorse questionnaire items reflecting this difficulty, such as "People who argue with Mum are awful", "I never say things my Mum may not want to hear" (see chapter 7). On the other hand it is likely that most clients would like to be more independent and empowered regarding their families (Barham, 1993). For example, theories from the 1960's (e.g. Laing, 1965) are very popular with clients partly because they blamed the parents for the client's illness, and in doing so empowered the clients. Clients themselves usually find the medical model alienating because it entails that sufferers themselves have no control over the illness and there is nothing they can do to get better, except take medication (Reeves, 1997). Clients are often very reluctant to accept that they are even ill (David, 1990). It also seems that many clients are really looking to have an issue on which they can legitimately oppose their parents, as if they were trying to start on the process of rebellion outlined above. Indeed, much of the psychosis literature resembles a battle between parents and their offspring as to who is 'right' or who is 'to blame' for the illness (Clare, 1980). Parents are often keen to embrace the medical model because it blames the sufferer's body, and reassures the parents that they are not to blame (Clare, 1980). Rejecting the medical model has previously seemed to imply one has to blame the parents, in the absence of alternative psychological theories; however clients can be empowered without blaming parents.

2.2.4 Adolescent phenomenon 3: De-idealisation and autonomy

Cognitive development is the driving force behind the adolescent's conflict behaviour. They would not be able to stand their ground and win their battles unless their perspective on their parent's behaviour had changed. A necessary part of gaining autonomy is a capacity for independent judgement and this entails a re-assessment and perhaps rejection of the old rules that used to bind them during their teenage years. Blos gives a poetic account: "Whereas previously the parent was overvalued, considered with awe, and not realistically assessed, he now becomes undervalued and is seen to have the shabby proportions of a fallen idol....The adolescent becomes arrogant and rebellious, defies rules because they are no longer universal absolutes, but have to be tested for being inventions of a deranged despotic parent." (Blos, 1962, p.91).

Does it happen? Steinberg and Silverberg (1986) devised the Emotional Autonomy questionnaire, based around the writings Blos (1962). One of the subscales is de-idealisation, and this was shown to increase linearly with age, for the 865 teenagers who completed it. The young adolescent begins to be aware of the fallibility of their parents: "What used to be the centre of his world and an authority on everything now becomes something human and motivated by hitherto unsuspected human motivations." (Blos, 1962, p185).

If de-idealisation is the process that precedes and facilitates autonomy, then the mechanism of change is taken to be simply the learning about other people that comes from repeated exposure to them. This is to say that a simple, parsimonious account can be gleaned from considering development in this way, although regarding cognitive development in adolescence there are many complementary schools of thought (e.g. *sociological* work focusing on role changes and demands (Thomas, 1968); or *lifespan-developmental* work,

where the emphasis is on the contribution the individual themselves actively makes to change, e.g. Lerner, 1987.)

2.2.4.1 De-idealisation/ autonomy and psychosis

To summarise the argument, de-idealisation may be an essential precursor to the development of autonomy which in turn may be essential to successfully completing adolescent development. Still seeing the world in a more childlike way would therefore make it very difficult for an individual to function as an adult. For example, still having idealised views of one's parents as especially powerful, knowledgeable 'gods' , (like a small child perhaps does) would make doing the things that adults do- e.g. cooking, driving, etc., very intimidating. Two specific hypotheses are derived:

1) Some people with a psychosis are not very autonomous, and still have a simplistic and idealised view of their parents. Their child-like viewpoint makes it difficult for them to operate autonomously in the adult world.

Later in the thesis, empirical evidence is presented for this claim. Compared to students, psychotic clients were significantly more likely to endorse items such as "My Dad is always fair" and "I have never known my Dad to lie" ($p<0.05$; chapter 7). Compared to gender, age and educational level matched controls they score significantly higher on the idealisation subscale of Steinberg and Silverberg's (1986) Emotional Autonomy scale (chapter 4). On their overall scores on this scale, the psychosis group resemble 13 year olds more than older adolescents (chapter 3).

As detailed above, one explanation for many of the characteristics of adolescent turmoil can be derived from the idea of developing autonomy and such concepts as "de-

idealising parents". In normal adolescents, part of the resolution of the uncomfortable period of adolescence comes with bonding to peers and leaving the family. The second hypothesis therefore is:

2) Some individuals with a psychosis have gone part way towards an adult, autonomous view of their parents, but cannot relate to their peers and end up stranded in a social and psychological 'no mans land'. For these people, their relationship with their parents has been re-negotiated, and they are experiencing common adolescence phenomena, (for example conflict with their parents, depression). Unfortunately, the situation does not get resolved, because their peer relationships are not well developed enough, perhaps because they have not de-idealised their peers yet (this will be explored later). In these circumstances the condition of being a troubled teenager may gradually and insidiously deteriorate to become a partial or full psychosis.

In another chapter of this thesis (chapter 6), data are presented where 80% of clients fitted the first hypothesis, whereas the remaining 20% fitted the second. Clients in the former group reported being anxious about ever expressing anger at their parents, and had strong rules about how they should behave towards their idealised parents. Clients in the smaller second group had no qualms at all about expressing anger towards their parents and behaved in an almost tyrannical fashion.

Not only are there resounding parallels between teenage phenomena, as found in the adolescence literature, and psychological experiences seen in psychosis, but also the explanatory theories of adolescence are remarkably consistent with cognitive theories of psychosis, as is seen below.

2.2.5 Adolescent phenomenon 4: Depression and loss. "Heaven knows I'm miserable now" (Smiths, 1984)

De-idealising parents is not going to be an entirely positive experience, because in return for the greater personal freedom that adolescents gain, they lose a lot in terms of security and attachment. This can lead to a sense of loss, depression and unsureness, amongst other things. Losing one's image of parents as ideal can be a great loss indeed. Often clients are reluctant to relinquish this comforting image. Some researchers have suggested it is as traumatic as a bereavement, as it is a bereavement of a kind. Does it happen?

There is much evidence that a number of negative experiences such as depression and loss go hand in hand with the development of autonomy. For instance, Ryan and Lynch (1989) suggested that the Emotional Autonomy Scale in fact measured more negative factors to do with detachment than autonomy. This was because the scale correlated very well with some apparently negative phenomena such as the amount to which adolescents said their parents did not accept them, and their lack of "felt security". However the argument is that emotional autonomy is something that disposes the adolescent to take a much less sympathetic view of the parent than non- autonomous, still -idealising teenagers do. It should not be surprising, therefore that people high on Emotional Autonomy also endorse items associated with poorer parenting.

2.2.5.1 Depression and psychosis

Depression is so common in psychosis that there is a separate category in the ICD-10 diagnostic criteria for "Post-schizophrenic depression" (WHO, 1990). Depression may come

from de-idealisation, but even if this is avoided, then depression may arise from a lack of individuation and adult functioning as it is suggested happens in some forms of psychosis. There is a significant prevalence of depression and anhedonia in psychosis. Often when the more florid symptoms of psychosis are in remission there is a depression still present, in a third of people (Birchwood et al, 1993). It has traditionally been thought that such emotion is a response to the losses involved with breakdown, such as loss of career aspirations, and loss of respect and standing amongst one's family and friends. It is suggested here that it may also be due either to thwarted needs for autonomy and the associated need to rebel against parents, or from the losses involved in a partial rebellion.

2.2.6 Adolescent phenomenon 5: Egocentrism, grandiosity and self-consciousness

Another important area of adolescence research that has enormous relevance for psychosis is adolescent egocentrism. David Elkind suggested that adolescents behave as if they carry an audience around in their imagination (Elkind, 1979). The idea of the "Imaginary Audience" can be used to explain many aspects of adolescent behaviour. For example, it lends teenagers a certain grandiosity: "Possibly because the adolescent believes he or she is so important to so many people (the imaginary audience) they come to see themselves, and their feelings as very special, even unique." (Elkind, 1967, p.1031).

The stereotype of the self-absorbed teenager is well known, but is it realistic? Empirical testing has shown that in normals, egocentricity is high in early (13) and mid (15) adolescence, and then declines from mid to late adolescence (17) (with a further peak in a college sample). Self- consciousness increases from mid to late adolescence (Enright, Shukla and Lapsley, 1980; Lapsley et al, 1986).

Elkind (1967) offered an explanation of the phenomenon; the adolescents find it difficult to distinguish between *what others are attending to* and *what they themselves are attending to.* They assume if they themselves are obsessed by a thought or a problem, then other people must be obsessed by the same thing. Elkind suggested that this is because they have yet to develop that cognitive capacity. The paradigm Elkind used was based on Piaget's work on adolescence (Inhelder and Piaget, 1958). To understand this aspect of Piaget's theories for adolescence, it is necessary to understand Piaget's theories on younger children:

Piaget saw cognitive skills as being learnt in fairly discrete stages, as the child progresses to being a fully equipped adult. He theorised that very young children have 'animism' - they have such a limited knowledge of the way the external world acts that they do not know that an object out of their sight continues to exist. With time, children are able to form representations of the object which can stand independently in their minds, hence they 'know' that objects exist independently (called the stage of 'Preoperations'). The stage after preoperations ('Concrete operations') is where children have developed the ability to have two or more symbols for the same thing (for example, in conservation tasks children know that the amount of a substance stays the same even if its appearance is altered. At the final stage of Formal operations individuals are able to represent thoughts and abstract ideas to themselves.

When Piaget and Inhelder extended the theory into adolescence, they postulated that the essential step away from egocentrism is to be able to conceptualise other people's thoughts. Elkind proposed that while an adolescent may now understand in principle the concept that other people may have a covert inner life and a unique perspective, in practice they have difficulty 'differentiating between the objects toward which the thoughts of others

are directed, and those which are the focus of their own concern' (Elkind, 1967, p. 1029). In other words, unless they make an effort to work out what other people are thinking of, they automatically assume that other people think the same way they do about everything. Hence they are egocentric because they see their perspectives and needs as practically the only existing ones.

A good analogy to what happens in adolescent egocentrism is found in privileged information tasks. It has been shown with younger children that when they have information that a story character does not have, they have difficulty realising that the story character will not make decisions based on that information (Mitchell et al, 1996). Similarly when an adolescent 'attempts to cognise the thoughts of others, he fails to suppress his privileged information, his own perspective intrudes, with the result that he reproduces his own perspective rather than anticipating the perspective of the other'. (Lapsley and Murphy, 1985, p. 206).

One might add to this debate that attachment-losses and de-idealising might also contribute to the formation of the imaginary audience. Adolescents start off with an unsophisticated and idealised opinion of all adults, not just their parents. As they progress to "debunk" their parents, they are left in a situation where the rest of the adult world then also needs to be debunked. This is a difficult task, all the more so because they are losing the protection of the parents (as parental credibility is being eroded). They are left exposed in front of a still somewhat idealised and quite frightening set of authorities in the adult world, without anyone to appeal to if it all goes wrong. Peers gradually take on a whole new importance, and are not as kind and supportive as parents are. Individuals are left much more open to criticism. For example, adolescence is a time when a person's self-esteem is frighteningly dependent on the attitude of opposite-sex peers (Arkowitz, Hinton, Perl and

Himadi, 1978). Parents worry about naive teenagers falling romantically for a person who may not treat them well. When they are older and have more experience of romantic relationships, they may be less likely to accept poor treatment.

Egocentrism diminishes in late adolescence, so it is assumed that the difficulty is overcome thanks to repeated social interaction and experience; hence it is from learning about other people and how they behave that egocentricity diminishes (Lapsley and Murphy, 1985).

2.2.6.1 Egocentricity and psychosis

The relevance of such egocentricity for psychosis is enormous. Many of the diagnostic criteria for schizophrenia would be seen typically as egocentric, for example the ICD-10 includes "persistent delusions...such as religious or political identity or superhuman powers and abilities (e.g. being able to control the weather...)"; (WHO, 1990). Many people with a psychosis show extreme grandiosity, often to the extent that they believe they are Jesus or similarly important figures. Grandiosity or narcissism has always been seen as a basic drive in children that is overcome in adulthood (Kohut, 1992), but it has not been fully stated that one of the main things that helps one to overcome it is an appreciation of other people's existence and importance. Many sufferers spend so much time on their own that it is sort of true for them to say they are the most important people in the world- they are virtually the only people in their world environment (there is such a case in chapter 6)! Also, delusions of reference, (where sufferers feel passers-by or TV s are referring to them) are showing a version of animism- everything that other people do is interpreted as other people only being interested in the sufferer. Voices can be seen as more severe versions of reference experiences- other people are assumed to be so preoccupied with the psychosis sufferer that they neglect their own lives (and bodies) to devote all their time to communicating intimately with the sufferer.

Psychosis research has already tried to include the 'Theory of Mind' literature (Frith, 1992). A classic observation of someone with a psychosis is that they have lost touch with what the people around them are really thinking, and become caught up in what they project onto other people as thinking. Laing (1965) described the way that people with a psychosis relate to other people as 'fantasms'- that is they had a rather strange and unusual image of the other person in their heads and hence were not really relating to the other person at all. Of course, even the average person's understanding of what makes other people tick is always going to be an approximation to the complexity other people's experience. It cannot be assumed that even normal people have a particularly accurate understanding of other people; "object relations theory, broadly defined, rests on the assumption that in our relationships we react according to the internal representations we hold of people important to us, in the past as well as the person actually before us now...Thus our responses to those before us now may have only the vaguest of associations with present tense reality." (Kroger, 1996, p.50-51).

Similarly there is a large literature on people with a psychosis having various deficits when it comes to interpreting facially displayed emotions (Bellack et al, 1992); such social perception deficits must surely arise because there is an impaired concept of other people having such emotions. If there is only a limited conceptualisation of other people being angry - -in that clients conceive of other people's anger as entirely relating to themselves (the client) - it should not be surprising that clients have difficulties recognising facial expressions of anger.

In summary, the ability to mentalise-for-others is something that develops during adolescence. During its development, it leads adolescents to be egocentric and self-conscious. It has been proposed that people with a psychosis remain egocentric (and perhaps get worse)

because they never develop a more sophisticated understanding of how other people work, such as is a vital part of individuation and autonomy, and "feeling like an adult"; without it, the adult world is a difficult place to operate.

2.2.7 Adolescent phenomenon 6: the 'Personal Fable' of spiritually significant events, uniqueness and indestructibility

Blos wrote that adolescents reported experiencing many profound effects, things that seem to occur just for them, such as particularly striking scenes in nature or theories. For example: "mother nature becomes a personal respondent to the adolescent; the beauty of nature is discovered and exalted emotional states are experienced" (Blos, 1962, p.93). Elkind called this sense of uniqueness and indestructibility 'the personal fable'. Adolescents have a belief in their own indestructibility (e.g. 'pregnancy will never happen to me/ I will never die'). "They believe that their thoughts or feelings are understood by no-one, least of all by their parents" (Elkind, 1967, p.1031). (Presumably these feelings of loneliness and uniqueness come at times when they are forced to realise that everyone else does not see the world as they do, as their egocentricity had led them to believe.)

Does it happen and why? Enright, Shukla and Lapsley (1980) showed that a measure of "personal fable" followed the same pattern as egocentricity- decreasing from mid to late adolescence. The personal fable was explained by Elkind as deriving from the 'imaginary audience'. "The emotional torments undergone by Salinger's Holden Caulfield exemplifies the adolescent's belief of his own uniqueness of experience." (Elkind, 1967, p. 1031). Many adolescents keep diaries; these are used to confide thoughts and events that cannot be shared with real people; "posterity looks over his shoulder as he writes." (Blos, 1962, p.95).

2.2.7.1 Personal fables and psychosis

As the personal fable is roughly akin to egocentricity, it should hardly need pointing out that experiences of uniqueness and loneliness, feelings of indestructibility and a sensation of things being especially significant, perhaps in a spiritual sense are fundamental experiences in psychosis; in fact they are intrinsic to the diagnostic criteria (ICD-10; WHO, 1979). A passage about *adolescence* by Barker (1951) cited by Blos shows this admirably:

> "Those exquisitely melancholy afternoons of my adolescence when I used to walk with the abstraction of a somnambulist through the damp avenues of Richmond Park, thinking that life would never happen to me, wondering why the banked fires of my anticipations, burning in my belly worse than raw alcohol, seemed not to show to strangers as I wandered in the gardens. And often it appeared to me, the frustration, in the disguise of an hallucination: looking between the trees that dripped with hanging mist I sometimes saw classical statues take on an instant of life, turning their naked beauty towards me; or I heard a voice speak out of a bush: 'everything will be answered if you will only not look around'. And I have stood waiting, not daring to look around, expecting a hand on my shoulder that would tender an apotheosis or an assignation. But there was only the gust of wind and the page of a newspaper blowing breezily up and past me like a dirty interjection. Or a bicyclist flashed by, offering possibility until he reached me and decamping with it when he had passed. For I was suffering from a simple but devastating propensity: I was hoping to live." (Barker, cited by Blos, 1962, p.92)

The author's eloquence testifies to his sanity, and yet within the context of normal adolescence, here there are reference experiences, anhedonia, voices, apocalyptic cognition and others.

2.2.8 Adolescent phenomenon 7: Mentoring and seeking "New Gods"

After the loss of the idealised image of their parents, adolescents are in a position where they are used to having parent- type figures, and are now left without them. It is common for them to seek new authority figures who take on a profound significance and are held in idealised esteem. Famous writers or statesmen, religious or moral leaders, footballers, pop- stars or perhaps figures in the young person's immediate environment can become powerfully important mentors (Hendry, 1983). They can be idealised to the extent that it can be a bit like a crush. The need is for a perfect person to replace the perfect authority lost.

"If a ten-truck truck
Kills the both of us,
To die by your side,
Well the pleasure, the privilege is mine." (Smiths, 1986).

In psychosis, a powerful and omnipotent character is nearly always assumed by the individual to be behind the voices or thought manipulations (Chadwick and Birchwood, 1994). Usually it is God or the Devil or somebody famous who is telepathically communicating with the client; by implication a very important person for someone so important to be in close contact with them.

2.2.9 Adolescent phenomenon 8: Psychosis-like experiences

Little research has been done to see if the more extreme positive symptoms (hallucinations, delusions) are common in normal adolescents. Researchers investigating prodromes (the gradual deterioration preceding a psychotic relapse) have found that prodromes appear to be far more common than would previously have been expected amongst normal students. McGorry et al (1995) gave an amended version of the Early Signs Questionnaire (A scale filled in by sufferers every week to help them to notice if they are becoming unwell) to 657 high school students (mean age 16.5 years). They concluded that 10-15% of students showed a clinically significant number of prodromal symptoms, 51% of all their students endorsed the "magical ideation" items, 46% reported unusual perceptual experiences, 22% reported blunt, flat or inappropriate affect and 18.4% of normal 16 year-olds reported social isolation or withdrawal.

Our own research has shown that not only are such prodromal signs common in adolescence, but *the incidence is directly related to scores on measures of emotional development.* For example, among 12-18 year olds, people with the highest number of prodromal signs are usually those who are the most emotionally developed for their age (see chapter 3). This implies that prodromal signs go hand in hand with normal psychological development.

2.2.10 Summary: still ill?

In this section a description has been given of the parallels between normal 'troubled teenager' phenomena and some of the main symptoms of young schizophrenia sufferers. It has been shown that conflict behaviour between parent and offspring during adolescence

reflects the need to individuate, and that it comes about mainly because of the stressful and often depressing process of de-idealising the parents. Moreover at the start of adolescence, individuals are grandiose, and demonstrate 'personal fable' cognitions, which was shown to be closely related to the fact that they have a limited understanding of other people's minds. Similarities were drawn out between the normal troubled teenager, and the individual of a few years older who is actively psychotic. It was argued that schizophrenia may emerge from a troubled teenage state which fails to resolve with normal maturation, with the result that the selfsame teenage 'troubles' now deteriorate into the appearance of psychotic symptoms. Two situations in which this might happen have been described:

First there is the individual who has not individuated from his parents, who continues to regard them and others in an idealised, overawed manner. Second is the individual who has partially individuated from his parents, but has not managed to bond to peers, and hence does not get the resolution of the turmoil that leaving the family and bonding to peers normally brings. Both types of individual are stuck in the middle of the uncomfortable turbulent experiences of adolescence such as loneliness, grandiosity, depression and delusion-like fantasy, yet unlike most adolescents they do not emerge from them.

2.3 From Adolescent Blocks to Psychotic Symptoms - Why and How?

The turmoils of the individuating adolescent as he or she matures have been described, and the blocks that may occur in this process that leave some at-risk teenagers stuck in this psychotic-like phase. In this section an attempt is made to explain these disruptions in normal development- why they may come about, and how they might lead to psychotic symptomatology.

2.3.1 Why might a non-autonomous individual show distress?

Why is it that the first group of psychosis sufferers, (the group of non-autonomous individuals who remain bonded to their parents) do not just live happily in this state? Why do they show any distress at all? Part of the answer might be that there has evolved a powerful sexual and maturational propensity to individuate from one's parents, the thwarting of which creates enormous emotional turbulence. One of the many ingredients integral to this maturational process is the role of sex-hormones; sex-hormones have been shown to be related to symptomatology in psychosis.

The drive to autonomy is not just an intellectual pursuit, it is also a biological goal. All group animals show a desire to be at the top of the hierarchy, and to find a mate. However, Gilbert (1993) has described an opposing mechanism, where an individual assumes a low-ranked position when threatened or defeated by a dominant other. Gilbert calls the latter the 'involuntary subordination' response, and it includes the tendency to be submissive, appeasing and to have low self esteem. In ethology, there is considerable evidence that sexual

maturation can depend on attaining status in group hierarchical relations. In many old-world monkeys, males do not sexually mature while they are in the company of dominant males. In stump tailed macaques, males do not show an adolescent growth spurt until the dominant male is removed; soon after this the next- highest ranking male begins sexual development (Steinberg, 1988). Effects have been shown amongst female tamarins and marmosets; young females living in proximity to their mothers show suppressed ovulation, and yet if they are removed from this proximity they develop ovarian cyclicity within 4 weeks (Evans and Hodges, 1984).

In humans, it has been shown that the timing of puberty can be influenced to a large extent by psychological factors. Brookes-Gunn and Warren (1985) found that more ballet dancers than normal controls were "late" maturers (55% vs 29%). Also, those dancers who had matured on time had a greater incidence of psychopathology and bulimia. They concluded that for dancers it would be disadvantageous to be mature because of the additional weight gain that adulthood would entail, and so this psychological factor had managed to delay menarche. Similarly, in a longitudinal study, Steinberg (1986) assessed how physical maturation and relationship measures developed together over a year. He found the usual results of more arguments, less cohesion and increasing autonomy with increasing physical development. He also found the reciprocal relationship in girls- autonomy and distance between parent and child resulted in increased physical development. Hence there is evidence that, like in ethology, a person's psychological environment can strongly affect puberty.

One of the seminal findings in psychosis research concerns people who have recovered from a psychotic episode in hospital who return to live in the parental home. They are twice as likely to relapse than those who leave hospital to live independently (Brown and Birley, 1968). It has been shown that people suffering from schizophrenia perceive

themselves as being in a low ranked position and show all the features of Gilbert's involuntary subordination response (Birchwood et al, 1998). A degree of associated sexual inhibition is also likely to occur as part of this response. It would not have to be as extreme or dramatic as actual maturational or pubertal inhibition or even ovulation suppression to be relevant; though this might be happening. Some sort of effect might be expected in the sex-hormone levels of people with schizophrenia; interestingly, there are now a number of reports on the connection between sex- hormones and psychosis.

Levels of sex-hormone in the blood have been seen to vary systematically with symptomatology in schizophrenia sufferers. Häfner et al (1993a) found that when levels of oestradiol (a female sex-hormone) were correlated with psychopathology measures, there were significant negative correlations with the Brief Psychiatric Rating Scale, paranoia measure and subjective well- being. They concluded that symptoms were better when oestradiol measures were high, and worse when they were low. (See also Oades and Schepker, 1994; Hernandez et al, 1994). Other researchers have used rats to attempt to show a relationship between symptoms and sex-hormones. Riecher- Rosler et al (1994) "injected rats with schizophrenia" (i.e. a psychoactive drug) after injecting a test sub- group with oestrogen. They concluded that oestrogen raised the threshold for vulnerability for 'schizophrenia'. One could speculate further on the biology involved (e.g. whether or not sex-hormones could be used as anti- psychotic medications). It is a relatively unexplored idea that psychology can affect biology in such a radical way, and there is a need for further research here. The current hypothesis is served well by the conclusion that there is some sort of irregularity in the sex-hormones of people with a psychosis. A proponent of the ethological theory could speculate that it is a biological drive to reach adulthood coming into conflict with a biological suppression effect that is due to the clients being in the proximity of dominant parents, because psychologically they 'do not feel like adults'. They may still

idealise their parents, and peers, and yet they may be experiencing the same self-construction and individuation urges against their parents that normals have. This may cause some discomfort because they may not feel that these urges are acceptable against ideal others.

2.3.2 Why might it be difficult to individuate from one's parents?

It has been argued that failure to psychologically mature and individuate from one's parents can in time lead to psychotic symptoms. But why is it so difficult for some at-risk adolescents to individuate? One reason may be the belief that to assert oneself against one's parents may provoke imagined hostility and criticism, and this is too psychologically traumatic to take. Rosenberg (1979) puts the point well: "Once the individual seriously attempts to fathom what others think of him, the conclusions that emerge are by no means palatable...In the early years the child has accepted the idea that others think well of him and has given the matter little thought. In early adolescence, when he is able to get outside his own viewpoint and see matters, including himself, from the perspective of others, he recognises the complexity of others attitudes towards him; he becomes aware of both their qualms and their sources of appreciation" (Rosenberg, 1979, p.238-9). As Rosenberg pin-points, the perspective changes of adolescence may be unpleasant, and difficult for an individual to accept. In the next section, situations are considered in which such transitions may be more difficult than usual.

2.3.2.1 It may seem unfair to rebel against 'good' parents

It has been argued that it is almost better for adolescents if their parents are particularly harsh, because then the adolescents will not find it so difficult to find issues on which to oppose them, nor will they need much reassurance about how right they are (Blos, 1967). (Here, for instance, peer groups can serve as a particularly potent source of outside validation; Berndt, 1982). But with parents who are 'good' it may feel too insulting to try to take control and be assertive. After all, parents generally think they have their offspring's best interests at heart. Normally parents have to put up with a lot of apparently unreasonable behaviours and conflicting messages: "No individual achieves independence without a number of backwards glances" (Coleman and Hendry, 1990, p.84). One moment adolescents are being unusually adult and taking the high moral ground on some issue against the parent. The next they are acting like a small child again, and using ways of behaviour thought by the parent to be long since gone, perhaps seeking reassurances like a much younger child would (Kroger, 1996). The lability of adolescent moods can be exasperating for parents. We have observed a similar pattern of rebelliousness cycling with guilt and more childish, reassurance-seeking behaviours operating in people with a psychosis (chapter 6).

Many clients idealise their parents, and are particularly anxious to protect them. Thus it is hard for these clients to individuate against them and do their own thing. To de-idealise them may seem like an aggressive act against a God , or against someone they have a genuinely warm and close relationship with.

For example, Dennis had been floridly ill for a period a year ago. He had been so in awe of his mother that he passively did whatever he thought she wanted of him. Every few months he would have built up such resentments and frustrations that he would have an angry verbal outburst. His mother took this as signs of a setback in his illness after a period of

having been "doing well". Den usually felt chronic guilt and shame after his outburst, and would return to being totally compliant for a few months (see chapter 6).

"*Opposition is true friendship*"- William Blake.

Parenting traditions have held that conflict in families is a bad thing. Research has shown that although conflict is unpleasant and difficult for all parties involved, it is actually a good thing because it reflects healthy self-assertion and rights to self-actualise on both sides (e.g. Lamborn, Mounts, Steinberg and Dornbusch, 1991). A political system in which dissent is voiced and tolerated is generally held to be healthier than one in which no one is ever allowed to disagree. Conflict is good here because adolescents have rights to assert their needs as adults against their parents. Also they need to have practice of arguing skills if they are to bond to peers successfully. To reiterate, an interesting implication of this theory is that one does not have to take sides in the debate of parents vs. child. It reconciles the two because it says it is natural for both parties to have grievances with the other. (Also it implies that in some cases, the parenting is actually very good, so the child does not want to leave home!)

2.3.2.2 Intimidating parents

Another situation where the adolescent may not feel able to individuate is in situations where the parent is frightening. Some parents take disagreement and difference as a threat to themselves, and try to disallow it. For instance, it has been suggested that people sexually abused as children are particularly at risk for schizophrenia spectrum disorders (Hunter, 1991). This could be because a child living with a dominating and abusive parent perhaps copes by being extremely subordinate and wary of adults. A person who is dispositionally stuck in an involuntary subordinate role (Gilbert,1993) may find this role impossible to break out of, even though it might later be possible to escape painful circumstances. The life

transition and role re-negotiations of adolescence for such an incapacitated person would be too difficult to attempt. Stuck in such a subordinate role, maintained by fear of adults, and unable to enter the adult world as one of them, and yet seeing all their friends successfully becoming adults, it can seem that there would be nowhere for the adolescent to go. They remain trapped in a child-like role when, in their eyes, everyone else is authoritative and powerful.

2.3.2.3 Individuated from parents but facing problems with peers?

Peer relationships may be so difficult and threatening that parental relationships are preferred, in the sense that clients are too anxious for them to be able to move away from the home base. In the same way that it is easier for individuals to interact with their parents when they have de-idealised them, there is a similar need to de-idealise and understand peers. Peers are often less tolerant, more competitive and perhaps more likely to be punitive.

Evolutionary theorists have suggested that losing one's peer group invokes all the built-in fears of being alone and vulnerable ('left to the wolves'; Gilbert, 1993). It also means that they are then trapped in the safety of the family, but feeling unbearable anguish and despair over their failure to individuate and all this implies in terms of not being able to bond to peers.

Although some (mainly female) clients actually get married and have children (Sartorius, 1986), most (mainly male) have enormous problems with romantic relationships. Around 90% of male clients asked in a recent study had never been on more than a couple of

dates (chapter 6). Our interviews showed that dating was such an impossible goal (though desperately desired) that it was never attempted. Some clients were terrified of dating; as one client put it "If you want to know the truth, I've never really had a girlfriend. I d like one in principle but not in practice. Mostly when I talk to girls I feel sure they hate me, they think I m a load of old rubbish, and how could I possibly think I am normal." Dating is one of the most important and common ways of getting security, support and recognition from one's peer group. It is also the path to marriage and parenthood- the next 'life-stage'. The consequence is that major life stages are cut off and most opportunities for self-construction (discussed in chapter 5) are lost.

2.3.2.4 Objectité

One of the characteristics of adolescence is high self-consciousness (Rosenberg, 1979). It is striking that when a person is feeling 'self aware', they can almost feel like an object in the other person's gaze. In such a state of *objectité* (Sartre, 1966), *it is impossible to be 'other aware'* (Duval and Wicklund, 1972). Being locked into an awareness of one's self-for-others prevents other-awareness judgments. Also, an integral part of self-awareness is negative self-evaluation: "...we would argue that the objective state will be uncomfortable when endured for considerable time intervals. As the individual examines himself on one dimension after another, he will inevitably discover ways in which he is inadequate, and at such a point he will prefer to revert to the subjective state" (Duval and Wicklund, 1972, p.4). Some clients hear critical voices that comment on their actions nearly all their time. For a person under such continual threat and relentlessly forced to be self-aware, an 'agent perspective' (where they could step back and actively judge the behaviours of the other people in their life) is nearly impossible. They can never get out of the object state, because

their voices are always with them. It is true to say that getting the voices to stop is what sufferers desperately want most.

Hence, for a shy teenager who is self-aware, it is unlikely they will be able to take an agent perspective long enough to start gaining an understanding of others. Their energies are more taken up dwelling on their deficiencies. It can be seen that de-idealisation and autonomy are unlikely to be forthcoming to someone locked into a state of objectité.

2.4 How to get from adolescent phenomena to symptoms?

In the process of separation from parents and attaching to the peer group, the normal teenager resorts to protective psychological mechanisms. They either defend their self from being controlled by powerful, idealised parents. Alternatively, they can defend against experiencing the void left from having no secure attachments during the interim phase. Similarly, psychosis-prone teenagers use the same mechanisms, but in a much more exaggerated and extreme form. In this section, a selective account is given of how when these normal defence mechanisms become overwhelmed, they might lead to psychotic symptoms. The two conditions mentioned, effectively representing extremes of attachment and autonomy, are a useful shorthand for summarising the individual's major goals (Trower and Chadwick, 1995); however autonomy and attachment have almost opposing aims; therefore, in effect, they create a double-bind in the head, although unlike the original double-bind concept (Bateson, 1956) this is not foisted on them by wicked parents but is an inevitable part of growing up.

2.4.1 Lack of autonomy, lack of agency

One thing which comes with the development of autonomy is a growing sense of agency and ownership over one's life. Adolescents who do not develop a sense of autonomy from their parents will have less of a sense of ownership over their actions, and effectively only act in the context of their parents. These skills may not translate to the wider world away from their parents. Comparably, experienced teachers know that following instructions or being told the answers is not enough; they try to motivate students to find the answers for themselves. In therapy, clients are encouraged through the use of 'Socratic questioning' to find answers for themselves, rather than the therapist imposing a solution on them (Rogers, 1967). Paradoxically, the one skill that parents cannot directly enforce on their offspring is for children to be independent of their parents. It is a dilemma for parents desperately trying to solve their psychotic offspring's problems that it seems parents can't impose a solution.

It is suggested that for many clients their deterioration in areas such as self-care (something also common in adolescents!) is because these skills were learnt as 'something one's parents wanted me to do' rather than as personal-goal-attaining behaviours in their own right. In a rejection of parental jurisdiction, skills such as these are also rejected because they are things the parents wanted, not what the adolescent wanted. After a psychotic episode, clients often display many different personality characteristics (Barham, 1993); it could be that these characteristics are the only ones that the clients actually feel originate fundamentally from themselves. In rejecting everything learnt under parental jurisdiction, it may appear that the individual loses all those skills.

It should not be surprising that for clients who have struggled to have an autonomous self independent of their parents, issues of control and power jurisdiction should be prominent in their delusions. Many theorists have suggested that a biological deficit in the ability to place a feeling of ownership onto ideas and concepts is the primary factor in schizophrenia

(e.g. Frith, 1992); it is hoped it has been outlined how such a problem would arise fundamentally from psychological development. We believe that not only can clients feel thwarted in their attempts to construct an autonomous self for themselves, but worse, some clients feel compelled by others to take onboard an identity crafted by the other that feels completely alien to them. This concept is important in psychosis and is discussed in detail elsewhere (Trower and Chadwick, 1995; see also chapter 5). For clients who feel that their very actions and thoughts are imposed on them by the other people in their life, their self-hood seems to be like an alien entity. Clients who fit the situation for the first hypothesis, (where the client has not individuated from their parents) would be vulnerable to such alienation threats. Psychobiological urges to individuate mean they would see their 'for-parents' identity as alien.

Some clients have such a fragile sense of identity that they have become extremely sensitive to interpersonal contact and can feel as if they are being controlled by the people they interact with (Trower and Chadwick, 1995). Many apparently unusual statements reflect the feeling of being engulfed, overwhelmed and controlled (e.g. "People take me over- they make me do things, think things."). Clients also relate to voices in a way that is often similar to the way they relate to the real people in their lives (Birchwood, Meaden, Gilbert, and Trower, 1998). Some clients have discourses with their voices that are power struggles, usually where the voices are critical and commanding. Voices 'take over' clients in a way similar to the way the people in their lives do, but here it is in a more fundamental way, because they are battling a character that is actually in their heads. Catatonia, and delusions of motor control, may arise where the voice character 'takes control' of even the person's motor functions, often a terrifying experience for the client.

2.4.1.1 Bizarre ideas

One of the reasons that people learn at their own rate is that people need to structure incoming data and ideas in a coherent manner. Teasdale and colleagues (e.g. Teasdale and Barnard, 1993) suggested that 'upper levels' are needed, where an active agent structures and sifts through material at 'lower levels' (akin to accommodation and assimilation in Piagetian terms). People with a psychosis sometimes hold bizarre beliefs, often beliefs that contradict other convictions they hold or recently held. It seems likely that such incongruity reflects a lack of a higher organising agency in their thinking, allowing wild and disparate interpretations and conclusions to thrive unchecked. Hence an extremely overwhelmed person whose thinking is clouded (Harrop, Trower and Mitchell, 1996) might not assimilate their incoming material coherently, leading to the formation of bizarre ideas. This is especially true when clients are in an episode of florid illness. In this state, they are in such a blind panic that anything that enters their environment is enough to overwhelm them- hence perseveration and incongruity.

2.4.1.2 Lack of attachment, too much agency

The second situation was hypothesised to be when an individual has individuated from their parents and yet has not successfully attached to their peer group. Because they are plunged into a vacuum, with no other person to be attached to and 'construct a self with' (Goffman, 1971), there is still a need for interaction. Existential theorists would argue that in the absence of a mirroring other, a person has no way to prove to himself he actually exists- and is plunged into 'a pit of nothingness and despair' (Sartre, 1957, p.241). For example, Andy was 18 when he first started withdrawing from interacting with even his family (see

chapter 6). He spent most of his time in his room, coming out only for meals (for 2 years). Andy, for instance was not 'alone' in his room, even though he was not interacting with anyone. He had quite a rich inner life populated with many characters, with whom he 'interacted'. Andy was a very important person in these delusions and voice interactions. This is something that applies to normal people, too: what literature there is on sensory deprivation and voluntary long-term isolation has shown a tendency for participants to develop a temporary psychosis (Bexton et al, 1954; Slade, 1984). Hence in the absence of a mirroring other, there is a need to invent characters who can provide mirroring.

Another way of filling the void is to blame others for not recognising the importance of one's self; this need might lead to paranoid delusions about persecution (Trower and Chadwick, 1995). Benevolent voice characters (Chadwick and Birchwood, 1994) may be comparable to 'imaginary friend' that children have. Loneliness and negative self-evaluations from losing one's peer group may be behind many of the experiences of reference, as well as some delusions.

2.5 Implications

2.5.1 The adolescence literature may be useful for normalising

Our experience has been that some clients are very much in awe of their parents, and this creates problems for them because they find it difficult to be around them (see chapters 6, 7). Other clients have urges to rebel against their parents but feel very bad about doing this. Such clients may benefit greatly from knowing more about normal adolescent development, especially given their isolation and lack of a 'normalising' peer group. For example, it would be important for them to hear it is not unnatural to rebel against ones parents, or to think ill of

them. It is also permissible to have differences of opinion with them on major issues. Wild mood swings in this context are not evidence of going mad, but may be taken as a typical occurrence during adolescence. Like normal adolescents, it may be comforting for clients to know that although these experiences seem unique to themselves (and many will be!), the feelings themselves may be typical for people undergoing adolescent maturation. (Obviously there are clients for whom anger is a problem, but therapy such as Rational Emotive Behaviour Therapy can be used to help them develop 'healthy' adaptive anger (Ellis and Dryden, 1990).)

Parents could be encouraged to see the client in the light of being like a rebellious teenager. This would certainly be less worrying than a label of schizophrenia. This might make them feel less bad about any conflict that arises, and make them feel less alone, too, as conflict is something most parents experience, and does not reflect on their parenting skills. Particularly shy clients might benefit from being encouraged by their parents to let go a bit, and be reassured the world would not end if they fell out with their parents briefly over something. Many clients in our sample fear dire consequences such as being thrown out of the house or being sacrificed to the devil if they stand up to their parents even once or even in a mild way (chapter 6). "Adolescents could not grow into adults unless they were able to test out the boundaries of authority, nor could they discover what they believed unless given the opportunity to push hard against the beliefs of others." (Coleman and Hendry, 1990, p.89).

2.5.2 People with a psychosis should be encouraged to work on their understandings of others

It was argued earlier (section 2.2.6) that a fundamental skill that people with a late adolescent psychosis have not developed, (that usually develops during adolescence) is an

understanding of the psychology of the other, or theory of other minds. This is part of the perspective of the person as matured agent - to be able to objectively judge the world and others around us. It is this 'agent perspective' that would enable people who are still very much in awe of their parents to individuate and rebel, something they probably want to do but don't know how to go about. For people who have individuated from their parents but are still very scared of their peers, a more thorough understanding of their peers will be a useful tool to enable them to gain the acceptance (and perhaps employment) they want. A better understanding of one's peers means one is more likely to be able to manipulate them to get what one wants in terms of autonomy and attachment needs. It has been shown that when people are less self-aware, they are more likely to be able to respond appropriately to social cues (Gollwitzer and Wicklund, 1985). It is also a good general rule that when one feels criticised and badly judged by others, looking at the causes, motivations and authority behind the judge's actions will be very valuable in understanding it.

Clients who hear voices are often locked into a state of objectité, i.e. relentless self-awareness and disallowed from being able to judge others. They are self-focused to the extent where anything that enters their consciousness seems to portend critical references to themselves (e.g. planes going overhead, messages from the television). They may appear hyper-aware of others as the ones looking and judging and themselves as the one looked at and judged (for example as they watch for threats from others as they walk down the street), but they often do not see others as being separate existing psychological beings with vulnerabilities, motivations and beliefs of their own, unrelated to the client. Clients could be encouraged to watch other people and to come up with explanations of their behaviour that are internal to these other people. They could perhaps concentrate specifically on understanding their parents, as a start to the process of de-idealisation, if necessary.

A good example of what has been proposed in this section comes from Bertrand Russell

> "In adolescence, I hated life and was continually on the verge of suicide... Now, on the contrary, I enjoy life; I might almost say that with every year that passes I enjoy it more.....Largely it is due to a diminishing preoccupation with myself. Like others who had a puritanical education, I had the habit of meditating on my sins, my follies and shortcoming. I seemed to myself- no doubt justly- a miserable specimen. Gradually I learned to be indifferent to myself and my deficiencies; I came to centre my attention increasingly on external objects: the state of the world, various branches of knowledge, individuals for whom I felt affection. External interests, it is true, bring each its own possibility of pain: the world may be plunged into war, knowledge in some direction may be hard to achieve, friends may die. But pains of these kinds do not destroy the essential quality of life, as do those that spring from disgust with the self." (Russell, 1930, p.14).

After nearly a century that has been predominantly characterised by *introspective* psychology, perhaps the time is due for a more *exterospective* psychology to take the ascendancy.

2.5.3 Peer relationships and romantic relationships as important focuses

Another common adolescent phenomenon is a need for acceptance- how ironic it is that a diagnosis of schizophrenia realises client's worst fears of being different in the most malignant sense. Much research to date has focused on parental and family relationships in psychosis, and the goal of this work seems to be a slightly un-natural situation of parents and

offspring living together in harmony. A greater emphasis on achieving peer relationships and leaving the family might be helpful. Most clients have very few friends, and those friends they have will be fellow users of psychiatric services. The area of romantic relationships is also of paramount importance to clients; many clients see a romantic partner as the most important thing (along with rewarding employment) that they would want for themselves in the long term (although many clients find it too threatening in the short term). Professional services are cautious about the area of romantic relationships (perhaps understandably so), and this is an area where much research is needed. It is suggested that clients may gain much from knowing more about the opposite sex, about whom many know very little. It often seems that the opposite sex is a source of fear for them. Many clients would benefit from being tolerably encouraged by their parents to look for romantic partners, as many seem to think this something their parents would not allow.

2.5.4 Conclusions

A theory has been presented in which psychosis that emerges in late adolescence is seen as a disorder of adolescent development- blocked maturation. There are a large number of similarities between common adolescent phenomena such as most people experience at that time, and many of the experiences of psychosis. It has been suggested that the problems may arise because individuals have difficulties in defining a self that is autonomous from their parents. Alternatively, the difficulties may be primarily in not being able to bond to peers.

The theory has many useful implications for the treatment of psychosis. It is particularly hoped that the framework is more acceptable to clients, as it is more enabling and less stigmatising than the medical model (although it is by no means incompatible with drug treatment; chapter 1). It demystifies and normalises the experience of psychosis, by promoting

the view that this arises out of a stage everyone goes through. By contrast, the prevalent medical model view of schizophrenia reifies itself unnecessarily, confuses the issues and adds stigma. The model here enables professionals to take both the side of the client and the side of the parents, within a coherent and easily understandable framework. Conflict within the family is seen as representing healthy psychological development and the client is viewed not as someone who is medically ill, but more like a rebellious teenager going through the difficult process of maturing (or indeed as someone who needs to be encouraged to rebel).

It is not suggested this model applies to every psychosis, for instance drug-induced psychosis or more reactive psychoses. Hassett (1997) has convincingly examined the psychological issues at stake in late-life psychosis. However the issues of self-construction should still be of paramount importance in these cases, especially in treatment (see chapter 6).

Chapter 3

3. Prodromal Signs of Psychosis in Normal Teenagers

Having proposed how some late-adolescent onset psychosis could be the result of blocked psychological development during adolescence, the question remained of how to test the theory. One interesting aspect of the theory is that it enabled a new approach to an old problem. Researchers have always wanted a way of identifying individuals at risk of psychosis as early as possible. It has been shown that the earlier in a psychotic phase help is given, the fewer effects remain in the long-term in terms of residual symptoms, probability of future relapse and social disability (World Health Organisation, 1979). Furthermore, helping people in their first episode of psychosis typically has a greater effect than intervening in later episodes (e.g. Macmillan et al, 1986). Accordingly, psychiatric services have reorganised themselves to speed up the time it takes to access care for people in their first episodes of psychosis (Birchwood and Tarrier, 1992). If intervention could be made really early, the outcome might be better. It is widely understood that psychosis generally has an insidious onset of about 1-2 years before florid psychological symptoms (Sartorius, 1986) and as mentioned in chapter 2, generally comes on in late adolescence. A long-standing holy grail paradigm - one which would be desirable, but too large to be undertaken by one centre - is a prospective longitudinal study of a large group of adolescents through the years leading to early adulthood. Such an epidemiological study would have to be large enough to include a few people who may develop a psychosis; statistically only about 1% of the general population go on to develop psychosis. Retrospective analysis of those who became psychotic and how they were functioning interpersonally during the years before breakdown might produce predictive indicators. If services had meaningful predictors then intervention at the very earliest possible would become a possibility.

Something similar to this has been attempted in Australia (McGorry et al. 1995) in a large study involving 2525 students. McGorry et al measured prodromal psychotic features in adolescents aged 12, 14.5, and 16 to see if a recognisable prodrome was apparent at these early ages. So far only data for 16 year olds has been published (n=657). A surprising finding was that prodromal signs were far more common in 16 year olds than might have been expected. For example, 51% endorsed 'magical ideation'- that they had unusual thoughts about things like telepathy, special powers, communications from God, TV, radio or others. By whatever criteria used, it appeared that at least 1/3 of the sample could be considered prodromal! They concluded that "DSM-III-R prodromal features are enormously prevalent among older adolescents and unlikely to be specific for subsequent schizophrenia." (McGorry et al, 1995, p.241). It was felt it was unlikely that prodromal signs could be used to identify people at risk.

Such a result would probably not have surprised someone who works with adolescents as this life-stage can be particularly turbulent, as detailed in the previous chapter. McGorry et al did not have any specific theoretical orientation as to why prodromal signs should be so prevalent. Nor did they report using any relationship measures or having any theoretical position such as might inform the choice of such measures. The theory described in chapter 2 provides a potential explanation as to why prodromal signs are so prevalent in adolescence, namely that psychotic-like experiences are an integral part of the cognitive changes involved in undergoing psychological maturation.

The present study replicates McGorry et al's (1995) assessment of mild psychotic ideation and experiences in normal adolescents, and takes their study further because it also looks at the relationships participants have with their parents and peers. It was hypothesised that adolescents' scores on the psychosis measures would be linked to development as measured by the relationship questionnaires. The relationship questionnaires used were the Parental Autonomy scale and the Peer Autonomy scale, both derived from Blos' (1962)

account of psychological development (Steinberg and Silverberg, 1986; Webb, 1996). They assess a number of aspects of psychological development, including non-dependency, de-idealisation and individuation; for the purposes of the present study what they measure is characterised in a general way as 'psychological maturity'. In previous work the two autonomy scales have been strongly linked to physical growth, argumentative-ness, felt closeness and dependency, and resistance to peer pressure (Steinberg and Silverberg, 1986; Silverberg and Steinberg, 1987; Steinberg, 1987; Webb, 1996; Ryan and Lynch, 1989).

The hypothesised outcome that seemed most likely was schizotypy/ prodromal characteristics would show a peak in mid-adolescence, (as people encountered the turbulence of adolescence), and decline in older adolescents. It was also hypothesised that teenagers who showed high scores on the Parental Autonomy Scale would also show high scores on the schizotypy and prodrome measures. If this was found, the high schizotypy/ prodrome signs there would be reflecting the emotional changes and distress arising for a teenager who has gone some way towards developing a more mature relationship with parents. Finally it was unclear how the Peer Autonomy Scale could be hypothesised to enter the picture - individuals who showed relatively low scores for peer autonomy might have close and supportive relationships with their peers and thus might be expected to show fewer signs of distress (i.e. fewer schizotypy/ prodromal signs). Alternatively, low Peer Autonomy scores might reflect over-dependence on an unsupportive and competitive group of peers, and hence be might be associated with higher schizotypy/ prodrome scores.

3.1 Method

3.1.1 Participants

Four hundred and eighty teenagers took part in three age groups; males and females were analysed separately as previous work has shown them to develop differently (Steinberg

and Silverberg, 1999). The number of teenagers in each group, as well as the average ages are shown in table 3.1. The first two age groups came from King Edward's High School in Coventry. The oldest age group was somewhat larger; because 16-17 year-olds are closer in age to when psychosis first arises, more subjects were recruited for this age group and it was around 4 times bigger than the other age groups (see table 3.1). The older adolescents came from two schools- Cadbury's school, Bournville, Birmingham, and Cooper's Company and Coborn school, Essex. The ethnic mix was 66% White European, 24.3% African, 4.6% Asian, and 5% other. Participants were given a booklet to fill in by their teacher during class, with the instructions that they were taking part in a survey about common experiences during adolescence. Incomplete answers were discarded (around 30 in total).

3.1.2 Instruments

Parental Autonomy: the Emotional Autonomy Scale (Steinberg and Silverberg, 1986, see appendix B)

This scale is based on Blos' (1962) work on psychological development during adolescence. Although Blos' perspective is possibly an over-clinically orientated viewpoint of adolescence, the scale has nevertheless been shown to relate well to many facets of adolescent development including physical development, (in fact it is a better predictor of physical growth than chronological age; Steinberg, 1988). It consists of 20 Likert-scale items rated on a one to four scale as to how much the participant agrees with a given statement. The items concern four subscales of emotional autonomy. The first subscale, de-idealisation, contains statements about parental character traits such as "My parents hardly ever make mistakes". Dependency statements are about using the parents as support in times of emotional stress (e.g. "if I was having a problem with one of my friends, I would discuss it with my mother or father before deciding what to do about it". Individuation statements are about being different to the parents (for example, "There are some things about me my parents do not know"). The subscale that

was perhaps the most relevant for this study was the 'parents as people' scale, because these statements assess the degree to which the teenager sees their parents as real people (for example "When they are at work, my parents act pretty much the same way they do when they are with me.") These statements reflect the extent to which the teenager has developed the mentalising-for-others abilities that are the basis of overcoming adolescent egocentrism (Elkind, 1980; see chapter 2). Steinberg and Silverberg (1986) report the internal consistency of the Parental Autonomy Scale to be 0.75 (Cronbach's alpha).

Peer Autonomy Scale (Harrop and Trower, Appendix B; Webb, 1996).

This scale is essentially the same as Steinberg and Silverberg's scale but adapted to refer to peers rather than parents. For example "My parents and I agree on everything" became "My friends and I agree on everything." It consists of 15 items, again on a 1-4 Likert scale. A split-half reliability test of the peer scale has shown a reliability coefficient of r_{tt}=0.8 (Webb, 1996). Previous work has shown that the peer scale can be a significant indicator of physical development (again, it is a better indicator of physical development than chronological age). It correlates negatively with the parental autonomy scale, in that as adolescents became more autonomous from their parents they became more dependent/ attached to their peers (Webb, 1996). This reflects the prevalent opinion in adolescence research that as teenagers become more independent from their parents, they become attached to their peers (Dunphy, 1972; Brown et al, 1986).

Schizotypy questionnaire (Claridge and Broks, 1984)

The schizotypy questionnaire was designed to measure mildly psychotic features in the general population of adults. It follows the theoretical stance that people with the symptoms of schizophrenia represent the extreme end of a continuum, with people with many symptoms (but not enough to merit diagnosis) in the middle, and those with few at the other end. Items are both perceptual, experiential and cognitive, for example, Item 30: "Do you believe dreams can come true?". The schizotypy scale has been demonstrated to have good psychometric properties (Cronbach's coefficient alpha = 0.86; Claridge and Hewitt, 1987). Claridge and Hewitt (1987) showed that items such as "Do you believe in telepathy?" were endorsed by 1 in 3 people in the general population.

Early Signs Scale (Birchwood et al, 1989)

The Early Signs Scale (ESS) is designed for use with psychotic individuals whose symptoms are in remission. By completing the questionnaire fortnightly, they are able to gain some sort of objective measure of how ill they are currently; hence it is especially useful for individuals who have little insight into their own current well-being. When a certain score is reached, medication can be increased, or an individual can come in to hospital for some short-term respite. Early Sign profiles are tailored to suit each individual's own 'relapse signature' (Birchwood et al, 1989), and they effectively quantify what good nurses can do for clients they know well. As was mentioned above, if an episode of florid psychosis can be identified and treated in its earliest stages, it is likely the individual will be frankly psychotic for a shorter period. The scale has reliability of 0.93 as measured by Cronbach's Alpha (Birchwood et al, 1989).

The Early Signs Scale includes detailed descriptions (e.g. Item 9: "Feeling stubborn or refusing to carry out simple requests. Have you noticed at home or at work you have been less willing or reluctant to do simple favours that you are asked e.g. If your Mum asked you to put some ironing away, what has been your reaction?."). Each item is rated on a frequency scale

(e.g. "Not a problem- 0 times a week" or "Moderate problem- several times a week but not daily."). There are four subscales within the ESS: Anxiety, Depression, Disinhibition and Incipient Psychosis. If the schizotypy scale deals with mild psychotic symptoms in the normal population, then the Early Signs scale is more likely to be assessing hard-core psychotic features. It was preferred to some of the many symptom profile questionnaires such as the Brief Psychiatric Rating Scale (Overall and Gorham, 1962) because these were thought to reflect a medical view of schizophrenia and over emphasise physical symptoms, and also because the Early Signs Scale offers more detailed verbal descriptions of symptoms.

3.2 Results

Table 3.1 gives the average scores by age group and gender for the four main scales. The data are graphed in Figures 3.1 to 3.4. Figure 3.1 shows how parental autonomy scores varied with age. Parental Autonomy scores can be seen to increase for both males and females throughout adolescence. Conversely, Peer Autonomy scores decreased through adolescence (figure 3.2), except for older teenage females whose scores were higher than mid-teen females. Although parental and peer scales follow the opposite general trend they did not correlate (Pearson's correlation: $r=0.017$, $n=479$, $p=0.9$) possibly suggesting that teenagers do not develop with regard to parents and peers at the same time (Coleman's focal theory, 1979).

Schizotypy also decreased with age (figure. 3.3); a surprising result was that schizotypy was largest in youngest teenagers. Unfortunately the teachers of the 12-13 year olds found that the Early Signs scale was too difficult for students to complete; hence it is difficult to interpret the results for the other two groups although as with schizotypy, late teens scored higher than mid teens (figure. 3.4). Early Signs scores (and all its subscales) correlated well with schizotypy scores for all groups (see table 3.2), so it seems reasonable to presume that Early Signs scores would have followed the same pattern in 12-13 year olds as schizotypy. Females

scored higher than males on both symptom measures. Females were also much higher than males for parental autonomy, and consistently lower than males on peer autonomy.

Table 3.1 Table describing participants by age, gender, origin and mean scores on the 4 measures.

		12-13 years	**14-15 years**	**16-17 years**
Females	Age (mean)	12.6 (1.1)	14.7 (0.7)	17.0 (0.7)
	Number in group	53	33	162
	Parental Autonomy score: mean (s.e.)	55.1 (1.01)	56.8 (1.00)	56.75 (0.51)
	Peer Autonomy score: mean (s.e.).	36.96 (0.61)	34.53 (1.12)	35.95 (0.23)
	Schizotypy: mean (s.e.)	22.1 (0.78)	16 (1.25)	19.17 (0.47)
	Early Signs: mean (s.e.)	n/a	24.27 (2.04)	27.3 (1.1)
Males	Age (mean)	12.8 (1.2)	14.5 (1.3)	16.8 (0.9)
	Number in group	54	43	135
	Parental Autonomy score: mean (s.e.)	53.7 (1.04)	54.2 (1.07)	55.72 (0.51)
	Peer Autonomy score: mean (s.e.).	38.65 (0.83)	37.12 (0.56)	36.93 (0.29)
	Schizotypy: mean (s.e.)	18.72 (0.93)	13.5 (1.3)	16.7 (0.45)
	Early Signs: mean (s.e.)	n/a	21.81 (2.73)	26.9 (1.19)

Table 3.2: Table showing how the two symptom measures, the Early Signs Scale and Schizotypy , correlated within each group.

	n	**r**	**p**
14/ 15 Females	n =32	r =0.70	p =0.000
14/ 15 Males	n =43	r =0.68	p =0.000
17 Females	n =162	r =0.60	p =0.000
17 Males	n =135	r =0.50	p =0.000

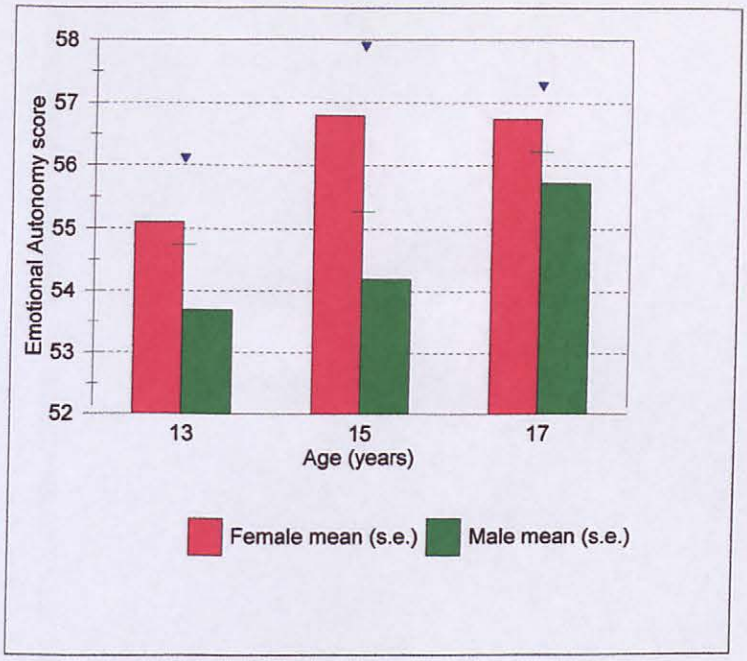


Fig 3.1 Graph showing Parental Autonomy scores for males and females at early, middle and late adolescence.

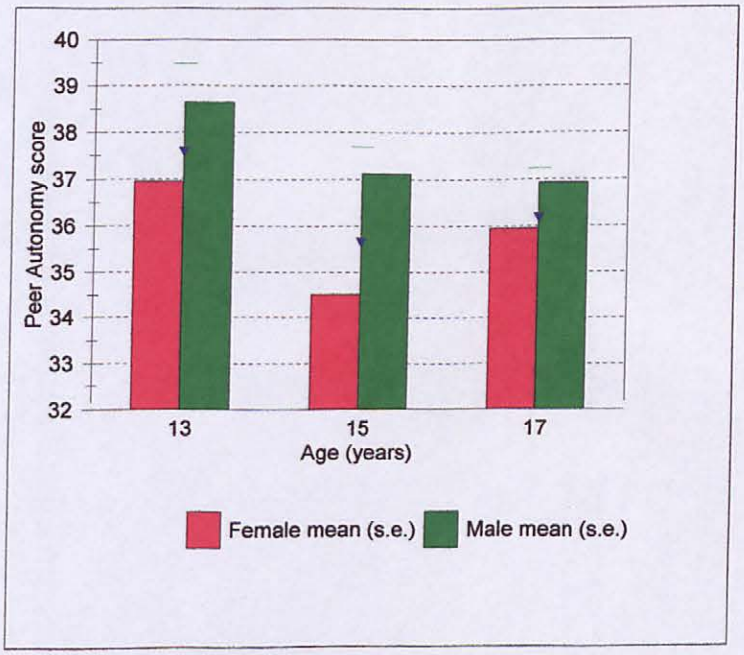


Fig 3.2 Graph showing Peer Autonomy scores for males and females at early, middle and late adolescence.

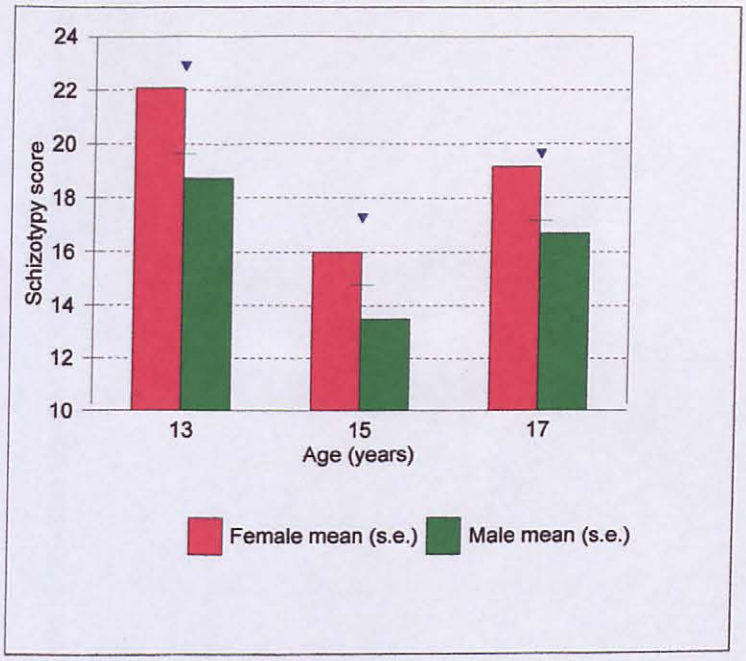


Fig 3.3 Graph showing Schizotypy scores for males and females at early, middle and late adolescence.

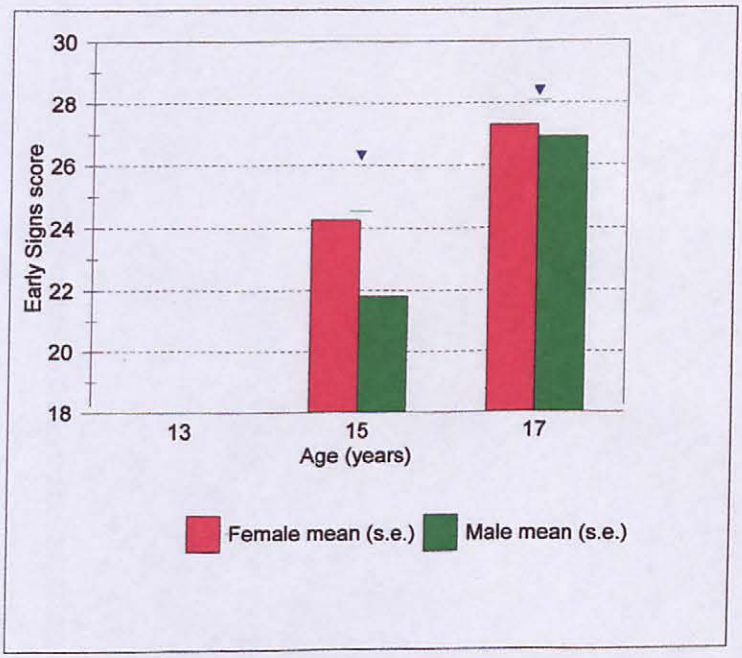


Fig 3.4 Graph showing Early Signs scores for males and females at early, middle and late adolescence.

3.2.1 Inter relations between the 4 scales

The most important analyses were to find if scores on the two autonomy scales (i.e. the relationship measures) could be used to predict scores on the schizotypy/ prodrome measures. Table 3.3 shows the scores on schizotypy/ prodrome measures correlated with scores on both of the autonomy measures. At most ages there were clear trends towards schizotypy/ prodrome scores being linked to both parental and peer autonomy measures, with the relationship reaching statistical significance in many cases. In all significant cases, high autonomy was linked to high schizotypy/ prodrome scores. The effect was especially strong for 17 year olds possibly reflecting the fact that this age-group included more participants. It seems likely that many of the trends seen, would have reached significance if these groups hadn't had smaller sample sizes than the others.

3.2.2 Using relationship measures to produce sub-samples

The correlations demonstrated a strong relationship between schizotypy/ prodrome measures and relationship measures, but it would be ambitious to expect the relationship to hold for the entire group. Research has shown that adolescence is only stressful for around a quarter of individuals (Sidique and D'arcy, 1984). Hence for this study, the patterns of autonomy and schizotypy/ prodrome measures for the entire class were not going to be as important as considering people at the extremes of the relationship measures relative to their peer group. Parental and peer autonomy measures were thus used to select sub-groups at the extremes of autonomy, and the schizotypy/ prodrome scores of these teenagers were tested. Individuals were selected in each group whose autonomy scores were ½ standard deviation higher and lower than the mean for both parental and peer autonomy. Figure. 3.5a represents the two autonomy scales as a mapping space and these two types of comparison are shown in figure 3.5b.

Table 3.3 Correlations between Parental and Peer Autonomy measures and two measures of prodromal symptoms.

Group: age, sex	Schizotypy Correlation r	significance p value	Early Signs Scale correlation r	significance p value
12/13 FEMALES (n=53)				
Parents	0.216	0.12		
Peer	0.267	0.05*		
12/13 MALES (n=54)				
Parents	0.371	0.006**		
Peer	0.373	0.006**		
14/15 FEMALES (n=33)				
Parents	0.319	0.075	0.393	0.026*
Peer	0.413	0.019*	0.423	0.016*
14/15 MALES (n=43)				
Parents	0.131	0.404	-0.038	0.80
Peer	-0.152	0.332	0.001	0.99
17 FEMALES (n=162)				
Parents	0.172	0.029*	0.362	0.000**
Peer	0.049	0.539	0.11	0.17
17 MALES (n=135)				
parents	0.199	0.02*	0.316	0.000**
peers	-0.086	0.322	-0.046	0.59

* = p value is less than or equal to 0.05
** = p value is less than or equal to 0.01

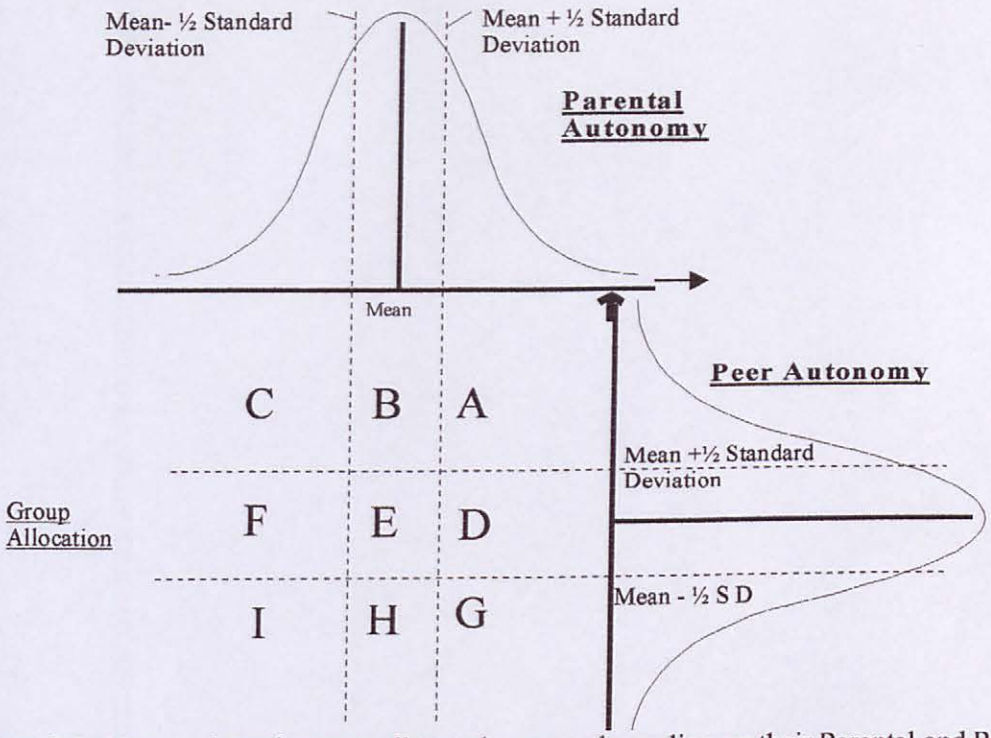


Figure 3.5a How each student was allocated a group depending on their Parental and Peer Autonomy scores.

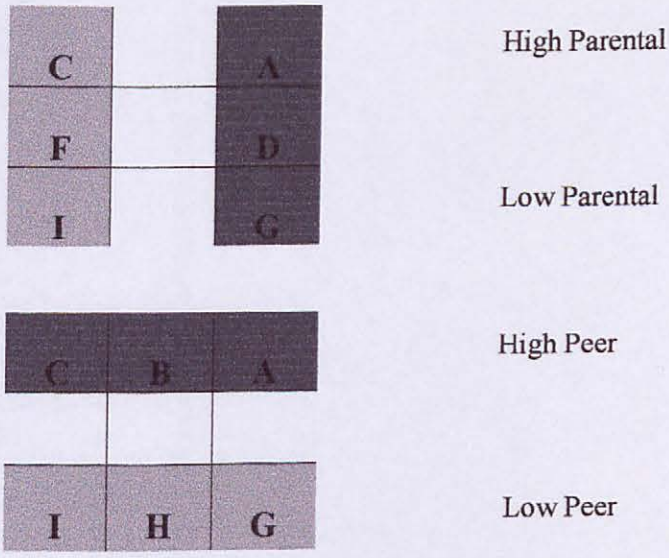


Figure 3.5b: Selection of high versus low parental autonomy and high versus low peer autonomy comparison groups.

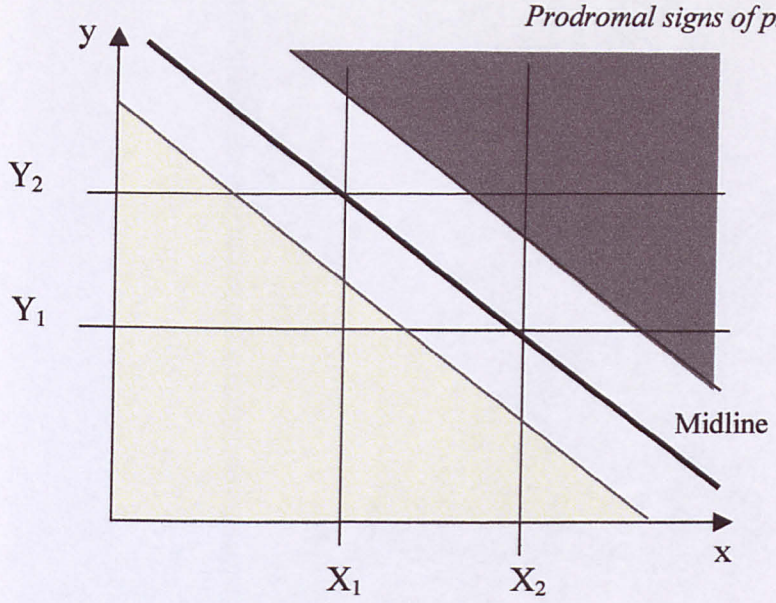


Figure 3.5c: Illustration of 'corner' comparison: {high parent/ high peer} versus {low parent/ low peer} sub-groups.

Midline is $y = ax + b$,
where the gradient, $a = \frac{X_2 - X_1}{Y_2 - Y_1}$

b is calculated by putting (X_1, Y_2) or (X_2, Y_1) into the equation $y = ax + b$

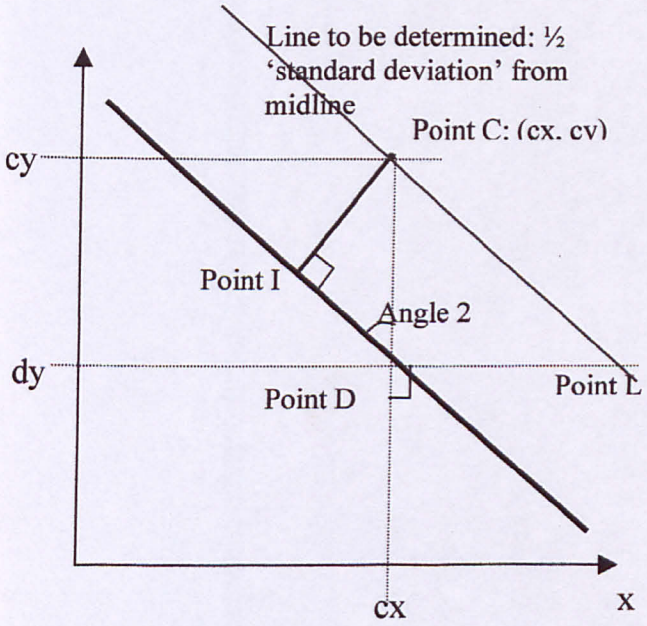


Figure 3.5d: This diagram shows how the equations for the lines involved in 'corner' comparisons were determined.

To find Point D (cx, dy):
cx is put into midline equation
$y = ax + b$,

$\text{Tan}(90^\circ - 2) = \text{gradient } a$,
$2 = 90 + \text{Tan}^{-1} \text{ gradient } a$,

$\text{Sin } 2 = \frac{CI}{CD}$,

$CI = CD \text{ Sin } 2$,

$CI = (cy - dy) \text{ Sin } 2$,

To calculate average CI:

$$\text{Mean CI} = \sqrt{\frac{\sum_{r=1}^{n} CI_r^2}{n}} \quad ,$$

Horizontal componant DL
$= ½ \text{ mean CI} \cdot \text{Cos } 2$

Lines ½ 'standard deviation' either side of midline:
$y = ax + b \pm DL$

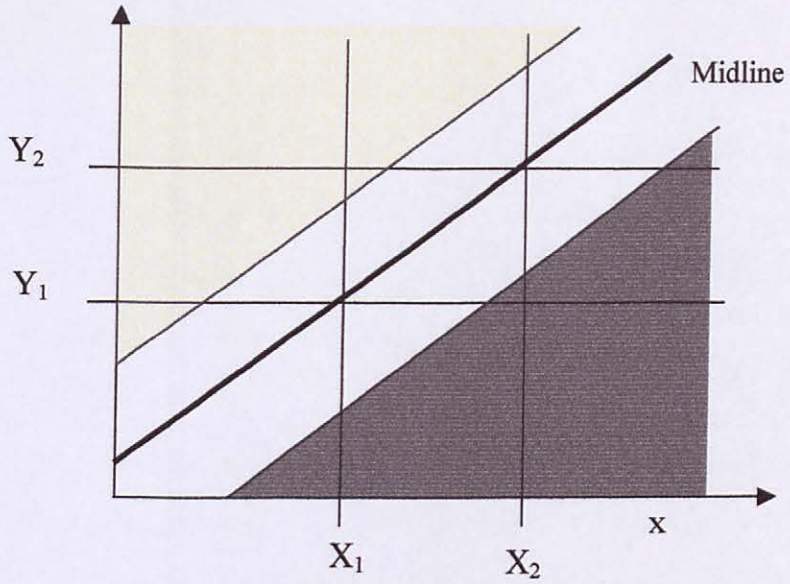


Figure 3.5e: Illustration of 'reverse' comparison{high parent/ low peer} versus {low parent/ high peer}.

The first two items for each group in table 3.4 show that using just the extremes of each age group revealed strong statistical associations. A non-parametric test (Mann-Whitney U test) was used rather than a t-test because the numbers in each group were fairly small, not normally distributed and also because in a non-parametric test one or two large outliers would not affect the comparison. The means and standard deviations of the two groups are recorded under the U and p values for each group in table 3.4.

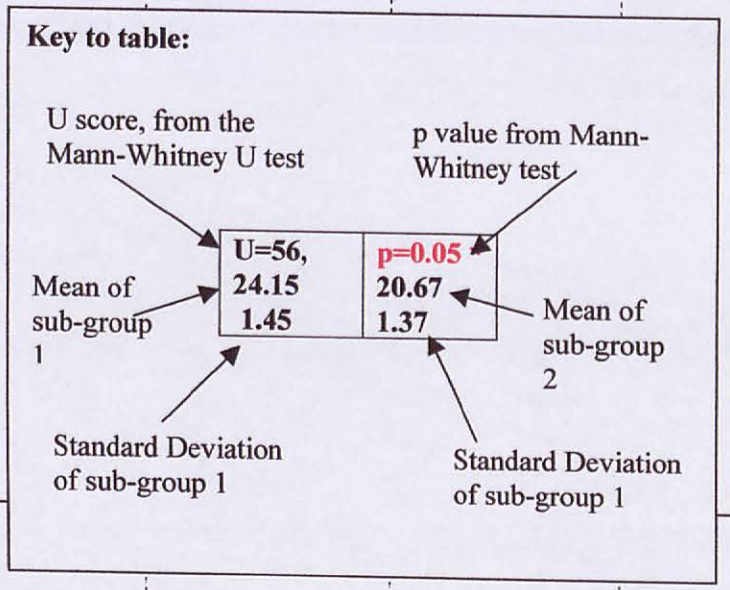
With both parental and peer autonomy being functionally related to autonomy, the most appropriate comparison using both scales was to compare quadrant A with quadrant I, but the numbers in each group are too small for the comparison to be meaningful (e.g. 3 in each group for 14/15 year old females). To increase the numbers in these 'corner' groups, the cohort was split diagonally as illustrated in figure 3.5c. As described in the previous paragraph, when using just one autonomy measure, a convention was established of using ½ standard deviation above and below the mean. This convention was respected for the corner analysis, using some basic geometry illustrated in figure 3.5d. The mid-line of the distribution was found for each age-group (figure 3.4c), and then the average perpendicular distance of each teenager from this mid-line was calculated (see figure 3.5d). This was effectively the standard deviation of the points from the mid-line. Finally a similar comparison was used to compare {low parental, high peer} with {high parental, low peer}, illustrated in figure 3.5e. These comparisons are also reported in table 3.4.

For the youngest two age groups, (excepting 14-15 year old males), higher scores on the schizotypy/ prodrome measures were always linked to higher autonomy scores, be that parental or peer autonomy. Using the subscales of the ESS, for 14- 15 year old females, Anxiety, Depression and Incipient Psychosis were consistently linked to parental and peer autonomy, although disinhibition did not seem to be linked.

Table 3.4 **Sub-groups were picked on the basis of the autonomy measures and the sub-group's scores on the schizotypy/ prodrome measures were compared using Mann-Whitney U tests. Means and standard deviations are also reported.**

Group	Schizotypy	Early Signs	Anxiety	Depression	Disinhibition	Incipient Psychosis
12/13 FEMALES (n=54)		n/a				
Parent n=18,15	U=93, p=0.085 22.87 10.61 1.7 2.75					
Peer n=13,15	U=56, p=0.05 * 24.15 20.67 1.45 1.37					
High parent/ high peer n=13, 18	U=56, p=0.014 * 23.23 18.44 1.76 1.15					
Reverse - high parent/ low peer n=12,14	U=74 p=0.6 22.58 21.5 1.1 1.5					
12/13 MALES (n=55)		n/a				
Parent n=17,19	U=84.5, p=0.014 * 21.88 17.16 1.21 1.37					
Peer n=14,11	U=50, p=0.114 20.93 16.91 2.09 3.12					
High parent/ high peer n=20,16	U=89.5, p=0.024 * 22.4 17.63 1.05 1.85					
Reverse - high parent/ low peer n=16,12	U=75 p=0.328 18.69 20.5 1.79 2.34					

Key to table:



Group	Schizotypy		Early Signs		Anxiety		Depression		Disinhibition		Incipient Psychosis	
14/15 FEMALES (n=32)												
Parent n=10,9	U=35.5, 18.6 3.93	p=0.44 16.0 3.0	U=26.4, 30.8 3.75	p=0.12 19.11 4.87	U=44 6.10 1.17	p=0.9 5.33 1.4	U=17.5 10.0 1.02	p=0.024 4.56 1.89	U=43 6.6 0.76	p=0.86 4.78 1.05	U=33 8.1 1.66	p=0.32 4.44 1.21
Peer n=10,11	U=21.5, 21.2 3.93	p=0.018 * 6.64 3.01	U=20, 34.3 2.81	p=0.014* 23.73 3.86	U=29 7.2 1.05	p=0.06 4.55 1.1	U=22 10.8 0.9	p=0.019 7.27 1.27	U=39 6.6 0.79	p=0.26 5.36 0.79	U=24.5 9.7 1.3	p=0.03 6.55 1.5
High parent/ high peer n=11,11	U=30, 19.55 2.16	p=0.045 * 12.82 2.2	U=17.5, 32.64 3.71	p=0.005* 18.73 1.62	U=32 6.64 1.09	p=0.05 3.73 0.63	U=12 9.73 1.18	p=0.001 4.45 0.47	U=52 6.55 0.73	p=0.57 5.91 0.78	U=25 9.73 1.7	p=0.02 4.64 0.62
Reverse - high parent/ low peer n=12,11	U=60 16.17 1.77	p=0.71 15.82 2.33	U=60.5 27.0 3.09	P=0.734 26.8 4.0	U=54.5 6.0 0.87	p=0.47 5.36 1.17	U=60.5 7.75 1.29	p=0.734 8.56 1.15	U=63 5.83 0.66	p=0.85 5.73 0.82	U=61.5 7.42 1.29	p=0.78 7.36 1.57
14/15 MALES (n=43)												
Parent n=13,15	U=92, 13.54 2.1	p=0.8 13.8 2.49	U=82, 19.92 4.42	p=0.475 25.73 6.09	U=77.5 3.62 1.15	p=0.35 4.93 1.24	U=87 5.69 1.47	p=0.62 6.87 1.94	U=85 5.62 1.21	p=0.57 7.67 1.74	U=80 4.92 1.1	p=0.42 6.6 2.49
Peer n=13,12	U=65.5, 11.85 2.32	p=0.49 13.58 2.68	U=66.5, 21.15 5.16	p=0.53 20.08 5.77	U=70.5 4.15 1.32	p=0.68 4.17 1.4	U=72 6.15 2.18	p=0.743 5.42 1.69	U=77 6.23 1.65	p=0.95 5.67 1.31	U=66 7.0 2.43	p=0.51 4.83 1.59
High parent/ high peer n=11,11	U=52 10.91 2.62	p=0.59 12.55 2.75	U=58.5 16.73 3.5	P=0.89 18.91 5.78	U=58.5 2.73 0.85	p=0.89 3.18 0.91	U=59.5 5.09 1.31	p=0.94 5.09 1.41	U=59 4.45 0.94	p=0.92 4.0 1.76	U=59.5 3.86 1.4	p=0.94 4.0 1.18
Reverse - high parent/ low peer n=12,13	U=35.5, 12.08 2.45	p=0.4 17.45 2.32	U=72.5, 22.91 4.98	p=0.926 23.92 5.17	U=77 4.08 1.37	p=0.95 4.77 1.34	U=68 5.58 2.26	p=0.683 6.15 1.54	U=62 6.15 1.54	p=0.39 7.31 1.28	U=76.5 6.92 2.59	p=0.93 5.69 1.46

Group	Schizotypy		Early Signs		Anxiety		Depression		Disinhibition		Incipient Psychosis	
17 FEMALES (n=163)												
Parent n=47,51	U=969, 20.26 0.93	p=0.10 18.16 1.35	U=726, 33.9 2.38	p=0.001* 23.3 1.9	U=813 6.62 0.55	p=0.01 4.61 0.5	U=664 11.57 0.87	p=0.000 7.12 0.79	U=955 6.77 0.61	p=0.08 5.2 0.42	U=869 9.02 0.77	p=0.02 6.39 0.74
Peer n=48,46	U=995, 19.96 0.81	p=0.41 18.9 1.47	U=875, 29.27 2.04	p=0.08 24.3 1.82	U=817 5.92 0.46	p=0.03 4.59 0.53	U=906 9.71 0.75	p=0.134 8.07 0.71	U1079 5.73 0.53	p=0.85 5.78 0.42	U=845 7.81 0.72	p=0.05 5.87 0.62
High parent/ high peer n=34,39	U=499 21.44 1.05	p=0.07 18.72 0.99	U=356 32.94 2.58,	p=0.001* 21.28 1.96	U=447 6.24 0.56	p=0.02 4.41 0.55	U=360 11.18 0.91	p=0.001 6.79 0.74	U=454 6.79 0.7	p=0.02 4.69 0.44	U=419 8.74 0.97	p=0.01 5.38 0.68
Reverse - high parent/ low peer n=38,30	U=500 18.76 1.02	p=0.39 20.1 1.05	U=466 25.95 2.13	p=0.199 29.97 2.53	U=529 4.92 0.5	p=0.61 5.5 0.68	U=414 7.97 0.81	p=0.05 10.3 0.9	U=525 5.79 0.54	p=0.57 6.3 0.61	U=546 7.26 0.74	p=0.77 7.87 0.93
17 MALES (n=135)												
Parent n=35,39	U=492 17.71 1.36	p=0.039* 15.36 1.11	U=475, 31.71 2.42	p=0.025* 23.56 2.18	U=553 5.46 0.57	p=0.16 4.15 0.44	U=487 9.14 0.78	p=0.034 6.72 0.69	U=478 8.31 0.73	p=0.03 5.82 0.64	U=553 8.8 0.85	p=0.16 6.87 0.69
Peer n=37,43	U=573, 15.11 1.04	p=0.03* 17.88 0.71	U=738, 27.3 2.58	p=0.57 28.2 1.9	U=662 4.84 0.57	p=0.19 5.35 0.38	U=793 8.05 0.84	p=0.98 7.65 0.56	U=775 6.78 0.65	p=0.84 5.98 0.72	U=712 7.62 0.92	p=0.41 8.23 0.74
High parent/ high peer n=32,37	U=574 15.96 1.08	p=0.98 15.7 0.87	U=504, 31.7 3.2	p=0.29 25.9 2.14	U=563 5.66 0.7	p=0.73 4.81 0.42	U=452 9.28 1.07	p=0.09 6.73 0.62	U=495 7.94 0.82	p=0.24 6.59 0.72	U=566 8.88 1.08	p=0.75 7.78 0.76
Reverse - high parent/ low peer n=46,39	U=695 16.04 0.91	p=0.074 18.4 0.7	U=640 25.2 2.34	p=0.023 32.21 2.29	U=692 4.67 0.49	p=0.06 5.82 0.47	U=659 7.04 0.74	p=0.035 8.97 0.79	U=683 6.41 0.61	p=0.05 8.41 0.78	U=680 7.07 0.82	p=0.05 9.0 0.81

* = p value is less than or equal to 0.05

** = p value is less than or equal to 0.01

For 17 year olds, parental autonomy is particularly well linked to high scores on the schizotypy/ prodrome measures, including all subscales of the ESS. For females, peer autonomy is not as well linked to schizotypy/ prodrome measures, showing a trend but only reaching statistical significance for anxiety. When combined with parental scores, (i.e. in the high parent/ high peer analysis), there is still a strong relationship with schizotypy/ prodrome measures. For males, Peer autonomy is still linked with schizotypy/ prodrome measures, but the direction appears to have changed, because here it is low peer autonomy which is linked to high schizotypy/ prodrome scores, along with the reverse 'diagonal' comparison to that which worked for females, between high parent/ low peer scores (this reverse comparison does not show any interesting trends for any other group).

Figure 3.6a shows the distribution for 16-17 year old males in more detail and depicts the autonomy mapping space; it shows that all the particularly high Early Signs Scale scores tend to be low on parental autonomy (this relationship is shown in table 3.3 to be significant). Figure 3.6b illuminates the result by showing the basic descriptive statistics for each of these groups across the same mapping space. The same trend can be seen using schizotypy for this group (figure 3.7). Conversely, all the high schizotypy and Early Signs Scale scores tend to be higher on parental autonomy in figures 3.8 and 3.9). The same trends were also observed in the female sample, although only one graph is included for brevity's sake (figure 3.10). Again, the lower part of the figure (fig. 3.10b) shows the differences in average Early Signs Scale scores for the various 'quadrants' very clearly.

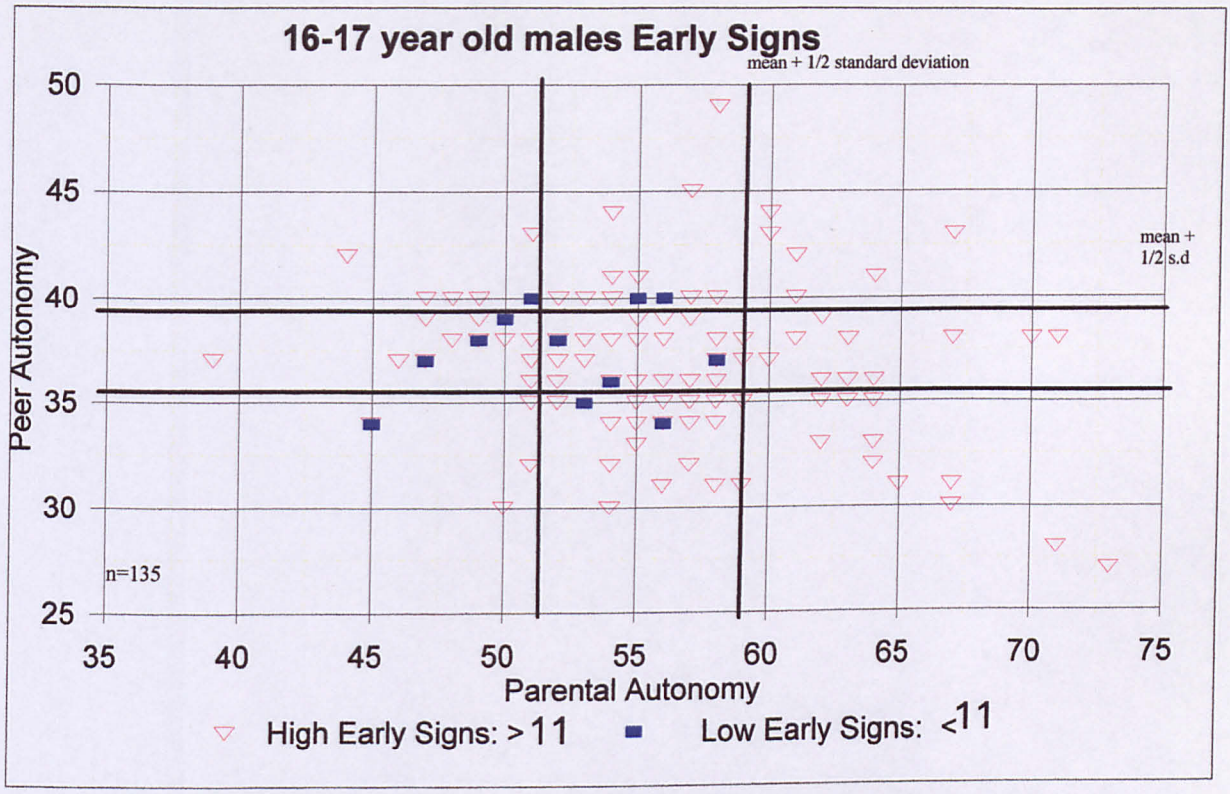


Figure 3.6a Graph illustrating profile of 16-17 year old MALES LOW EARLY SIGNS scores: the two Autonomy scales are depicted as a mapping space, and each adolescent is depicted in this space as either high or low Early Signs.

Output table
N= 135

	Low Parental	Medium Parental	High Parental		
average Early Signs=	**21.55**	**31.11**	**26.63**		26.43 High Peer
standard deviation=	10.06	19.62	9.93	SD	
number per group=	11.00	18.00	8.00	N	
	23.71	**23.41**	**32.67**		26.60 Medium Peer
sd limits:	12.11	10.40	17.50	SD	
58.73	21.00	22.00	12.00	N	
52.79	**26.29**	**25.05**	**33.67**		28.33 Low Peer
38.65	13.23	12.00	13.69	SD	
35.20	7.00	21.00	15.00	N	
	23.85	26.52	30.99		

Figure 3.6b Table showing basic descriptive statistics for the nine 'quadrants'.

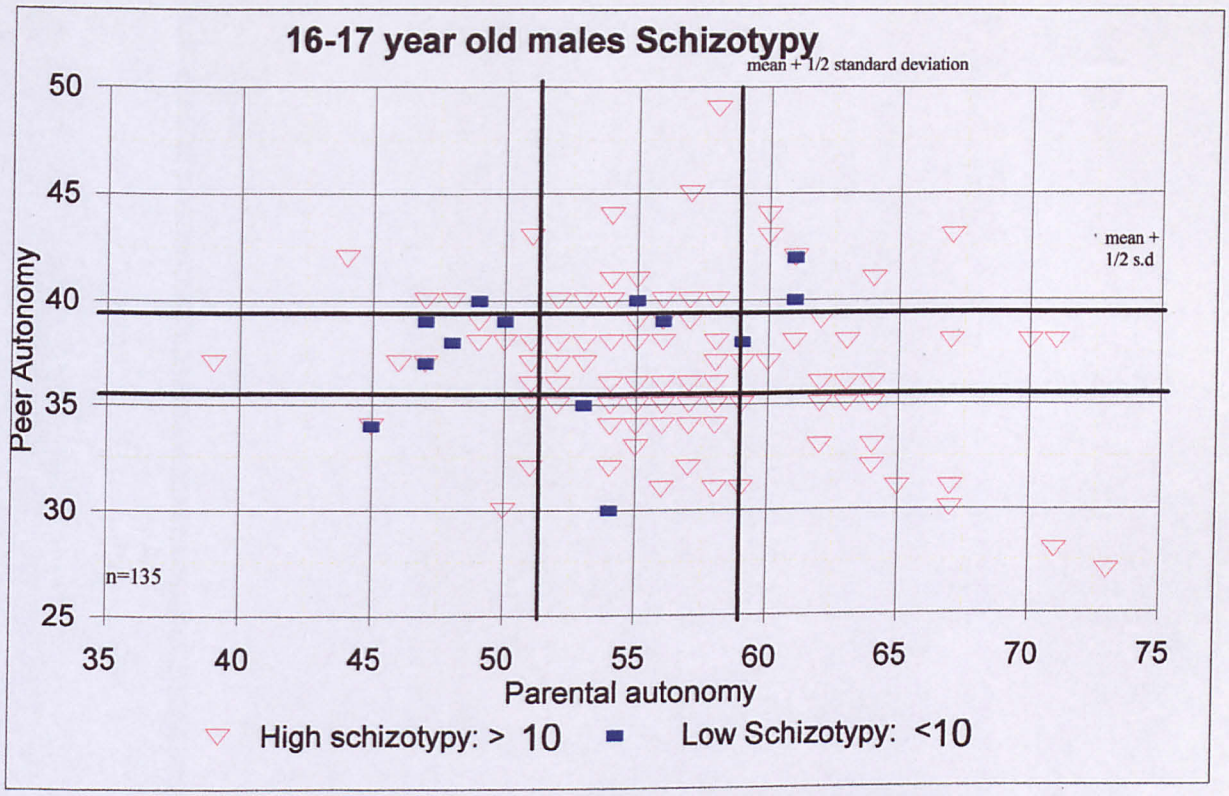


Figure 3.7a Graph illustrating profile of 16-17 year old MALES LOW SCHIZOTYPY scores: the two Autonomy scales are depicted as a mapping space, and each adolescent is depicted in this space as either high or low Schizotypy.

Output table
N= 135

	Low Parental	Medium Parental	High Parental		
average Schizotypy=	**13.18**	**16.17**	**15.38**		14.91 High Peer
standard deviation=	5.36	7.04	6.12	SD	
number per group=	11.00	18.00	8.00	N	
	15.95	**17.95**	**16.33**		16.75 Medium Peer
sd limits:	5.13	4.83	4.01	SD	
58.73	21.00	22.00	12.00	N	
52.79	**17.00**	**16.62**	**20.07**		17.90 Low Peer
38.65	3.70	5.54	3.51	SD	
35.20	7.00	21.00	15.00	N	
	15.38	16.91	17.26		

Figure 3.7b Table showing basic descriptive statistics for the nine 'quadrants'.

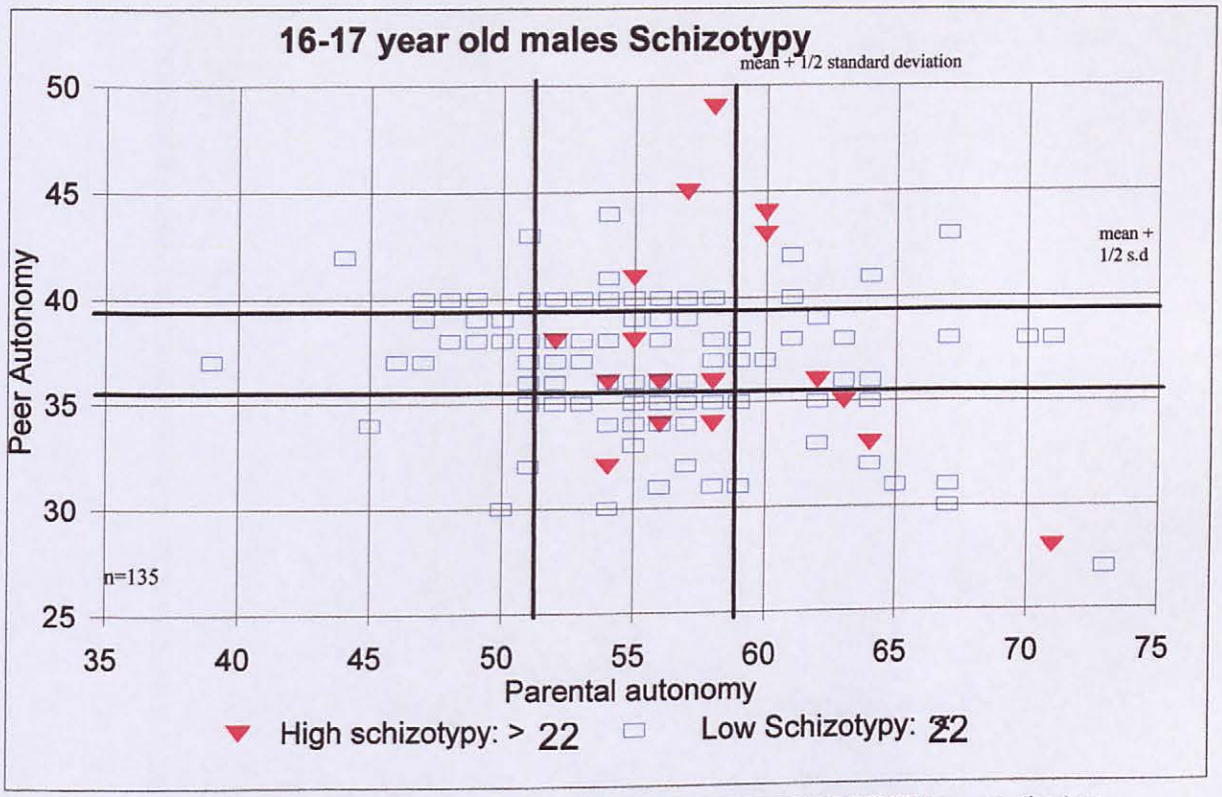


Figure 3.8a Graph illustrating profile of 16-17 year old MALES HIGH SCHIZOTYPY scores: the two Autonomy scales are depicted as a mapping space, and each adolescent is depicted in this space as either high or low Schizotypy.

Output table
N= 135

	Low Parental	Medium Parental	High Parental		
average Schizotypy=	**13.18**	**16.17**	**15.38**		14.91 High Peer
standard deviation=	5.36	7.04	6.12	SD	
number per group=	11.00	18.00	8.00	N	
	15.95	**17.95**	**16.33**		16.75 Medium Peer
sd limits:	5.13	4.83	4.01	SD	
58.73	21.00	22.00	12.00	N	
52.79	**17.00**	**16.62**	**20.07**		17.90 Low Peer
38.65	3.70	5.54	3.51	SD	
35.20	7.00	21.00	15.00	N	
	15.38	16.91	17.26		

Figure 3.8b Table showing basic descriptive statistics for the nine 'quadrants'.

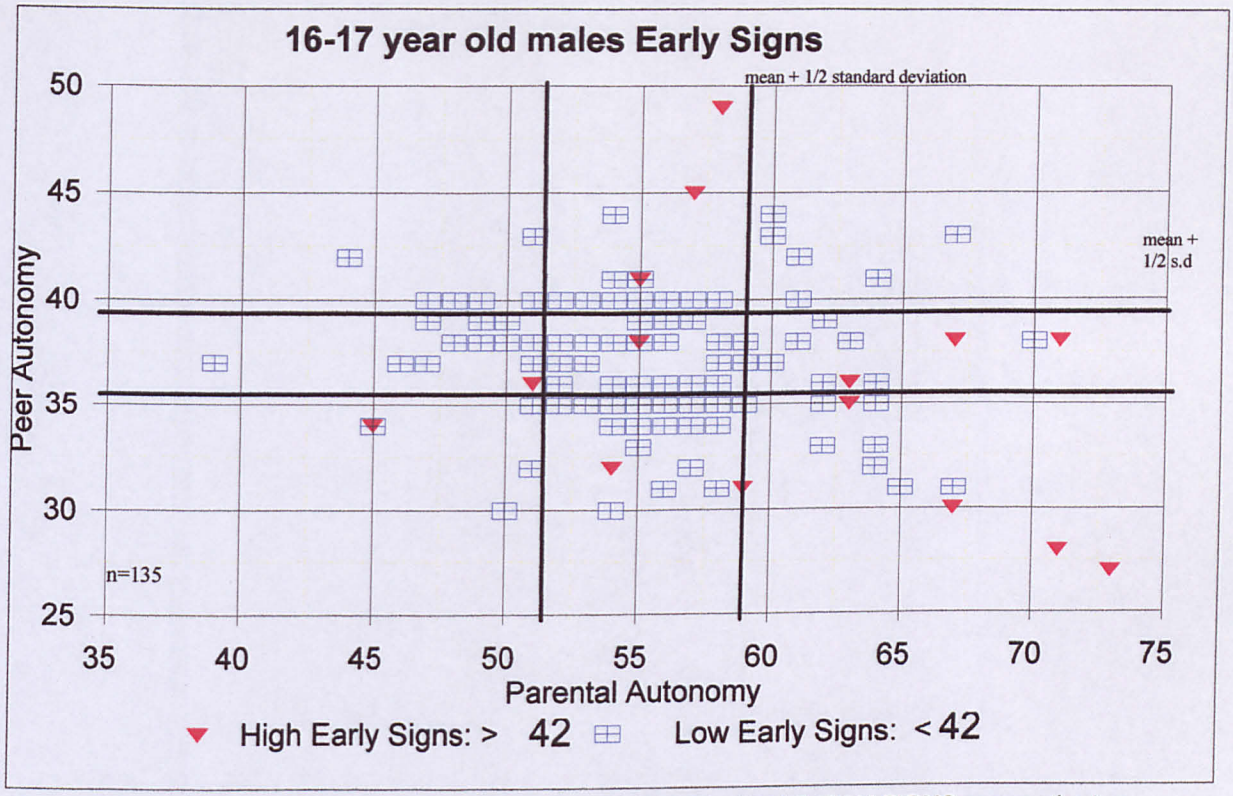


Figure 3.9a Graph illustrating profile of 16-17 year old MALES HIGH EARLY SIGNS scores: the two Autonomy scales are depicted as a mapping space, and each adolescent is depicted in this space as either high or low Early Signs.

Output table
N= 135

	Low Par	Medium Par	Hi Par		
average Early Signs=	**21.55**	**31.11**	**26.63**		26.43 High Peer
standard deviation=	10.06	19.62	9.93	SD	
number per group=	11.00	18.00	8.00	N	
	23.71	**23.41**	**32.67**		26.60 Medium Peer
sd limits:	12.11	10.40	17.50	SD	
58.73	21.00	22.00	12.00	N	
52.79	**26.29**	**25.05**	**33.67**		28.33 Low Peer
38.65	13.23	12.00	13.69	SD	
35.20	7.00	21.00	15.00	N	
	23.85	26.52	30.99		

Figure 3.9b Table showing basic descriptive statistics for the nine 'quadrants'.

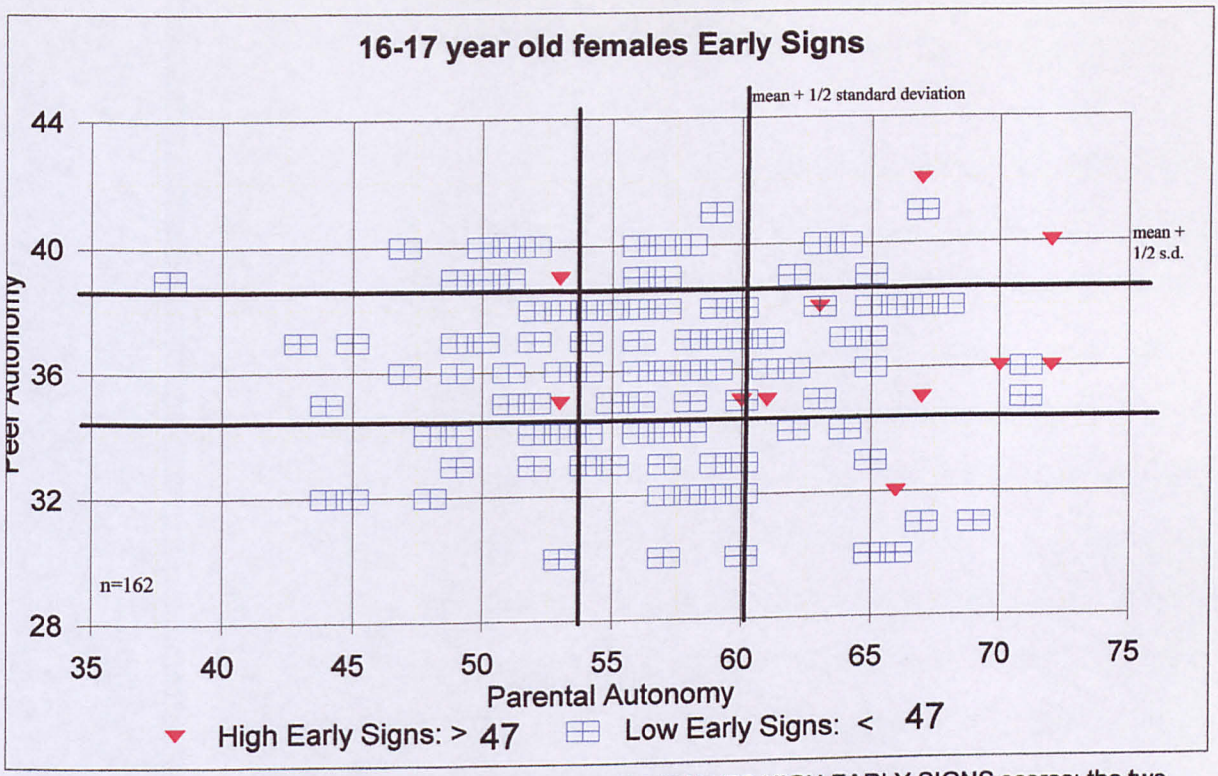


Figure 3.10a Graph illustrating profile of 16-17 year old FEMALES HIGH EARLY SIGNS scores: the two Autonomy scales are depicted as a mapping space, and each adolescent is depicted in this space as either high or low Early Signs.

Output table
N= 162

	Low Parer	Medium Parental	High Parental		
average early signs=	26.19	26.50	35.13	29.27	High Peer
standard deviation=	12.08	10.30	17.92		
number per group=	16.00	16.00	16.00		
	22.41	26.56	36.32	28.43	Medium
	15.03	11.17	16.06	SD	Peer
sd limits:	22.00	27.00	19.00	N	
60.00					
53.50	21.31	23.62	28.75	24.56	Low Peer
37.39	13.16	10.26	14.49	SD	
34.51	13.00	21.00	12.00	N	
	23.30	25.56	33.40		

Figure 3.10b Table showing basic descriptive statistics for the nine 'quadrants'.

3.3 Conclusions

The data show clearly that mild psychotic-like psychological experiences are present for normal teenagers throughout adolescence; this confirms the findings of McGorry et al (1995) that prodromal signs are remarkably common in 17 year olds. Youngest teenagers show the highest levels of schizotypy in this study, which could be interpreted as schizotypy representing a way of thinking that is more child-like and simplistic. As expected, late adolescents show more 'symptom' signs than mid-adolescents, possibly reflecting the strains of psychological maturation. The data here compare well with the adolescence literature, confirming the established finding that many individuals find adolescence difficult (e.g. Sidique and D'arcy, 1984). The average Early Signs Scale score for the 17 year olds was 27 which compares surprisingly to people with a psychosis- each psychotic client has their own "relapse signature" and hence their own score beyond which they are becoming unwell, but it is not uncommon for scores in the mid 30's and 40's to be indicative of the need for care in some form, be it a short respite inpatient stay or medication (Birchwood, 1996).

The data also show that schizotypy/ prodromal signs are closely related to relationship measures. For all age groups, high Parental Autonomy scores are related to higher schizotypy/ prodrome scores. For older teenagers both extremes of high and low peer autonomy are linked to higher schizotypy/ prodrome scores. To my knowledge this link has not been shown before in the context of psychosis. It seems fair to relate these higher schizotypy/ prodrome scores to the process of reaching adulthood and becoming less attached to the parents.

Interpreting the result is difficult, and real answers may only be obtained with a longitudinal study with larger numbers of participants. But these preliminary data suggest that there are two explanations of the mild psychotic experiences endorsed here: because schizotypy is highest in early teens, psychotic-like thinking might be equated to childish-ness in thought. This is consistent with the theory proposed in chapter 2, that blocks in psychological development underlie psychosis (although it might be taken to be inadvertently insulting and

unsympathetic by psychosis sufferers). Careful inspection of the schizotypy/ prodrome measures in appendix B may suggest an alternative explanation: far from measuring psychosis-like phenomena, these scales may inadvertently only tap typical childish thoughts. For example, a belief in evil spirits is not thought to be a developmental failing in a 13 year old (question 28, Schizotypy). Similarly, a belief that one's body is changing shape may not be inappropriate in a person undergoing puberty (question 19, Schizotypy). Although there are not many questions that lend themselves to such dual meanings, caution is needed in drawing conclusions from scales designed and tested on adults being used on adolescents.

The other explanation for high schizotypy/ prodrome prevalence in adolescence is that (as the theory suggested) developing autonomy is difficult and disturbing, and hence would be accompanied, if only transiently, with distressing experiences of unsureness and emotional turbulence. This is borne out by the data in that for each class, it is those students who have highest parental autonomy who have highest schizotypy/ prodrome scores. High peer autonomy is associated with highest schizotypy/ prodrome scores for most age groups. For the oldest teenagers, low peer autonomy is connected to high schizotypy/ prodrome scores, reflecting that peer autonomy decreases with age. This seems to indicate that people at either extreme for peer autonomy are vulnerable to distress when things get tough - possibly because they are either too dependent or too remote and isolated from their peers for them to be a useful source of support.

Where does this leave someone looking for predictive indices for the early identification of potential schizophrenia? A simplistic view of the data here would suggest that one possible path into psychosis is trodden by those people highly on parental autonomy, because in this study high parental autonomy is always associated with high schizotypy/ prodrome scores. Possibly of these the most vulnerable would be those with no peer support (either very high or very low on peer autonomy) - those who have individuated from parents but not made the corresponding attachment to peers in the terminology of chapter 2. However, it is essential to bear in mind here that these patterns, (for example of high autonomy and

psychosis-like scores) are *normal healthy* signs of maturation. (More accurate and extensive measures of autonomy into early adulthood will be needed to illuminate whether this is truly a pathway to psychosis or not.) There is a danger in extrapolating too far from these data, because the data only indicate how normal adolescents fare up until leaving school. Leaving school or leaving home may be the biggest single factors in changing psychological well-being. Future work could study 19-22 year olds if suitable samples can be found - university students and unemployed school-leavers suggest themselves as two potential populations.

In fact these sorts of life changes may well be most difficult for individuals who have prior to them been relatively sheltered, and have therefore not psychologically matured as much. Therefore, it may well be the *low* autonomy and therefore low schizotypy/ prodrome scorers that will be most vulnerable to the changes involved in leaving home. This is an implication of the theory in chapter 2 which suggests that the people most at risk are the people who show low scores for parental autonomy, because these people have never properly negotiated adolescence. People who gain autonomy from parents late on (or not at all, except perhaps covertly) will find it most difficult to leave home and enter a more adult world. If the low parental autonomy group are at risk this is interesting because at the age of 17 they show no signs of individuation and hence low scores on schizotypy/ prodrome measures.

In sum, it is an encouraging start that despite the limitations support for the theory has been found in a relatively small sample, and in a relatively simple study. The data suggest a relationship between relationship measures and measures of psychotic-like thinking. Such a connection does not appear to have been demonstrated before in the literature, especially not with a theory to explain the relationship. Future research is needed to continue the study further into early adulthood. Another continuation of this study would be to investigate how people who have already had a psychotic breakdown fare on the autonomy questionnaires; this is the subject of the next chapter.

Chapter 4

4. Measuring the Autonomy of People with a Psychosis

The data in the previous chapter showed a relationship between autonomy measures and mild psychotic-like symptoms, and are consistent with the theory in chapter 2. Another way to evaluate the theory was to see how people who have already had a psychotic breakdown scored on the autonomy measures. Theoretically, the people most vulnerable to psychosis would be the people who were lowest on parental autonomy coming into adult life. It was therefore hypothesised that people who have had a breakdown and still show residual symptoms should be particularly low on parental autonomy. It is commonly known that clients are particularly dependent on their parents, and this is often thought to be a consequence of their condition; unfortunately, there is no way of showing whether any low parental autonomy came first or not, short of a huge prospective longitudinal study. At least if it could be empirically shown that clients were remarkable in their autonomy profiles, then this would be consistent with the theory and not discordant. It was hypothesised that clients would be low on Parental Autonomy and either very high or very low on Peer autonomy.

Given this hypothesis, the question remained of what comparison group would be appropriate to show that psychosis-sufferers are particularly low on parental autonomy; i.e. low relative to whom? Given that autonomy is something that changes with age in normals, controls had to be matched for age. Gender, ethnicity and educational level have all been shown to have an influence on incidence for both psychosis and parental autonomy (Birchwood et al, 1992; Steinberg, 1988). Hence adult controls who had no previous psychiatric history were matched for all these factors. Another comparison was to use the data from the previous chapter to see what age-group of adolescents the participants most resembled.

4.1 Method

4.1.1 Participants

Participants were consecutive referrals to the study from psychiatrists in South Warwickshire, Northern Birmingham and South Birmingham Mental Health NHS Trusts. (Ethical approval was obtained from all 3 trusts and the relevant documentation is in appendix C). 33 clients (25 men and 8 women) with an ICD-10 diagnosis of paranoid schizophrenia were interviewed; a further 8 clients declined to take part. All diagnoses were made by Colin Campbell, Steve Chung, Mike Radford, or Femi Oyebode, all consultant psychiatrists (see appendix A for a consideration of reliability and validity of diagnoses). The mean age was 32.4 years (s.d.=9.7). Interviews generally took one session of 45 minutes, although for one or two more impaired clients it took longer. All interviews were done in the client's homes, or on an outpatient basis at St. Michael's Hospital in South Warwickshire, the Queen Elizabeth Psychiatric Hospital in South Birmingham and the Archer Centre in North Birmingham. No one else was present during the interviews. No clients were included who were currently misusing drugs or alcohol, or who had a primary organic impairment. All clients were in "regular and meaningful contact" with their parents.

Controls were employees of the University of Birmingham. Matching for educational level meant that, for example, some were labourers, some caterers, some white-collar workers and some students; 7 people declined to take part when asked. Their average age was 31.7 years (s.e.= 12.7). To show that they matched the clients group, a matched-pairs t-test showed that the distribution of the differences between ages was compatible with a distribution around 0 (t=-0.37, df=32, two-tailed p=0.71). The mean difference between ages for pairs was 0.45 years, (s.e.=1.2). Both groups had an average number of years of education of 13 years; a matched pairs t-test showed no difference between the two groups in terms of education (t= -

0.89, df=32, two-tailed p= 0.38). Controls also matched the psychosis group for gender and ethnicity. No one with a previous psychiatric history was used as a control.

4.1.2 Measures

The questionnaires used were, **The Emotional Autonomy scale** (Steinberg and Silverberg, 1986), the **Peer Autonomy scale** (Webb, 1996) (as described in chapter 3). Some of the items in this scale were inappropriate for an older group because they mentioned school; clients were instructed to answer these items replacing 'school' with 'work')

The SCL-52 or the **Brief Symptom Inventory** is a symptom inventory derived from the longer SCL-90 (Derogatis and Melisaratos, 1983; see appendix B). It has test-retest reliability of 0.87, and has been shown to be well validated with both clinical and normal populations. It was used in this study primarily to ensure that the normal control group was significantly lower on psychopathology than the client group, which proved to be the case - means were respectively 28.4 and 63.9, (Levene's t test assuming unequal variances t= -3.06, p=0.006).

4.2 Results

The psychosis group were significantly different from the normal control group on Parental Autonomy (means were 52.1 and 56.8 respectively; matched pairs t-test: t=2.55, df= 32, two-tailed p=0.015). All 4 sub-scales of the parental autonomy scales were significantly different for the two groups, especially the parents-as-people scale (see table 4.1).

No effect was found for peer autonomy (means 37.0 and 36.8 respectively, matched pairs t-test: t= -0.29, df=32, p=0.77), however the variances were strikingly different (21.2 for psychosis group and 5.6 for controls). These differences are best seen graphically in Fig. 4.1 The sample sizes are only small but it seems that more of the psychosis group (in fact around half) are at either extreme for peer autonomy.

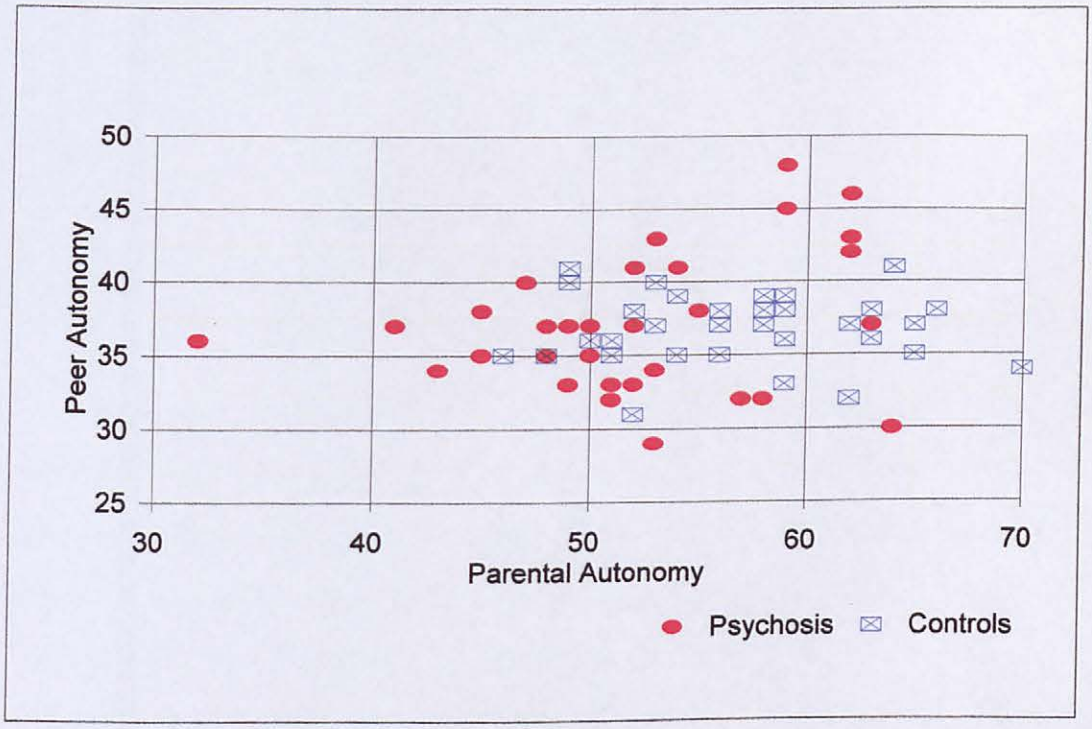


Figure 4.1 Graph showing autonomy profiles of psychosis sufferers compared to matched normal adult controls.

Table 4.1: Table showing differences between the psychosis group and normal controls for the parental autonomy scale with all its subscales, and the peer autonomy scale. The means for the psychosis group are on the left.

	Parental		Disinhibit'n		Parents as People		Non-Dependency		Individuat'n		Peer	
Means	52.1	56.8	13.7	15.4	14.5	14.2	10.6	11.5	13.6	15.2	37.0	36.8
s.d.	6.0	6.9	2.7	2.8	2.1	2.9	2.1	1.9	2.8	1.8	4.59	2.37
t	2.55		1.68		3.5		2.58		1.9		-0.29	
p	0.015		0.048		.001		.006		0.025		0.77	

Comparison with the data from the previous chapter showed that the psychosis group scored below the scores for 15 and 17 year olds, and were even below 13 year olds for parental autonomy (see figure 4.2). T-tests showed that the psychosis group was significantly below 17 year olds males and females together (t=-3.16, df=328, p=0.001), and below 15 year olds (t=1.66, df=106, p=0.06). On Peer autonomy the psychosis group was less different (figure 4.3), and none of the differences were significant. Finally figure 4.4 shows a scatterplot of all the 17 year olds and the psychosis group, plus the matched adult control group.

Within the psychosis group, 18 were fairly young and were in remission from their first episode of psychosis. Analyses showed that this group was significantly lower than the rest of the psychosis group for peer (but not parent) autonomy (see figures 4.2 and 4.3; t= -2.23, df=42, p=0.015). This effect was due to age alone, because the same difference was seen between the matching younger versus older controls.

19/ 33 of the psychosis group were living at home with their parents, compared to 7 of the control group. Comparing clients living away from home with controls living away showed that the psychosis group had significantly lower parental autonomy (t=-1.73, p=0.04) and significantly higher peer autonomy (t=2.01, p=0.026). Comparing clients living at home with controls at home showed the psychosis group had significantly lower parental autonomy (t=-1.85, p=0.03) but no difference in peer autonomy (t=0.18, p=0.42). Within the psychosis group, those living away from home showed the same parental autonomy as those living away (t=-0.522, p=0.3), but significantly higher peer autonomy (t=2.03, p=0.02). No such difference was seen within the control group, as those living at home did not differ significantly from those living away on either parental (t=0.22, p=0.41) or peer autonomy (t=-0.69, p=0.25). In summary, controlling for living arrangements showed that the psychosis group had significantly lower parental autonomy than controls irrespective of whether clients were living at home or away. For the psychosis group in particular, living away from home was related to higher peer autonomy.

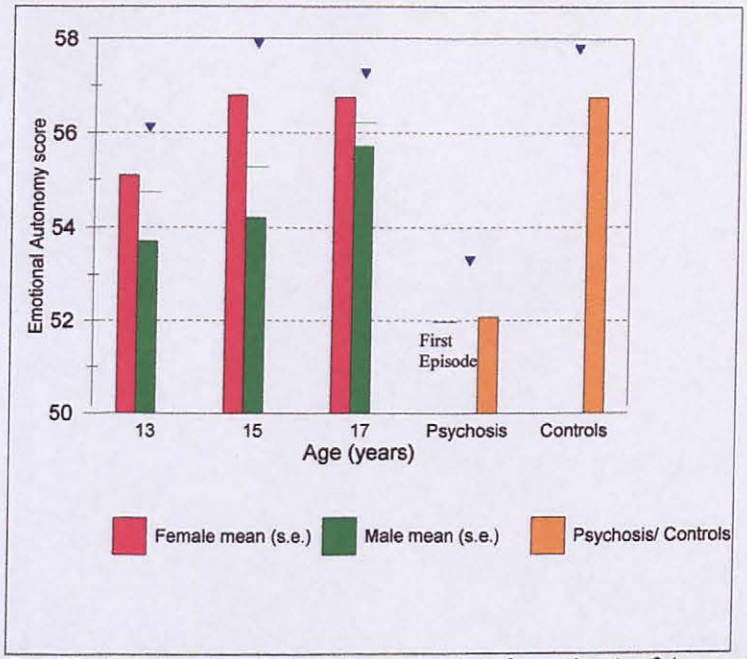


Fig 4.2 Graph comparing adolescence data from chapter 3 to psychiatric group of this chapter: PARENTAL AUTONOMY scores for the adolescents are in the first 3 columns. Psychosis-sufferers and normal adult controls are in the last two columns.

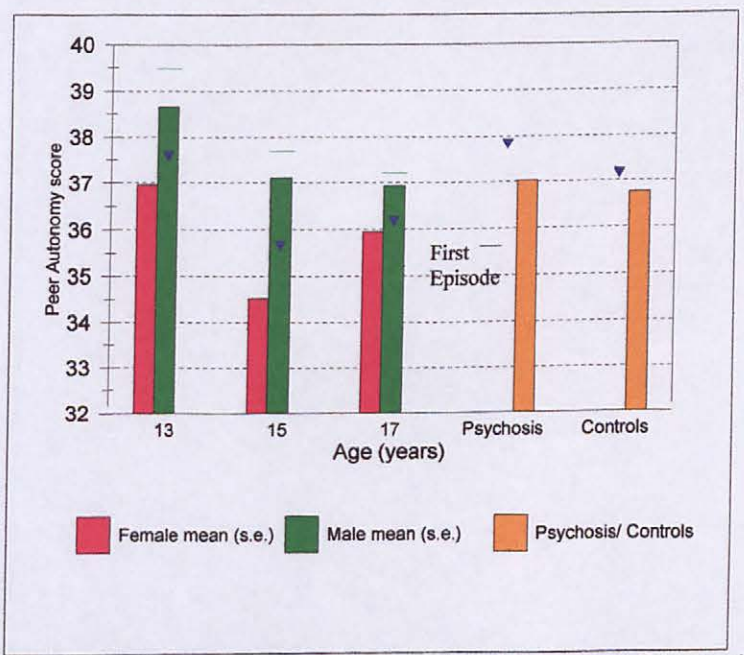


Fig 4.3 Graph comparing adolescence data from chapter 3 to psychiatric group of this chapter: PEER AUTONOMY scores for the adolescents are in the first 3 columns. Psychosis-sufferers and normal adult controls are in the last two columns.

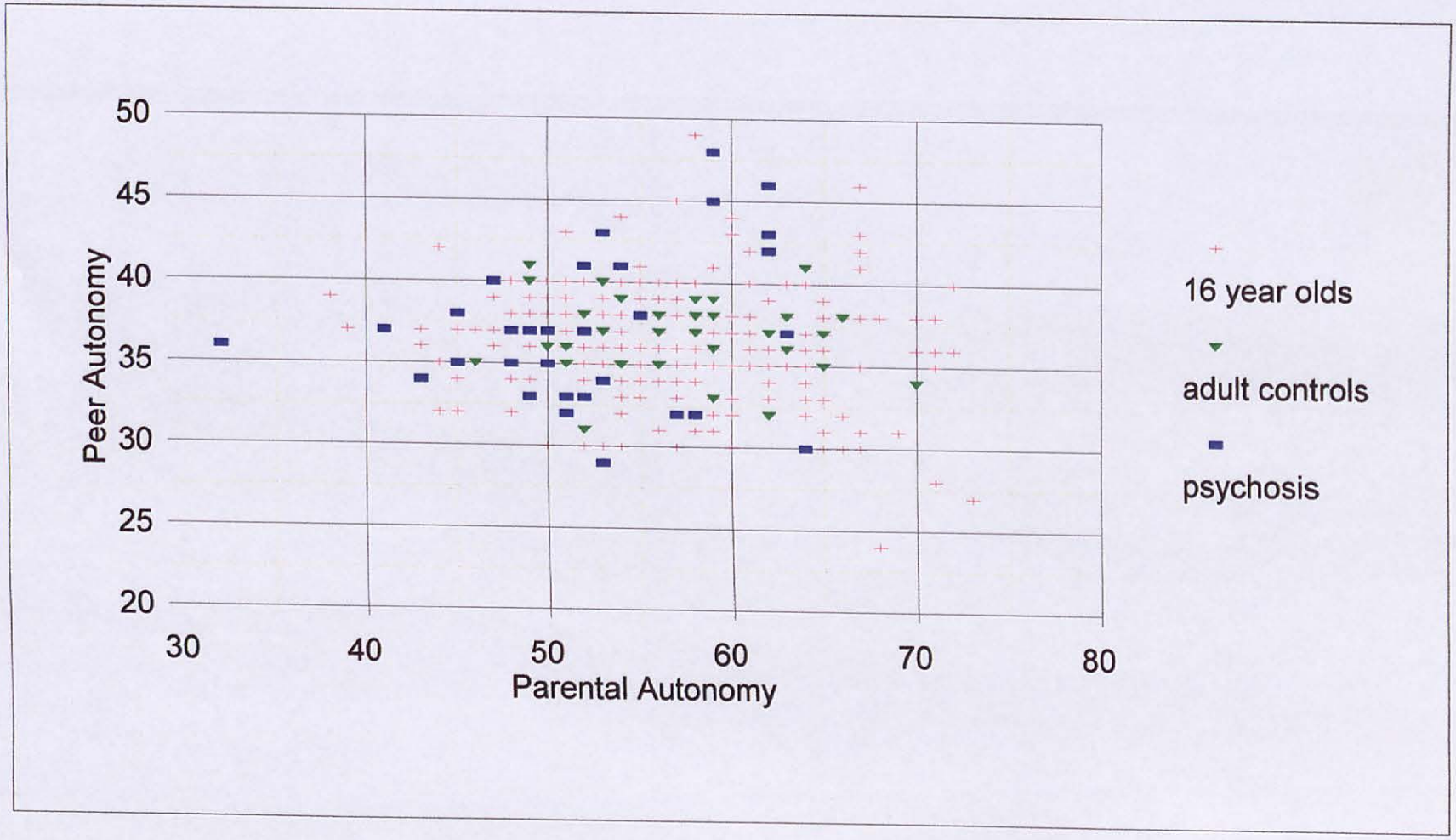


Figure 4.4 Speculative scatterplot of all 16 year olds, all psychosis sufferers and all adult controls on autonomy mapping space

4.3 Conclusions

The data are consistent with the theory that people who are most vulnerable to psychotic breakdown are those who are lowest on parental autonomy. Those who have had a breakdown are particularly low on parental autonomy when compared to both adult matched controls and teenagers. The comparison with teenagers shows they are significantly below 15 and 17 year olds, and are even below 13 year olds, although not significantly. The data also indicate that clients also tend to show especially high or especially low peer autonomy with regard to both teenagers and normals. In conjunction with the previous chapter this indicates that unusually close or distant peer relationships might be vulnerability factors for psychosis.

There is no way of showing from these data whether the autonomy differences observed are due to an extensive period of illness and perhaps hospitalisation, or *vice versa.* The fact that the psychosis group is below even the youngest teenagers suggests that at least some of this is an effect of the illness and hospitalisation. Younger, first episode clients were lower than older clients for peer autonomy but this was shown to be due to age alone, as the same effect was seen amongst normal controls. Clients living at home also had lower peer autonomy scores than those living away, and this trend was not seen in the controls. This suggests that the experience of living away is related to higher peer autonomy in psychosis sufferers, possibly reflecting their isolation from the community, which is likely to be higher than for controls.

The Parental autonomy scale is made up of 4 sub-scales- Non- dependency, De-idealisation, Parents-as-People and Individuation. That psychosis sufferers are very dependent on their parents is common knowledge. It is not well known that a psychosis group would idealise their parents. Sample questions in this category are "my parents hardly ever make mistakes" and "I try to have the same opinions as my parents". (It might be said that such

statements have a slightly different meaning in the context of psychosis, therefore a limitation of the study might be that it is unclear to what extent these scales designed for teenagers can be used on a psychotic adult population.) The Parents-as-People scale was the most significantly different from controls of the sub-scales. This is particularly interesting because the Parents-as-People scale directly reflects the Theory of Mind-style capacities that are hypothesised to be acquired during adolescence (Inhelder and Piaget, 1958, Elkind, 1979). Many of the psychosis group were surprised to even be asked such questions such as "I might be surprised to see how my parents behaved when they are with their parents", because to them, it was never likely that their parents were not parent-like in every aspect of their lives. Together with the idealisation, this suggests that, like the young adolescent, psychosis sufferers have only broad-brush notions of what makes their parents tick, and could profit from a closer observation and understanding of the other people in their lives. One reason why some clients have such limited understanding of others is because they are mostly self-focused and suffer from *objectité* (chapter 2); in the Individuation sub-scale, another facet of *objectité* is observed. The statements in this section refer to whether or not the participant feels that they have no secrets from their parents and that their parents "know everything there is to be known about me. " In chapter 7 the idea is investigated empirically that many clients even feel their own thoughts are open to scrutiny from their parents.

It is an encouraging sign for a new theory when that theory prompts an investigation into something hitherto unsuspected and meets with some support, as was seen here with the Idealisation and Parents-as-people sub-scales. As was mentioned in the previous chapter, if the concept of autonomy could be refined and enlarged upon, then application to psychosis might be even more telling. Future research might also want to reproduce the results in a larger psychosis group.

To look more closely at how psychosis comes about, the next empirical study (chapter 6) considers a small number of psychosis sufferers in much detail to examine the dynamics of

their interactions, and how the psychology might translate into symptoms. To do so, questionnaire techniques are abandoned in favour of a more qualitative approach, using a framework derived mainly from Rational Emotive Behaviour Therapy (Dryden, 1990). Another theoretical outline is needed before this can be done, to provide a form of representation that makes the interactions more amenable to study. It is common to use continuum theories to describe psychosis as an extension of normal functioning (Claridge and Broks, 1984). As well as describing psychosis in terms that seem more normal, the next chapter (chapter 5) describes normal interactions in a more existential manner, from their philosophical roots, which is a format that lends itself to uncovering fundamentals behind the symptoms and their functions.

5. Psychosis and the Self: Construction, Deconstruction and Recovery

From the previous chapters it was concluded that two major developmental tasks in adolescence are to disengage from the family and engage with a peer group. These stressful life tasks are often accompanied by psychotic-like phenomena, as inevitable consequences of the types of cognitive changes going on, as the individual struggles out of the chrysalis of childhood and metamorphoses into adulthood. Having passed through these transition periods, the psychotic-like phenomena usually disappear as the person psychologically matures into adulthood. However a proportion of people become stuck in the middle of the transition, and the accompanying psychotic-like features are not transitory, and in fact get much worse.

In this chapter the hypothesis is explored that a key to understanding the symptoms lies in a closer appreciation of how normal people experience and construct themselves. The theory of self construction, threat and defence put forward by Trower and Chadwick, (1995) is used to explain this process, and to show how in people diagnosed schizophrenic, the normal threats to self construction attempts overwhelm the individual and block or severely disrupt the self construction process as a whole. By way of illustration before addressing the theory proper, it can be said that the processes involved are particularly stark and important for normal adolescents, who (as detailed in chapter 2) have just developed the cognitive processes involved in conceptualising themselves in terms of interpersonal traits (which pre-teens don't do; Rosenberg, 1979), and thus are coming to terms with the realisation that other's don't necessarily have the high opinion of themselves that they have. Adolescents have also physically changed to an extent that their body-image (and hence much of their self-image) is enormously

tenuous (Simmons, and Blyth, 1987). They are also fast approaching adulthood, which requires a major realignment of thinking on many, many topics (Elkind, 1980). These sorts of uncertainties about themselves lead to a situation described by Rosenberg (1979):

> "For youth in particular, self-presentation is likely to assume the function of testing and attempting to validate one or more self-hypotheses...In a groping and tentative way, different selves may be rehearsed- the glamour girl, the caustic wit...Hence the common sense question 'What is he trying to prove?' has profound psychological significance, for that is precisely what the adolescent is trying to do. A girl wants a date in order to have evidence that she is attractive. ...When an adolescent- or anyone else- tries to achieve a certain goal, he does so not simply for the advantage it affords, but because it enables him to *prove* something about himself to himself. What concerns them is the uncertainty about what they are like, and what motivates them is the desire to know, to achieve certainty. Yet ultimate certainty forever eludes us so that the responses of others are required not only for confirmation but for the lifelong reconfirmation of our working self-hypotheses." (Rosenberg, 1979, p.48)

This process of self-construction is the focus of the current chapter, because careful reformulation of self-construction theory leads to important insights into some of the notoriously puzzling and bizarre symptoms of schizophrenia. That the self is a key concept in understanding schizophrenia is a long-standing idea that has recently received renewed interest (Alanen, 1994; Hingley 1992). Davidson and Strauss (1992) have shown that an emergent sense of self is an integral part of the recovery process. Bentall, Kinderman and Kaney (1994) have shown evidence that paranoid delusions serve the function of defending the self and maintaining self esteem. Trower and Chadwick (1995) have extended this model and shown evidence of two types of threat to and defence of self giving rise to two types of paranoia. In addition the concept

of self is a key component in recent developments in cognitive behaviour therapy (Chadwick, Birchwood & Trower, 1996).

The topic of the self in schizophrenia has also had many distinguished contributors. In particular, it was well recognised by the founding fathers of the classification and development of the concept of the psychoses- Kraepelin, Bleuler, Jaspers, Meyer, Schneider, Sullivan and Freud himself- that major disruption in the integrity of self was a core component in these disorders. The topic of the self has been out of favour both within psychiatry - with the advent of descriptive, diagnostic and biological approaches to mental illness- and within mainstream psychology with its positivist approach to empirical observation and experimental manipulation. But, it is now clear that the "self" is an area of recognised importance in cognitive psychotherapy in particular - both rational-emotive behaviour therapy (Ellis, 1994) and cognitive therapy (Beck, 1983)- and increasingly so again in mainstream social psychology following the emergent paradigm of constructivism (Stevens, 1997). Indeed the methodologies and theories now exist in experimental cognitive, social and clinical psychology to pursue research into these concepts (e.g. Suls 1993).

Some of the problems inherent in earlier self theories have been at least partially overcome in post-modernist and existentialist accounts in which the self is conceptualised as a social construction rather than an independent psychological object (Mahoney, 1991; McCullough, 1994). This view provides an opportunity for revisiting the topic of the self and schizophrenia. Following this line of reasoning, this chapter draws on Trower and Chadwick's (1995) account to summarise a reformulation of self construction theory which is intended to provide psychological understanding and therapeutic implications of psychotic phenomena. This account begins with an analysis of the concept of self by concentrating on the necessary and

sufficient conditions for the construction of a social self. It is then proposed that the construction of self is a fundamental human need but that the self is not a given and is never secure- it has to be empirically constructed, and continually maintained, and is always under threat. Some of the inevitable problems are considered in the construction and maintenance of self, giving rise not only to undesired and insecure selves, but more seriously to the collapse of the self. An attempt is made to identify some of the main kinds of failure and suggest some of the types and symptoms of psychosis associated with dysfunctions in self construction. Finally some recent findings are summarised in the light of these predictions.

5.1 The necessary and sufficient conditions for self

Trower & Chadwick (1995) proposed that there are three necessary and sufficient conditions for the construction of self, namely an objective self (the reflected self, or empirical, phenomenal, public, behavioural self) a subjective agent (reflective, conscious agent), and the Other (encompassing an equivalent subjective agent and objective self).

5.1.1 The objective self.

The objective self is the product - the self that is constructed. This, the most familiar aspect of self in everyday life, refers not to some mysterious inner entity, but to the observed, behavioural, public self, or what James (1891) called the phenomenal "me". The objective self as defined here is close to Sartre's concept of Being-For-Others (*Etre Pour Autrui*)

5.1.2 The subjective agent.

In order to construct an objective self, I as agent self must first define and present my 'self' i.e. perform self-presentational acts (Goffman, 1959). As subjective agent (Harré 1979) I

choose the roles, the rules and the subsequent actions - the self presentation behaviours - that constitute the objective self, and I monitor (i.e. observe and judge) those behaviours, and also monitor the feedback from the other. As agent I not only have the power of action but the cognitive processes of observing, interpreting, inferring, attributing, evaluating, recalling etc. I evaluate and generate self presentational behaviours according to rules - social and moral rules of conduct which as agent I know the other will recognise and value (Harré, 1979) - and also according to the guiding concepts I have of a desired possible self (Markus & Nurias, 1986). The evaluative function is particularly complex, and entails not only the direct evaluation of my own actions, but the evaluation of the other's evaluation of my own actions. In addition I can evaluate the *other's* action (these meta-appraisals were mostly clearly drawn out by Laing, 1969, and are currently conceptualised as a theory of other minds; Frith, 1992; Mitchell *et al*, 1996). These appraisals have important ontological (self objectifying) implications, as explained in the next paragraph. The subjective agent as defined here is close to Sartre's concept of Being-for-Itself (*Etre Pour Soi*).

5.1.3 The other

In order to become an objective self, the presented self must be recognised as a legitimate social and moral self by the other (Harré, 1979). The other therefore has two interlinked powers. The first power is to be able to reify the presented self into an objective self, for in the very act of observation, the appraiser can *objectify* that action, that self-presentation behaviour, and thus objectify the other's self, turning him into a Being-For-Others. The second is the power to define or redefine the presented self, and thereby influence how the self is presented. The second power enables the other to implicitly or explicitly state the social and moral rules according to which self presentations must conform in order to be recognised as a legitimate social self. The other of course is also an agent, and I (as subjective agent) am also an *other*. For the present purposes, the

other's role and function is defined as observer, and the power emphasised of providing the "public" objectivity of an audience which transforms the presentations of self into the objective self. This transformation is a vital part of the theory, and asserts that there can be no objective self without recognition by the other.

5.2 Motivation and Limitation of Self Construction

In this section it is proposed that there are two opposing imperatives involved in the process of self construction. The first is the motivation that I, as agent, have to construct an objective self, in accordance with my desired self concept, and which entails gaining the other's recognition. This is described here as the existential imperative. The second is the imperative to construct a self that conforms to the other's desired self concept *for me.* This is described as the moral imperative. This distinction has similarities in common with the distinction drawn by Higgins (1987) between the ideal self (one's hopes, aspirations and wishes) and the ought self (one's sense of duty, obligations or responsibilities), and is a distinction that, as Higgins points out, has been made by a number authors. The two imperatives are particularly akin to what are known in REBT as 'musts' (Dryden, 1995), one of the core types of irrational beliefs. In this section each imperative is described and then the interaction of the two detailed.

5.2.1 The existential imperative.

The existential imperative is the proposition that the making of a self is the most fundamental human passion and need. This idea is perhaps most explicitly expressed by the humanist-existential thinkers, with such concepts as the drive toward self-actualisation (Rogers, 1961; Maslow, 1973), and the concept of being-for-itself (etre-pour-soi) (Sartre, 1943/57), and by the "self" school of psychoanalysts with the concept of narcissistic need (Kohut, 1973).

Rogers (1961) describes the motive to become a self as "man's tendency to actualise himself, to become his potentialities" (p.351). By this he means "the directional trend which is evident in all organic and human life - the urge to expand, extend, develop, mature - the tendency to express and activate all the capacities of the organism, or the self...it exists in every individual, and awaits only the proper conditions to be released and expressed. It is this tendency which is the prime motivation for creativity as the organism forms new relationships to the environment in its endeavour most fully to be itself. " (p.351)

Rogers identifies a number of components of becoming that self which one truly is. The first is self-direction or autonomy, by which a person gradually chooses the goals toward which *they* want to move. He becomes responsible for himself. He decides what activities and ways of behaving have meaning for him, and what do not. The second is what he calls "toward being process." This concerns being more openly in a process, a fluidity, a changing, flowing current. He quotes Kierkegaard's description of the individual who really exists - of someone constantly in process of becoming. The third is "toward being complexity", that is to *be*, quite openly and transparently, all of ones complex and changing and sometimes contradictory feelings, with nothing hidden. Fourth is " toward openness to experience." This involves being in a close relationship to one's own experience rather than being closed off to them - a child-like acceptance. The fifth is "toward acceptance of others". Closely related to this openness to inner and outer experience in general is an openness to and an acceptance of other individuals. Sixth is "toward trust of self". This involves developing "more trust of the processes going on within themselves, and have dared to feel their own feelings, live by values which they discover within, and express themselves in their own unique ways."

Psychoanalysts within the school of "self psychology" express the drive to become a self

in rather more dramatic terms. Kohut (1977), argues that all people have at infancy and throughout life a primitive narcissistic drive or ambition within them to be grandiose and exhibitionistic, to have a tendency to regard themselves as omnipotent and to become enraged or thrown into despair when thwarted. These "archaic" drives are healthy and necessary, but must be modified through appropriate experiences with mirroring and idealised self-objects - significant others who are functionally part of the self - to a mature realism with a stable and secure self. Kohut (1977) sees it as essential to the child developing a self that he has a dependable "mirroring" parent (mother). The child performs and thereby seeks confirmation of its valued self by the mirroring self-object. The self will only develop if he receives loving, valuing reflections from the other. As Miller (1979, cited in Mollon, 1993) puts it: " the child has a primary need to be seen, noticed and taken seriously as being that which it is at any given time, and as the hub of its own activity."

For the existentialists the drive to become a self is *the* fundamental human project. Taking Sartre's (1943/1957) account, man's passion is to become a real, tangible being-in-the-world. His account emerges from the phenomenological nature of consciousness. Consciousness has no identifying characteristics, no content, no "being" or essence of its own, but can only reflect upon objects outside of itself. This emptiness or "*no-thing*ness" of consciousness is what I experience, according to Sartre, as anguish, and underlines the need to *become*, i.e. to fill the gap and become a real object. From this comes the drive to construct a self, to become a real me in the world. In technical terms, the Being-For-Itself *(etre pour soi)* seeks to become a Being-for-Others (*etre pour autre).* How does he try to achieve this? There are various ways, but one way is to play a particular role or act a part:

> "...he is playing *at being* a waiter...A child plays with his body in order to explore it, to make an inventory of it. The waiter plays with his situation in life in order to *realise it*..."

But since I (and the waiter) can only play at being x, I can never actually become x. So the project to *become* is a never-ending project, with all the implications this entails, of a continuous process, of freedom to change, of insecurity and so on. In addition, I cannot realise or become a self alone, but only through the other, a feature elaborated on later, and which echoes the principle discussed by Kohut of the necessity of the mirroring self-object.

5.2.2 The moral imperative.

This proposition is that any individual will, to varying degrees, experience a moral imperative to construct a self which the other wishes them to construct. Harré (1979) among others has argued that people construct themselves and each other according to "moral" rules that specify and guide the behaviour required to be a warranted and legitimate "social being." This works at the macro level - the level of the social group or generalised other, where it reflects general social rules or norms of conduct - or at the level of the specific other, where it may reflect the personal wishes of the individual other. The reward for conforming to the rules of the other (both the generalised and the specific other) is that the other is more likely to give the recognition that is needed to become an objective self. The other may evoke the moral imperative in order to try to make sure that the individual will present himself in the way he *ought*. The punishment for refusing to conform to the rules is that the other is more likely to refuse to give recognition, or will attempt to redefine the actor by means of a shaming label - two types of threat which are described later. The problem with the moral imperative, then, is that it can be in direct conflict with the existential imperative. To interpret Sartre (1943/1957) this is because I wish to found my own being - to be the author of my own self construction - but the other (who I need to achieve this) may wish to be the author of my self construction, and uses the moral imperative to try to achieve this control.

5.2.3 Interactions of the existential and moral imperatives.

In co-operative relationships, people may negotiate their existential and moral imperatives without conflict. If A wishes B to affirm his presented self, B may agree to do so if A also agrees to modify his behaviour to conform in significant ways to B's requirements, which may include A giving affirmation of *his (i.e. B's)* presented self. Thus people affirm and objectify each other but maintain mutual respect. However in dysfunctional relationships, there may be conflict between the existential and moral imperatives. These conflicts are discussed below.

5.3 Self-construction process

Given the dynamics of the existential and moral imperatives how does this self-construction process work in social interaction? Goffman's idea (Goffman, 1959), like Sartre's, draws on the metaphor of drama - a person attempts to construct his self by means of self presentation performances before an audience. Goffman proposed that people are engaged in 'impression management' all the time, acting in accordance with the type of person they wish to appear as. A good illustration of what Goffman meant by self-presentation comes from a story he cited involving Preedy, a man arriving on the beach at the start of his holiday:

> "But in any case he took care to avoid catching anyone's eye. First of all, he had to make it clear to those potential companions of his holiday that they were of no concern to him whatsoever. He stared through them, round them, over them- eyes lost in space. The beach might have been empty. If by chance a ball was thrown his way, he looked surprised; then let a smile of amusement lighten his face (Kindly Preedy), looked around dazed to see that there *were* people on the beach, tossed it back with a smile to himself and not a smile *at* the people,

and resumed carelessly his nonchalant survey of space.

But it was time to institute a little parade, the parade of the Ideal Preedy. By devious handlings he gave any who wanted to look a chance to see the title of his book- a Spanish translation of Homer, classic thus, but not too daring, cosmopolitan, too- and then gathered together his beach-wrap and bag into a neat sand-resistant pile (Methodological and Sensible Preedy), rose slowly to stretch at ease his huge frame (Big-Cat Preedy), and tossed aside his sandals (Carefree Preedy, after all)." (Sanson, 1956; cited in Goffman, 1956).

The story illustrates the various roles the self-conscious man sees himself as playing in this situation. Self-presentation has been defined as the attempt to control images of self before real or imagined audiences, and thereby to influence how audiences perceive and treat the actor (Schlenker, 1980). This sort of self-presentation is goal- driven -e.g. to attain one's love goals one seeks to display the appearance and behaviour that will arouse feelings of love in the target. Other authors have argued that the goal being achieved is not merely some social or material advantage, but the goal of *proving one's own reality in the world.* "It is difficult to maintain our self-view as a profound philosopher if others consider our ideas trite or trivial; as a wit, if they yawn at our jokes; as a dignified figure, if they puncture our pretension." (Rosenberg, 1979, p48). Hence, Rosenberg describes that we get something unique from other people that we can't get from ourselves-confirmation of whether we are what we think we are. At a more fundamental level, we have no way of being certain of our very existence without the other's mirroring (Sartre, 1943/1957).

Trower and Chadwick (1995) operationalise the process of self construction as a sequence of stages. The process begins with self-presentation behaviour for others, as just

described. In terms of the current model, this means I attempt to get the other to affirm my self as presented (for example by means of the moral imperative), and thereby enable me to achieve my goal of self construction. The second stage is the perceived, anticipated or imagined evaluation by others of the self so presented. This is where I judge whether the other accepts or is indifferent to the presented self, or rejects and redefines my presented self as in breach of the moral imperative. The third stage is the evaluation of self by the actor him or herself, consequent upon the other's evaluation . This is where I accept, am indifferent to or reject the other's affirmation or redefinition of my presented self.

In functional, co-operative relationships the process may be simple: A as agent presents to B as agent. Second, B observes and thereby "objectifies" A as an objective self; third B appraises his objective self-through-the-eyes-of-the-other. Here A succeeds in his self construction goal. In the following section ways are explored that this process can fail in conflictual relationships.

5.4 Threats to the Self

The construction of the objective self in the way described above occurs in an ideal world. In the real world the process often falters or breaks down, resulting in a variety of what Goffman called "spoiled identities" (Goffman, 1956). Social psychologists, philosophers and others have identified a whole range of sophisticated ways that people prepare for, recover from or repair identities, such as giving "justificatory accounts" (Harré, 1986). However further along this continuum comes into the realm of dysfunctional "selves" (e.g. as in personality disorders) or worse, into the failure to construct a self or the collapse of self, as may be the case in some types of schizophrenia.

There are three major forms that self construction failure may take: 1) the Insufficient Self where the self as agent apparently lacks the skill repertoire, the self-efficacy etc. to construct behavioural self-presentations. 2) The Insecure Self in which the agent, on account of the existential imperative, produces their desired self-presentations but the other is largely absent (as in neglect, indifference or abandonment) and thus cannot achieve the status of objective self. 3) The Alienated Self in which the objective self is imposed and controlled by the other by means of the moral imperative. The Insufficient self is not enlarged on here, but the second and third forms of vulnerability are focused on, as briefly outlined in Trower and Chadwick (1995).

5.4.1 **Insecure Self.**

The self as agent may fail to construct an objective self due to the lack of the attentive, 'objectifying' or 'mirroring' Other. The agent needs the other in order to *be* - to be an objective self in the real world. If the other is indifferent or negligent - if the other fails to value, nurture or even attend to the self as presented, or worse still is completely absent - then the agent has a problem - of failing to *be* in the profound sense of Sartre's *nothingness,* or more exactly no-thingness - of not being a thing, or object in the world. The essence of the insecurity threat is that the other leaves me unconstructed (consistently negligent) or deconstructed (inconsistently negligent, mirroring sometimes, and then withholding), but either way, of not being an objective self.

A dramatic example of this failure of mirroring is given by Kohut (1977). In responding to her young child, the mother

> "...responds - accepting, rejecting, disregarding - to a self that, in giving and offering seeks confirmation by the mirroring self-object. The child therefore

> experiences the joyful, prideful parental attitude or the parent's lack of interest...as the acceptance or rejection of his tentatively established, yet still vulnerable creative-productive-active self. If the mother rejects this self just as it begins to assert itself as a centre of creative-productive initiative (especially of course if her rejection or lack of interest is only one link in a long chain of re-buffs and disappointments emanating from her pathogenically unempathic personality)...then the child's self will be depleted and he will abandon the attempt to obtain the joys of self-assertion and will..." (page 76).

In the psychoanalytic literature this phenomenon is known as "narcissistic vulnerability" - referring to the fragility and uncertainty in the sense of self. This leads to strong reactions to the "narcissistic injuries" of feeling slighted, ignored or treated without respect or empathy. The most prominent reaction is of narcissistic rage (Kohut, 1972) - with secondary reactions of depressive withdrawal or of a retreat to an arrogant, grandiose and somewhat paranoid state of mind. According to Mollon (1993), these overt reactions seem to be protective responses to a more fundamental injury or break-up of the sense of self.

Mollon (1993) gives examples of client's who felt unreal, who had a sense of disappearing, who had a dread of evaporating, of having no sense of self etc. when significant others ignored them or looked through them. He gives a specific clinical example of a client who, if she felt she was not being focused upon by another person, would feel overwhelmed with an uncertainty over who she really was, or even doubts about her existence. Her response was often to fly into a rage (the narcissistic rage which comes from a need to make other's obey one's will).

The origins of this problem are classically to be found in early abandonment - the

experience of insecure-avoidant or insecure-ambivalent attachment, where the self-other bond is tenuous. Bowlby usefully distinguished various stages in the response to breakdown in bonding - the first two being protest and despair (Bowlby 1969). During the protest stage the person may vigorously pursue the other, try to compel, coerce etc. the other to be securely *there*. They may use care eliciting or care giving manoeuvres to maintain the bond; they may use guilt, attraction, power to bring the recalcitrant other into line. They may take the role of masochist or "poor me" to 'pull' from and thereby lock the other into the reciprocal role of sadist or persecutor. Using the present concepts, these manoeuvres would be described as emanating from the moral imperative. However once they have entered the despair stage, the scene is set for future psychopathology and what Masterson (1989) calls abandonment depression. This arises when the mother's continuous unavailability or inconsistency produces the climate in which the child's real self will not be able to emerge.

What is the evidence for this Insecurity threat in early development? Blatt and Homann (1992) in their review of the extensive parent-child interaction research literature, characterise one pattern of parental style as one of being psychologically unavailable, uncaring and neglectful, and if affection was given, this was inconsistent. They related this to what they call anaclitic depression, in which the individual intensely and chronically fears being abandoned and left unprotected and uncared for. Goodman and Brumley (1990) found lack of maternal responsiveness and affectional involvement was most characteristic of schizophrenic mothers.

What is the evidence for the unavailability pattern in the families of schizophrenics? The argument here may not concern high EE families so much as low EE caregivers. Both Leff and Vaughn (1985) and Smith (1993) have written about a subgroup of low EE 'burnt-out' relatives in inner city areas where the low EE response reflects apathy and indifference rather than calm

concern, and may be engendering apathy, negative symptoms and increasing levels of social impairment - even reinforcing social withdrawal.

5.4.2 Alienated Self.

It was considered earlier that the self as agent may not be able to construct an objective self due to the other being psychologically absent - apathetic, indifferent, disinterested , preoccupied and generally unavailable. But the self as agent may fail to construct an objective self due to a diametrically opposite reason, namely the other being excessively present and intrusive - of not only mirroring the objective self but of taking possession of it, by means (it is argued) of the mechanism of the moral imperative. To be *my* objective self, *I* as agent must construct the self presentation *for* the other, and the other must empathically recognise and value this self as *my* self, freely constructed. But if the objective self is controlled and indeed constituted by the other, then it is not my self but an alien self imposed upon me.

Sartre develops this notion in his analysis of 'being-for-others' (1957/1943). First he develops the thesis that I can only become a real object in the world by being recognised as such by the other. But secondly he states:

> *...we must recognise that we experience our being-for-others in the form of a possession. I am possessed by the Other; the Other's look fashions my body in its nakedness, causes it to be born, sculptures its, produces it as it is, sees it as I shall never see it. The Other holds a secret - the secret of what I am. He makes me be and thereby he possesses me, and this possession is nothing other than the consciousness of possessing me. I in the recognition of my object-state have proof that he has this consciousness. By virtue of consciousness the Other is for me simultaneously the one who has stolen my being from me and the one who causes*

"there to be" a being which is my being. Thus I have a comprehension of this ontological structure: I am responsible for my being-for-others, but I am not the foundation of it." (1943/57, p. 364)

In other words A is looked at, evaluated and labelled by B, and thereby becomes an objective self *defined* and constituted by the other *as* labelled by the other. A *feels* like an object, as labelled, experienced through shame and self-consciousness. Sartre uses the term *objectité* to identify this quality or state of being an object.

One client, Jane, diagnosed as paranoid schizophrenic, said one of her main fears was being taken over - 'everything being taken from me, your personality. You can't be yourself. You're not in control of your own person'. She dreaded the idea of someone 'telling you what to do. Like you *have* to do what someone else says all the time. I'd just run away. I won't let anyone get near me. If someone cared for me I'd feel they want to take my life over, be swallowed up, overwhelmed. That would be *possessive caring - being the other's property.*'

In reviewing the expressed emotion and social support research in schizophrenia, Davidson and Strauss (1992) comment that a "highly critical and over-involved family milieu can be seen as interfering with the development of an active sense of self by fostering negative appraisals and undermining a person's efforts at establishing his/her own sense of agency" (page 142)

To recap, if you are in the *objectité* state, you, as object, lose your sense of agency to the other as subject, i.e. ability to stand back and be an observer and hence judge of yourself and creator of your actions. According to Sartre, when you are object for the other as subject, you experience the other as being able to control your being as object, much as a puppeteer controls

the puppet. In the extreme forms just described, there are examples of clients who feel so deeply penetrated by the other that the other can control their thoughts, movements and sense of self. It is not difficult to imagine that a person, when in such a phenomenological state, will fail to attribute thoughts and actions to self as agent and will instead attribute thoughts and actions (which are in fact their own) to the other (whether real or hallucinated). The notion of being an object possessed and constituted by the other may help to explain a number of schizophrenic symptoms which have external control as their theme. These would include voices referring to the individual in the third person, voices criticising, delusions of influence - both control and somatic passivity - and some of the thought disorders, including thought insertion, thought broadcast, thought withdrawal and movements being controlled. Chadwick and Birchwood (1994) found that malevolent voices were extremely powerful (omnipotent) and all knowing (omniscient), and in the case of command hallucinations, individuals felt compelled to carry out the voice's commands.

How do clients respond or cope with the experience of alienation? There are at least three ways - constructing a false self, avoidance or withdrawal, and by turning the tables and alienating the other.

The first way of coping with the experience of being the other's object is by constructing a false self, behind which the true self may hide. Winnicott (1960) introduced the term 'false self' into psychoanalysis. He saw this as a part of the personality based on *compliance* to an environment which did not respond to the infant's own inner initiative. For example:

> *...the mother who is not good enough...repeatedly fails to meet the infant's gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stage of the False Self*

and belongs to the mother's inability to sense her infant's needs.

Another way of dealing with being the other's object is to escape or avoid the other, as in the case of Jane referred to earlier. A study by Egeland et al (1993) showed this to be true of children with over-intrusive mothers - they developed a characteristic "defence" of avoiding interaction.

Such a response pattern also appears to be fairly typical of those relapsing schizophrenics who are exposed to high Expressed Emotion relatives - the critical, the intrusive and the hostile. Leff and Vaughn, (1985) give some examples: a mother waves her hands and snaps her fingers in front of her daughter's face in an attempt to elicit some kind of response; disregards requests for privacy, walk into the patient's bedroom unannounced, monitors a patient's routine activities such as bathing and dressing, offers unsolicited advice. The common response was protective withdrawal. A young man spent more and more time by himself, retreating to his room or going for solitary walks. During arguments he ceased to speak at all - he would cower in a corner of the room and put his hands over his ears as if to shut out the noise. (Interestingly depressed controls tended to seek out comfort and support) (Leff and Vaughn, 1985, p. 114). Altorfer et al (1992) in a detailed micro-analysis of verbal and non-verbal behavioural sequences, found schizophrenic patients displayed evasive reactions to negative affective style of the relative. Specifically they found a decrease in patients non-verbal behaviour following negative affect statements, and an increase following positive statements. They interpret this as the patient's way of withdrawing from the communicative situation, eventually resulting in 'freezing' behaviour.

Enabling separation and modifying such communications is a key part of family intervention and helps reduce relapse. However there are additional problems with those who have introjected/incorporated the parent, particularly when this takes the form of a malevolent

voice, from which the client cannot escape.

The third way of dealing with alienation is by turning the tables and absorbing the other: Sartre again:

> *...if in one sense my being-as-object is an unbearable contingency and the pure "possession" of myself by another, still in another sense this being stands as the indication of what I should be obliged to recover and found in order to be the foundation of myself. But this is conceivable only if I assimilate the Other...Thus my project of recovering myself is fundamentally a project of absorbing the Other. (1943/1957, p. 365)*

A may try to "absorb" B by not only observing B's self-presentations but labelling them bad, worthless or even wonderful etc., hence constituting B's objective self and thus having control of it. This way A is free of control and controls the other in turn (though in the process he has lost his own objective self).

It is most likely that this third way of responding to alienation would be the strategy of someone with perceived high self-esteem or moral superiority or specialness, such as the narcissist, or the manic or the angry paranoid. The other two strategies will be most likely used by those who are low in self-esteem and powerless.

A number of experimental social and clinical psychologists have looked at various facets of alienation. One area is concerned with self-consciousness or self-focused attention- a major part of the phenomenology of being an object for the other. Duval and Wicklund first developed this into a theory known as Objective Self Awareness Theory in 1972. Recently Ingram (1990) showed that heightened self-focus was associated with a wide range of psychopathological states, including alcohol abuse, depression, and various forms of anxiety.

The effects of increased self-consciousness are likely to vary depending on the perceived self-esteem of the individual. Something is known about those with low self-esteem. Hope, Gansler and Heimberg (1989), looking at self-awareness and social phobia in particular, reviewed a number of studies showing the effect of this state: being painfully aware of one's physiological arousal, e.g. sweating, disrupted performance at a task, amplifying whatever emotional state one was in, heightened sensitivity to negative feedback such as rejection, tending to attribute negative outcomes to the self and related to this a reversal of the usual self-serving bias. Furthermore the self-focused anxious person becomes more aware of discrepancies between ideal and actual performances (alias selves) and an increased likelihood of disengaging from the desired course of action.

However the effects of increased self-consciousness on people with perceived high self-esteem is likely to be different. As Bentall and his colleagues have shown, deluded subjects showed an *increase* in the self-serving bias effect (blame others and not themselves for negative outcomes), which supports what was speculated earlier about turning the tables on the other.

5.5 Integration and conclusion

The insecurity threat and the alienation threat were described in terms of dispositional vulnerabilities, such that for any given individual, threats of one type will predominate over the other, leading perhaps to sociotropic (dependent) versus autonomous (independent) interpersonal styles, as defined by Beck (e.g. Clarke and Beck; 83).

However there are likely to be intra-personal cycles - where a person oscillates between insecurity and alienation, as may occur in certain types of borderline personality disorders - and

interpersonal cycles - insecure person A tries to ensnare person B as his Other by means of the moral imperative, thereby creating alienated self experiences in B, who withdraws, avoids etc., leading to further insecurity in A, and exacerbation of this particular vicious cycle. This interpersonal cycle would not only maintain, for example, high EE interactions, but probably lead to an exacerbation of them, to the point where a 'breakdown' occurs leading to yet another hospital admission for the family member who is in the subordinate position in the interaction.

Furthermore there are probably simultaneous occurrences of insecurity and alienation. For example B imposes an alien objective self on A, but ignores or in other ways devalues any attempt by A to present an authentic (i.e. their own) self to B or anyone else. A is thereby caught in a complete trap - entrapped in an alien self and blocked from constructing a self. One of the few options left is to withdraw into a vacuum of nonbeing, which may help explain negative symptoms, or wildly procrastinates between approach and avoidance. In fact this latter is the type of picture that Masterson (1988) paints in his portrait of the borderline - that mothers show both over-involvement (uses the child for her own dependency needs) and inconsistent (stops the child "individuating" i.e. authentic self presentation). Indeed Bezirganian et al (1993) showed this to be true in a large-scale study - that both child-rearing practices had to be present together to be "pathogenic".

It has been argued that many problems, particularly in psychoses, will at least involve a problem in the construction of self, and have described two of the major threats to this- the unavailability of the mirroring other, or the intrusive possession by the other. Cognitive psychotherapy has rather neglected this topic. This approach would suggest a new research agenda, examining the specific ways that people with schizophrenia are failing to construct their selves, and to develop therapy in the direction of enabling them to repair the process and begin

again - or for the first time - to construct a self, providing them with the enabling conditions - the mirroring others - to carry out this project.

6. Empirical Analysis of Self-Construction within Conflicts

In the previous chapter a theory was outlined of self construction, threat and defence, and there was speculation on the basis of the psychiatric literature about some of the consequences of threat to, and breakdown of, self construction in schizophrenia, including some of the symptoms that may result from self construction failure. The next part of this thesis was to empirically examine and understand the process of failure in self construction in a sample of people diagnosed as schizophrenic. The approach to this task was to ask participants to identify a set of interpersonal events where threats to self construction were most likely to occur, and to devise an ecologically valid methodology for examining those events in a way that would reveal the crucial psychological processes.

The earlier chapters on adolescent blocks highlighted relationships with families and peers as the two most likely arenas for turbulence and quasi-psychotic experiences. Conflicts in family and peer relationships were therefore the two areas where closer scrutiny was likely to be fruitful. That family relationships are important has obviously also been found by many investigators; a large number of studies have consistently found a significant relationship between psychotic relapse and certain types of attitudes held by family members towards the index client (Bebbington and Kuipers, 1994). These types of attitudes and communications that family members exhibit have been labelled as high 'expressed emotion' (EE; Vaughn and Leff, 1976), and include critical, hostile or emotionally over-involved attitudes towards the index client made by family members during the Camberwell Family Interview (Vaughn and Leff, 1976). The theory of self construction might be able to explain one crucial cause of the effect these communications have, namely that the high EE communications that are so consistently linked to relapse may constitute one or other (or both) of the two types of threat to self construction, and that at least some of the symptoms that characterise relapse may be construed

as forms of defence against such threats (e.g. paranoia, command hallucinations) or manifestations of an actual breakdown in autonomy of the self (e.g. delusions of passivity and control). Even short of actually causing relapse, high EE communications may block self development, causing the individual to become trapped in a dependent role without self integrity, with consequent negative symptoms or at least a pattern of chronic social withdrawal.

Given this line of reasoning, the aim of the study was to identify, analyse and compare accounts of interaction episodes that constituted conflicts in high EE families, to analyse these interactions in terms of our model of interpersonal threats to self, and to compare them with low EE families. In order to carry out these analyses, a structured interview was developed, using a methodology which was based on the paradigm of discursive psychology (Potter & Edwards, 1992; Harré and Gillett, 1994) rather than traditional experimental psychology, with the former's focus on the social construction of everyday situations, and the emphasis on an individual's particular construction of conflicts. The basic approach, therefore, was to encourage participants to describe their conflicts as unfolding stories of specific interactions between themselves and a significant other (parent or peer), with a focus on how the client saw his 'self' being constructed, reconstructed or deconstructed, and the psychological sequelae of this process in terms of beliefs, actions and emotions. However rather than obtain accounts using the initial *tabula rasa* approach of grounded theory, the structured interview developed for the present study was theory-driven, the theory being the self construction theory, operationalised within a rational-emotive behaviour therapy (REBT; Ellis, 1994) framework.

The interview - described fully in the Method section and in Appendix B - is designed to help the participant give an account of the conflict, from the point where they started to feel an emotional reaction to an event, to the moment when they judged the incident ended. The aim is

to help the participant to identify at least two and up to five chained sequences or stages, each of which may contain perceived threats to self of either the insecurity or alienation types. The first sequence begins with a description of an interpersonal event, e.g. a critical comment by the other. The participant gives their appraisal of this event in terms of a threat to self, and a description of and rating of how he felt and what action he took or wanted to take, e.g. anger and a critical counter-retort. This first sequence is then followed by the identification of a second, in which the participant is asked to describe the other's reaction to his actual or imagined response behaviour (e.g. an escalation of criticism), his appraisal of this second reaction (again in terms of a threat to self) and his emotional and behavioural reaction to this (e.g. a counter-escalation of anger and angry behaviour). There may be a third, fourth or even fifth sequence, each linked to the preceding one to make a complex chain. The final sequence explores the participant's self construction outcome, and the emotional and behavioural consequence of that outcome.

The main prediction of this study was that a typical sample of people diagnosed as suffering from schizophrenia, and especially those who are living with or are closely attached to a high expressed emotion family, would show demonstrable blocks to self construction. The study aimed also to identify types of blocks, to unravel the psychological pattern of these blocks, to explore the relationship between self construction problems and psychotic symptoms, and explore connections between these phenomena - self construction blocks and symptoms - and family relationships. Expressed emotion was measured by the Camberwell Family Interview (Vaughn and Leff, 1976), which was also useful because it obtained the viewpoint of the other family members involved in the conflicts. Self construction blocks were measured by the ABC Structured Interview (see appendix D). A number of questionnaires were also used to assess other aspects of family life: the Self and Other scale (Trower, Dagnen and Chadwick, 1997), the Impact inventory (Kiesler, 1987), and the Level of Expressed Emotion scale (Kazarian et al,

1990). Details about client's symptoms were obtained from case notes and interview, and also the SCL-52 (Derogatis and Melisaratos, 1983), the Beliefs about Voices Questionnaire (Chadwick and Birchwood, 1994), and the Manchester scale (Kraweieka et al, 1977).

6.1 Method

6.1.1 Participants

Participants were consecutive referrals to the study from psychiatrists and other mental health workers in South Warwickshire, Northern Birmingham and South Birmingham Mental Health NHS Trusts. (Ethical approval was obtained from all three Trusts and the relevant documents are included in appendix C). In all there were 35 referrals, of which 9 were excluded because they fell outside our inclusion criteria, and 5 did not want to participate. The inclusion criteria were a) an ICD-10 diagnosis of paranoid schizophrenia or delusional disorder; b) age range 17 to 45 c) living with or in "regular and meaningful contact" with the parental family. People were excluded if a) they had primary organic impairment, b) were currently misusing drugs or alcohol. The number of participants was 21, including 17 men and 4 women, age range 17 to 45 (mean age = 30 years, SD = 1.9). Six had a history of drug misuse (but not currently). All clients had at least 2 and at most 5 acute admission, and a psychiatric history ranging from six months to 7 years. All were receiving neuroleptic medication. See appendix A for a consideration of the reliability and validity of diagnostic categories.

6.1.2 Procedure

All participants were approached in accordance with the procedure laid down in the ethical approval documentation (see appendix C). All patients volunteered for the study, and

were approached to meet with a psychologist for a few sessions "to discuss relationship and family issues". The confidentiality of what they might disclose was emphasised, as was the fact that nothing would be entered in their case notes, and that the interviews would not have any effect on their medication or future treatment from the services. All participants were seen on an outpatient basis. The interviews were conducted by the author (a postgraduate psychologist) and Peter Trower PhD, a senior lecturer and clinical psychologist trained in REBT.

6.1.3 Measures

ABC Structured Interview

The ABC interview protocol is described in detail below; a summary how it should be administered is in appendix D. The interview is based largely upon, and conducted according to the well-established ABC cognitive assessment procedure of REBT (Dryden, 1995). The interviews were carried out by an experienced and trained REBT therapist (Peter Trower) and the author. The author was trained by Peter Trower in the administration of the interview (see appendix D), including supervision of tapes. Since all the data was provided by the participants, and no ratings or judgements made by the interviewers, inter-rater reliability checks were not relevant, except for rater categorisation of Activating Events, where an inter-rater reliability check gave a kappa of 0.81 (see first part of results section). Sample interviews from both interviewers were rated by two external experts in REBT as to how the interviews were conducted. The experts were Dr. Antoni Diller and Dr. Andrew Jahoda, who were unaware of the hypotheses of the study. Tapes were rated for 1) *fidelity* (how faithfully the interviewers implemented the guidelines for the ABC sequences, 2) *skill* (how skilfully they implemented the guidelines and 3) *bias* (how much bias they demonstrated). Raters reports are included in appendix G, which show that both interviewers were rated to have performed very well on these

criteria. An annotated transcript of a sample interview is included in appendix F. Other aspects of validity and reliability for this kind of qualitative interview are discussed in appendix E.

Camberwell Family Interview

The Camberwell Family Interview (Leff and Vaughn, 1985) is a semi-structured interview completed with the relatives of clients. The complete transcript of the interview is rated using strict criteria for scores on 5 categories of communication- critical comments, hostility, positive comments, warmth and emotional over-involvement. 7 or more critical comments, any presence of hostility observed as generalisation of criticism or a rejecting atitude, or a score or 3 or more on emotional over-involvement is rated as 'high' expressed emotion; otherwise the expressed emotion rating is 'low'. In deciding the rating scores, behaviours referred to in the interview and non-verbal communications during the interview are also taken into account. Rating scores are then most commonly used to divide relatives into two categories, high and low Expressed Emotion (EE), the dichotomous nature of the categorising reflecting the fact that the most frequent use of the scales is to predict or not predict relapse in the future. Clients whose relatives are classed as "high EE" are generally twice as likely to relapse (Bebbington and Kuipers, 1994). Little is known for sure about the mechanism whereby high EE translates into symptoms, except for non-specific theories about EE just being very stressful. The CFI has good psychometric properties, and the present author was trained in administering and rating it by its originator, Christine Vaughn, to an acceptable criterion standard on rating tapes blindly.

Level of Expressed Emotion scale (Cole and Kazarian, 1988; Kazarian et al, 1990).

Because the CFI is so time-consuming to learn and administer, a number of alternative measures have been devised, such as the Level of Expressed Emotion scale (LEE; Cole and Kazarian, 1988; Kazarian et al, 1990). The scale is completed by the client about their relative, and therefore measures the EE that the client is aware of receiving. It has been shown to

correlate significantly with EE as measured by the CFI (Kazarian et al, 1990), and has an internal reliability coefficient of 0.95 (Cole and Kazarian, 1988). Some client's parents were not available to take part in the CFI, and for these clients their LEE score was used to rate parental EE.

Self and Other Scale (Trower, Dagnen and Chadwick, 1997).

The conflicts assessed by the ABC interview are fairly concrete examples of threats and defences; in order to assess more general ongoing vulnerability to the two main types of threat, the Self and Other questionnaire was used (Trower, Dagnen and Chadwick, 1997). This asks clients to endorse common phenomena relating to alienation and isolation experiences and has been shown to have good reliability (r=0.82-0.84).

Impact Control Inventory (Kiesler, 1987)

There was a need for another validatory measure of how the relationship between parents and child was currently, so the Impact control inventory (Kiesler, 1987) was used. This is a measure of how people's interpersonal styles pull at each other, in effect the impact they have on each other and how this impact affects the relationship. It has been shown to have satisfactory internal consistency scores (Cronbach's alpha> 0.71), and has been used to investigate a number of topics including assertiveness and maladjustment (Kiesler, 1987).

Beliefs about Voices Questionnaire (Chadwick and Birchwood, 1994).

This instrument differentiates primarily between clients who hear malevolent voices and those who hear benevolent voices, and gives a quantified score for each type. It has been shown to accurately classify 90% of individual's voices (Birchwood and Chadwick, 1995).

Manchester Scale (Kraweieka et al, 1977).

Two widely-used measures of symptomatology were used, the first of which , the Manchester scale (Kraweieka et al, 1977), is filled in by the interviewer, and consists of around 5 items, each one answered on a 5 point scale. Previous work has shown this scale to have

satisfactory psychometric properties (average co-efficient of concordance W> 0.7). This scale has commonly been used in drug trials because it is weighted towards assessing physical symptoms.

Symptom CheckList (52 items) or *Brief Symptom Inventory (*Derogatis and Melisaratos, 1983).

The SCL-52 is filled in by the client (see chapter 4; Derogatis and Melisaratos, 1983). It has a test-retest reliability of 0.87 and consists of 52 items related to psychological experiences and physical signs such as breathlessness or palpitations.

6.1.4 The ABC Structured Interview and Interview Procedure

As described earlier, the interview is designed to capture in an operationally defined way the two main threats to self construction, the participants' cognitive, emotional and behavioural responses to them, the other's reaction to the participant's own reaction and the repeating chains of such sequences during a complete conflict episode. The interview accommodates threats that occur in a complex sequence, and responses to threats that were inhibited as well as those that were executed. To recap, the two main threats are Insecurity (I), where the other fails (for example, through indifference) to recognise and objectify the presented self, and Alienation (α), whether the other either coerces the client to construct a false self that is usually of demeaned status (coercion subtype) or defines the client as bad or flawed (redefinition subtype). There may even be a complex dynamic interaction of the two, where indifference is followed by control or vice versa, depending upon the situation, and the response of the individual to the initial threat. A fictitious description of each of these types is as follows:

6.1.4.1 First situation: Insecurity threat.

John (excited and expectant): Hey Mum, look what I've made!

Mum (watching TV): Not now, John, Just be quiet a minute, will you?

John (angrily): Piss off then.

In this situation, John makes his 'self-presentation' and looks for affirmation from Mum. Mum however is indifferent, leaving him 'unconstructed' with the consequence of angry feeling, angry behavioural intentions and critical thoughts about Mum.

6.1.4.2 Second situation: Alienation threat.

Dad: God, you are a lazy young man. Get out of bed and find yourself a job!

John (lies there, says nothing)

In this situation dad 'constructs' John's self by defining him with the phrase 'lazy young man'. By saying nothing, John allows this definition to be true, and is alienated negatively from his 'true' self-construction goals (α-).

Alternatively, Dad might be actually praising John in some way, and defining him in what he (Dad) thinks is a positive way, but John doesn't. If it isn't a role that John would have chosen for himself according to his own self-construction needs, and if it is odious to him, then this is defined as an experience of positive alienation (α+).

Dad: Your room looks so much better now you've tidied it- you really are an obedient young man.

John (fumes)

6.1.4.3 Third situation. Alienation-insecurity complex threat.

Husband: Look at this dust. Some wife!

Wife: Sorry dear, I've been cooking you this nice meal instead- would you like some?

Husband: No thanks, I'm off down the pub.

In this situation both threats are in the same interaction. Husband 'constructs' a bad self for his wife by the term "some wife". By apologising, she allows this definition of herself. She then makes a self presentation, to which he is indifferent, leaving her unconstructed.

Clients were taught the concept of self-construction and threats to self-construction; most clients grasped the ideas fairly quickly. In the conflicts reported, the categorisation as to whether the conflict is an α or I or whatever was made by the client themselves. In some cases, the interviewer described the types of threats very carefully and the client said which (if any) applied to their situation (there were a number of situations where no category applied; see results).

6.1.4.4 How the types of threat were used to build up sequences.

The main aim of the interview is to elicit from the client an account of an entire emotional episode, usually a family conflict, defined as any interactive incident between themselves and one or more members of the family (usually a parent) or peer group, in which the client feels significantly distressed. A wide range of conflicts were reported, and an attempt was made to get something in each of the following categories- an important issue with parents, a day-to-day repetitive issue with parents, a issue from with their friends, a symptoms issue, a romantic issue. Some clients did not talk about family issues; however after a lengthy engagement process it usually became clear that there were issues, but the client was reluctant to disclose them for whatever reasons. For example, some clients initially claimed to never feel uncomfortable in their relationships with their parents, and yet spent the best part of their day avoiding their parents at all costs. Obviously clients were not coerced and were free not to talk; clients were also continually reassured that they were free to discontinue the interviews at any point, an option some chose. It was important during engagement that it was essentially client-

led, and that they felt able to talk freely and be supported; the interviewers were careful not to put words in the client's mouth. For example, it was also important that the client felt able to contradict and disagree with the interviewer should the need arise.

The interview is designed to assist the client in reconstructing the 'story' of the incident, from the point where he started to feel an emotional reaction, to the moment he judged the incident ended. The account usually starts with:

- a description of an event, e.g. a critical comment by the other,
- the client's emotional and behavioural reaction, e.g. anger and a critical counter-retort, and
- his appraisals of the event which mediate the emotional and behavioural reaction.

This 'first sequence' is then followed by another, in which the client is asked to describe:

- the other's reaction to his actual or imagined behaviour, e.g. an escalation of criticism,
- his emotional and behavioural reaction, e.g. an escalation of anger and angry behaviour, and
- a second set of mediating beliefs.

There may be a third, fourth or even fifth sequence, each linked to the preceding one to make a complex chain.

The framework for the interview is the ABC (Activating event, Belief, Consequence [emotional and behavioural]) method from REBT, but modified in a number of ways (guidelines and an assessment form for the interview are given in appendix D).

The client is asked for the initial emotional reaction they experienced at the beginning of the selected incident. Key aspects of the emotional response are then explored (noted under C for

Consequence). Clients identify the general emotion or mood they experienced (the phenomenological aspect) including anger, anxiety or depression/ dysphoria (see Figure 6.1 for a map of the interview results sheet; the emotion is identified as item 1 on this figure). Second the client is asked for a *specific* emotion within the general mood such as guilt, shame, hurt, grief, etc.) (see Dryden, 1990, for a list of key emotions). This specific emotion (item 2 in figure 6.1) may be experienced currently (I feel ashamed) as would often be the case in anxiety. Third the client identifies the emotional impulse- the behaviour that they felt they impulsively wanted to carry out at the time, such as aggression in anger, or avoidance or escape in anxiety (item 3). Finally the client is asked to report whether this is an actual or inhibited behavioural impulse (item 4).

The triggering event that set the emotional reaction off is asked for, and key aspects of this noted, particularly verbal or non-verbal communications by the significant other towards the client (These are noted under A for activating event; item 5).

The next part of the interview is concerned with the client's beliefs (B) about the activating event (A) which cause the emotional and behavioural responses at C. Beliefs are divided into those that constitute the appraisal (or evaluation) of the event and those that constitute the coping response to the event- a distinction borrowed from Lazarus (1992). The three main appraisal beliefs are the three person evaluations- other-to-self (what the other thinks of me; item 6), self to-self (what I think of me; item 7) and self-to-other (what I think of the other; item 8) (Trower, Chadwick and Dagnen, in press). The questioning begins with the first of these- the client's appraisal of the other person's explicit or implicit evaluation of him- and continues to the second and third. A number of other measures are taken such as conviction level in the beliefs, and 'negativity' (in a sense the badness potency of the evaluation; item 9). The coping response beliefs are those beliefs that define the actions that the client wants to take,

given the appraisal of the event and their emotional reaction to it. The first of these beliefs concerns the emotional goal (item 10). For example, the emotional goal for anger, given a negative appraisal, may be to stop, coerce or discredit the other. Finally the action beliefs are rated (item 11) for whether they are something the client feels they *want* to do for themselves, or whether they are something they feel they *ought* to do for others (Higgins, 1987)), the intensity with which they want this goal (item 12), and the discomfort experienced if they fail (item 13).

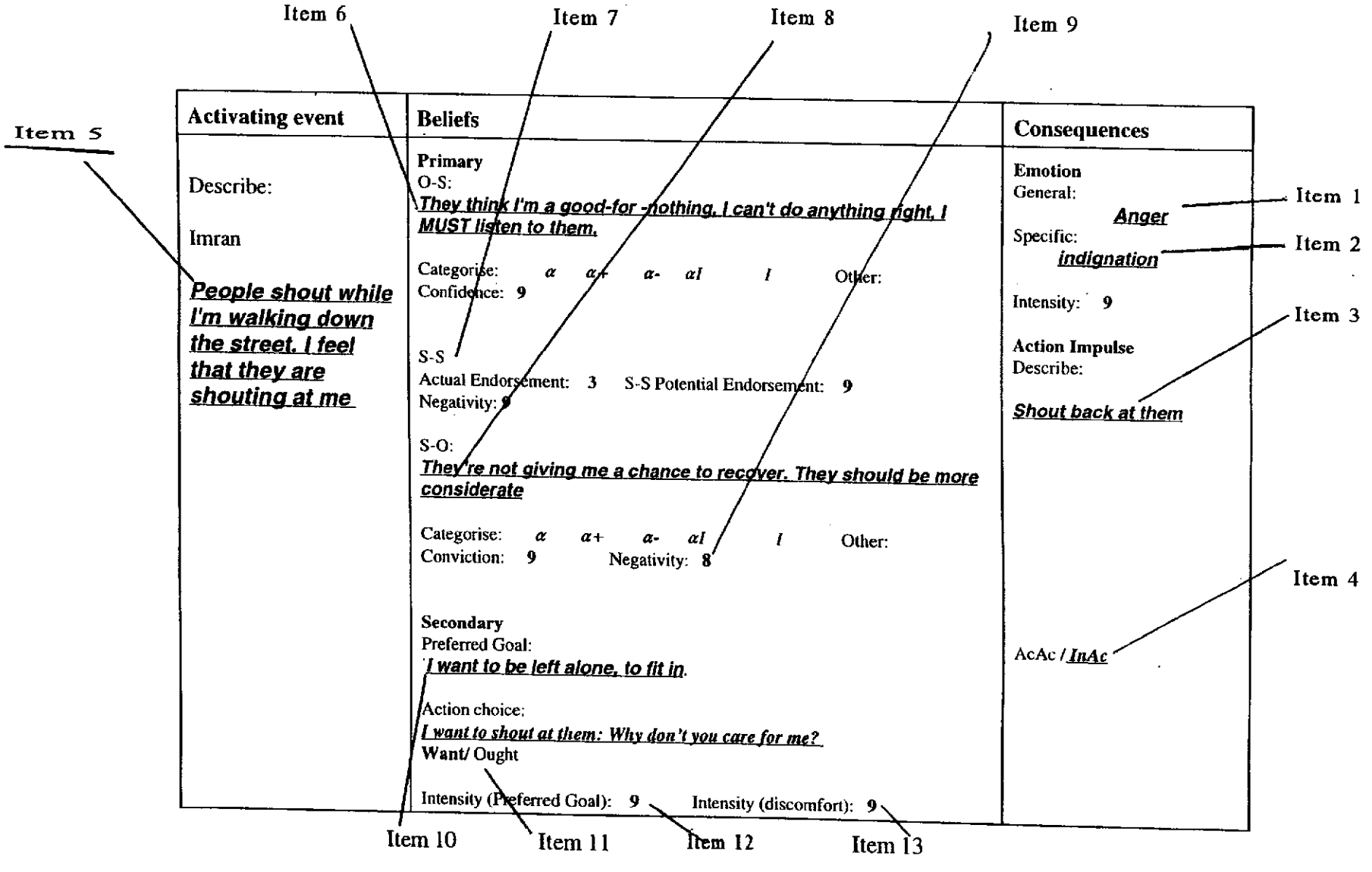
Although each sequence has the ABC structure, all sequences subsequent to the first are 'chained' to the one before, in that the behavioural C of the previous sequence becomes new A of the next. This can happen in two ways:

First the client may report carrying out a behavioural C, (e.g. getting aggressive such as throwing cups, shouting), which become the first part of the A for the next sequence. The client reports the other's reaction to their aggression, and his reaction becomes the second part of the new A. The interviewer explores the emotional and behavioural Consequences to this new A, and finally the appraisal and coping response beliefs.

Second, the client may report that they inhibited their behavioural impulse at C, (e.g. they had an impulse to be aggressive, but inhibited this behaviour). In this case the client is asked to imagine carrying out the inhibited aggressive behaviour as the new A in an imaginary ABC sequence. The client reports how he imagines the other would have reacted (second part of the A), how he would have felt and behaved at C, and what appraisal and coping response beliefs he would have had at B.

The final sequence in the chain is the one in which the client judges that the episode comes to an end. In truth, sequences have no ends and no beginnings- actual conflicts have histories of preceding sequences that set the scene, and following sequences that set the conditions for the next conflict.

Figure 6.1: Map of the conflicts interview sheet; first sequence



Results

The first part of the results section details the self-reported accounts of all the conflicts selected by the 21 participants. The second part of the results shows the findings from the questionnaire data. The third and final part contains a more interpretative account, looking for themes within the data and using individual cases to illustrate these themes. All names and other such identifying details have been changed to preserve anonymity of the participants.

6.2 Results part I - All conflicts

In all 50 conflicts were recorded. Each conflict starts with an engagement between client and a significant other, (real or imagined) and ends with disengagement. Each conflict also has an internal structure, consisting of a linked series of between 2 and 5 sequences, each of which in turn consists of a sequence of activating events, beliefs, and emotional and behaviour consequences - the ABC structure as described in the method section. Each conflict contains within it a 'difficulty' in self-construction, and the descriptions show the unfolding process of this difficulty. The results and interpretations will be presented sequence by sequence, beginning with the first and continuing through the last, in a way that tracks the unfolding process. Parental conflicts and peer conflicts appeared to be substantially different and so these are considered separately as we go through the results.

6.2.1 First sequence

The first sequence encompasses the interpersonal events that mark the opening of the conflict (the Activating events or As), the appraisals of those events (the Beliefs or Bs) and the emotional and behavioural consequences (the Cs) that follow from the Bs, given the As. The

first sequence therefore captures the first, immediate impact of and response to the other's behaviour.

6.2.1.1 Activating Events. (The 'facts' as perceived by the client)

There is substantial confirmation of the well-established finding from the expressed emotion literature that the conflicts are initiated primarily by actual and/or perceived critical or hostile communications. Table 6.2.2.1 lists the activating events that start the conflicts, and range from seemingly innocuous requests like "make us a cup of tea" through to "policeman and father coming up the fire escape and grabbing me by the arms". To give an overall impression of what types of scenarios were involved, two raters agreed (kappa= 0.81) that: approximately 16 incidents were the other being critical, 6 were the other being hostile and 1 was them being emotionally over-involved. Six were the client showing annoyance, 4 were neutral, 2 positive, 4 being ignored, 2 shame, and 7 were a demand from the other. This confirms an original expectation, that key conflicts reported by the clients would provide specific, concrete examples that would exemplify (for example) the high expressed emotion assessed in a general way by the Camberwell Family Interview.

6.2.1.2 Consequences (emotional and behavioural)

This section reports the emotions and behaviours that clients reported in response to the actions by the significant other that started the conflict. These are also shown in table 6.2.1.2 (on the same sheet as table 6.2.1.1). The main finding here from parental conflicts is that a majority (79%) involved the client getting angry in response to the activating event, usually intensely so (average of 7.5). Of this group, just over half (52%) also wanted to shout something angrily. However this was inhibited in all but 2 cases (88%).

Only 42% of peer conflicts show clients reporting anger (5/12); in these none actually expressed their anger behaviourally, although two did resolve not to have anything to do with their friends again.

The finding that there was a lot of anger in parental conflicts is consistent with the notion of the existential imperative, which would predict some degree of annoyance/anger and assertive/aggressive intent as the immediate *normal* response to the thwarting of self construction. Evidence for this was obtained with a non-clinical group of first year psychology undergraduate students in a parallel study to this one, where the majority (91%) of students responded with irritation or annoyance to criticism (Huber, 1997). The clients responded with roughly the same level of anger as the students (both had an average anger intensity of 8). Students also inhibited their aggressive impulses, but to a lesser degree- 61% of students inhibited their impulses, compared with 83% of clients. Students also expressed a more moderate and appropriate level of assertion.

A small percentage did not get angry. It may be that these clients did not have any anger at all, or that they were not admitting to it. Clients generally found it very difficult to report their anger, depending on whether or not they anticipated being judged critically for it; in some cases there was even a fear that they would get their medication increased, or perhaps be sectioned. Certainly client reluctance to report anger can explain why their anger is so often overlooked. The fact that clients found anger so difficult was due to an inhibitory process, the nature of which is uncovered in the analyses.

6.2.1.3 Beliefs (primary and secondary)

Thus far results show that a majority of clients respond angrily or with aggressive but inhibited impulse to perceived criticisms or hostile or indifferent communications. However to gain an understanding of the psychological mechanism - in particular whether this really is a

response to a thwarting of the existential imperative - it is necessary to examine the types of beliefs; these are shown in table 6.2.1.3.

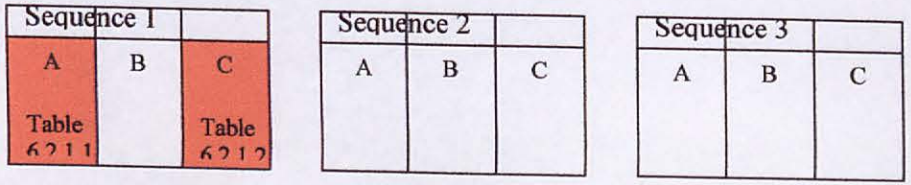
Table 6.2.1.1 Table listing initial Activating Events for all conflicts

Name	Activating Events
Mick 1	My Mum and my Brother said I should listen to Les Smothers and not use the fire escape
Mick 2	I say 'I'm sick of taking medication'. They say 'you have to take it'.
Mick 3	Policeman and father came up fire escape and grabbed me by the arms. (This was when I was sectioned because I wouldn't leave my flat.)
Nigel 1	I was sitting in the lounge and my father asks 'have you got a job yet? you've got to apply for hundreds' (he was wanting me to get a demanding job).
Nigel 2	Andrew looked at me out of the corner of his eye, sneered, looked away and shook his head. Happened mid-September 1996, in a pub one evening.
David 1	Mum said "Go and fetch me a cup of tea".
David 2	Mum said "Go and fetch me a cup of tea".
David 3	Mum said "Did you get the flour?"
Den1	I hadn't slept all night. Mum woke me and said "Get up, you have to go to the gym".
Den2	I was taking ecstasy. Dominic (21) said: "Why are you taking that you prat - you'll kill yourself".
Sandra1	About 7/8 years ago: Mother said "Nobody's talking about you - why should they? They have other things to talk about".
Sandra 2	I was going to the Institute of Education (Goldsmiths College) when in 2nd year, in concourse, people looking at me because I came in late, ruffled. They were nudging each other, laughing.
Cathy 1	To do with staffing levels. Staff asked me to work on the side.
Cathy 2	Went to pub scruffily dressed after badminton. People looking at me.
Cathy 3	Mum asked me if I was going to do the dishes or not. I had said I would after I had posted my letter.
Jack 1	I was in this club, on holiday with my mates. I was singled out by this really incredible girl, who sort of, 'dirty danced' with me in front of all my mates.
Jack 2	I sometimes think I am going to become the chosen one. But it does worry me a bit.
Jack 3	A big bloke who was with two of his mates and two girls attacked me, trying to get my watch.
Jack 4	Pretty girl in a cafe smiles at me; what do I think?

Table 6.2.1.2 Table listing Consequences derived from sequence 1.

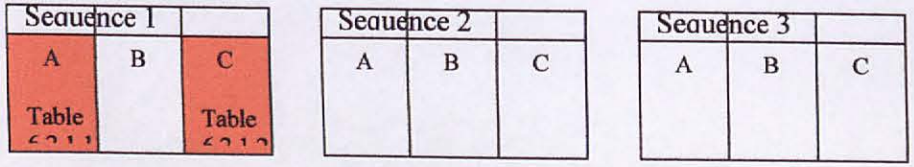
C: emotion	C: rating
Angry	6
Angry	6
Angry	9
Angry	6.5
Anxious	10
Angry	9
Angry	9
Anxiety	7
Angry	8
Angry	9
Anxious	9
Angry	10
Anxious	8
Angry	9
Happy	7
Anxious	8
Angry	7
Anxious	10

Map showing where in a typical 3 sequence conflict the columns detailed here would be



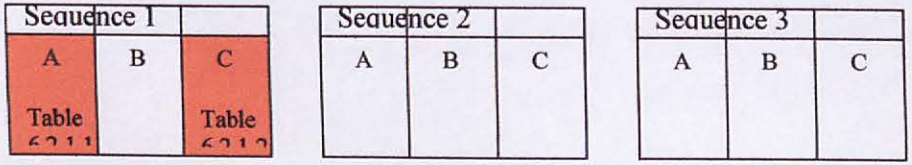
Name	Activating Events	C: emotion	C: rating
Bill 1	My Mum is never really interested in talking to me. She just watches her soaps. Like I'm a nobody.	Angry	8
Bill 2	I rang my friend up, (Michael) to ask about a game of footy. Someone answered the phone and just said 'Wrong number'. I'm sure it was my friend Michael pretending it wasn't him, to avoid me.	Angry	7
Bill 3	When I was first admitted into hospital: I was complaining about how I had this awful pain in my head. The doctor finally came out and just give me a few pain killers.	Angry	10
Bill 4	Romantic: Imagining I'm in a cafe when a pretty girl who is there smiles at me.	Anxious	9
Pete 2	I used to get really angry with my friends when we were playing football).		
Pete 1	My Mum sometimes nags me to do things properly, washing and cleaning, looking after myself. this used to really upset me (although now I know she's right and I should respect her.)	Angry	8
Pete 3	Romantic: Imagining that a pretty girl smiles at me in a cafe. How do I feel?	Anxious	
Pete 4	Critical Voices, Constant criticism over what I do and what I don't do. The way I live my life, 'the decisions I make, the way I mix with people.		
Imran 1	Whenever I do something wrong, Mum and Dad never let me forget it. They go on about it for ages.	Angry	9
Imran 2	People shout while I'm walking down the street. I feel that they are shouting at me.	Angry	10
Imran 3	I was carrying these bags of sand for my mother. They were far too heavy for me and I wasn't feeling very well, I had a weak stomach. I felt really ill but she was Insisting I do it.	Anger	10
Imran 4	Imagining how I would feel if I was sitting in a cafe or something, and a pretty girl sat nearby, etc	Nervous	10
Ali 1	Symptoms: Atul gets headaches which he attributes to people sending him thoughts. He is the most intelligent man in the world, according to the people on TV,	Depressed	
Ali 2	Atul has an enormously hostile relationship with his sister, who also appears to be very ill. A typical situation is when she's being annoying and I have to correct her	Angry	10
Ali 3	Atul has spent a lot of time in his room (around 2 years) just avoiding everyone. Sometimes my Dad would come in and communicate somehow that I wasn't doing what I ought to be doing.	Confused	8
Rachel 1	I went out late; when I came home my parents wanted to know where I has been.	Anger	5
Rachel 2	I bumped into a friend of my boyfriend while I was out. he invited me back to his house to wait for my boyfriend Gary. When Gary arrived he was really angry. He said 'What were you doing there?'	Guilty	6

Map showing where in a typical 3 sequence conflict the columns detailed here would be



Name	Activating Events	C: emotion	C: rating
Elizabeth 1	Mum wrote me some letters; they made me really angry because I felt Mum and Dad were trying to take over Grace (8 year old daughter). She was saying that Grace needed bringing up properly.	Angry	10
Elizabeth 2	At the start of my illness, I felt my friends weren't good enough; they were just silly kids.	Angry	10
Elizabeth 3	I hadn't got enough patience. Grace was about 2 then and she wasn't doing things quickly enough.	Angry	10
Matt	I kept seeing visions; things trying to get me. They were little creatures about a foot high. At first I could only see them out of the corner of my eye, but later, I could see them full on.	Anxious	10
Richard	My sister was driving me in the car, and we had a disagreement over a tape. I wanted it on loud. She took it out and threw it in the back of the car.	Angry	8
Pat 1	Mum and Dad were dismissive of my religious ideas. They said 'Live a good life and you will be saved: you read too much of the scriptures.'	Angry	8
Pat 2	I went to a massage parlour and tampered with a whore. I was very worried about HIV after this.	Guilt	10
George 1	I was really angry at God for the mess I was in. Sometimes my fingers and toes talk, saying bad things about God. They say swear words, F-words and that, about the holy spirit.	Anger	6
Matt N 1	My dad found a load of empty bottles of spirits under my bed. He called out for me, angrily	Fear	8
Matt N 2	I had a nice girlfriend for a while; I finished with her. Dad was really angry and told me I was stupid,	Anger	9
Matt O	Mum found out I had been trying on my cousin's clothes.	Guilt	10
Louise	I wanted to take an overdose to kill myself. The key wasn't there. He (my husband) had locked it, he didn't want me to take my tablets.	Angry	10
Martin	I asked my Dad about some of the things I've been worrying about recently. He said "Not now, son".	Angry	9

Map showing where in a typical 3 sequence conflict the columns detailed here would be



Almost the entire sample (92%) perceive the other (other-self) as communicating a negative evaluation of one form or another. A majority were classic put-downs, defining the client as bad or flawed in some way (α-) but about a third were interpreted as coercions to fulfil, and thereby be defined by, a menial role which, to the relative and outside observers (for example, staff) would be seen as evaluatively neutral or even positive (α or α+), and thus the patient's interpretation would be regarded as surprising or simply paranoid. The other's evaluation of themselves was not endorsed (self-self evaluation) by the majority of clients (55%), though this majority group did think that the negative evaluation was "potentially" true. However, 61% also express critical put-downs (α-) of the other (self-other). The interpretation is that these data reveal an anger-driven defence of the self, (shown by the clients' refusals to endorse these evaluations) against a perceived threat to the desired self or imposition of the undesired self (Markus and Nurius, 1986). In other words they attempt to protect their desired self and reject the undesired self. It is important to show the connection to A and C thus: A picture emerges in which clients, driven by the existential imperative, (I) perceive the other as rejecting or indifferent to their desired self and/or imposing an undesired self (negative other-self), (ii) mirror the rejection, indifference and/or negative labelling of the other and thereby attempt to discredit them as evaluators (negative self-other) and thereby (iii) protect their evaluation of their desired self (self-self).

Table 6.2.1.3: Table showing participant's beliefs for 1st sequence Activating Events: the Existential imperative.

Client	B: Other self evaluation	Self self evaluations					Self other evaluations	C:Emotion	
		Rate		Actual		Neg.			
	Parental Conflicts		Type		Potential				
Mick 1	Treated like a disobedient kid. Implying I was a bad boy.	7	α -	2	7	7	They were bad; morally wrong, raving mad.	Anger	6
Mick 2	They don't recognise my opinion. Treating me like a disobedient kid- a bad boy.	7	α -	2	7	8	They are morally wrong- raving mad.	Anger	6
Mick 3	Arrested, treating me like a criminal . Put down, bad person.	7	α +	0		10	Policeman was morally wrong.	Anger	9
Nigel 1	Telling how to live. If you're not permanently doing something you're worthless. 'You're a good-for-nothing. Dad keen to push me to get a job, not indifferent.	8	α -	1	6	10	Give us break- hasn't much understanding; nasty person .	Angry	6.5
David 1	There she goes again. Using me - treating me like a slave, worth nothing.	9	α -	4	9	9	How dare she- the bitch.	Angry	9
David 2	Treats me like a skivvy.	9	α -	4	9	9	She's selfish.	Angry	9
David 3	Have I forgotten the flour? Maybe she thinks I am stupid?		I					Anxiety	
Den1	Undermining my views: Therefore treating me like a worthless child. What I say is bullshit	7	α +	1	8	8	She is being unfair. Bad person.	Angry	8
Sandra1	Accusing me of being an egocentric, selfish person. Felt unvalued, dismissed.	7	α -	0			You stupid woman.	Angry	9
Pete 1	When I think it over, I think its for my own good. She doesn't think I'm useless, but it makes me feel useless. She likes me, but she treats me like a kid.	7	α +	5	7	7	She's a nuisance; its unnecessary.	Angry	8
Imran 1	They treat me as if I'm worth nothing. Its like 'you should be nothing'. I'm wrong.	8	α -	9		9	Its for my own good. They have to do this because of my condition. They care.	Anger	9
Imran 3	She thinks I'm the only one that can do it. I have to do what She wants, even if I'm feeling ill. Coerced, in the spotlight. She'd look down on me if I didn't.	9	α -	9		9	Stupid woman.	Angry	9
Ali 3	He told me I wasn't doing what I ought to be doing.		α -	0	3	0	I just let him do it. I didn't feel angry or depressed at all.	Confused	8
Rachel 1	They were angry with me, treating me like a child.		α -	10	0	0	They're wrong to treat me this way.	Anger	5
Elizabeth 1	She's shown me up in front of my husband. She's saying I'm no good at anything.	10	α -	0		15		Angry	10
Pat 1	Its like they were saying 'We're proud of you, but we're Not proud of you'.		α -		7.5	9	They were good people, nevertheless.	Anger	8
Matt N 1	He'll think I am a failure.	9	α -	9			What a bastard; why can't he be normal, just talk about things.	Fear	8
Matt N 2	He thinks I'm useless, worthless. Not good enough for her.	10	α -	1	9		He's manipulating me, the bastard.	Anger	9
Mick O'C.	Mum and Dad would think I was a dirty minded little prat.	10	α -	0	10	10		Guilt	10

Map showing where in a typical 3 sequence conflict the columns detailed here would be

Sequence 1		
A	B Table 6.2.1.3	C

Sequence 2		
A	B	C

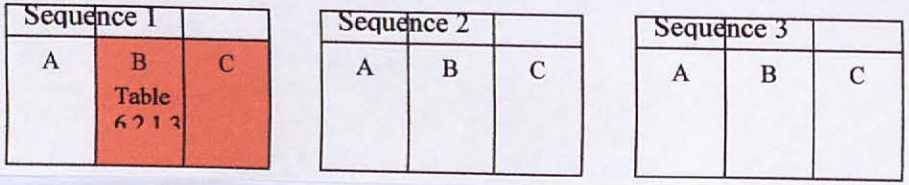
Sequence 3		
A	B	C

Key to symbols

α - = Negative alienation: imposed 'bad' self.
α + = Positive alienation: imposed self that other values but I do not.
I = Insecurity threat. Being ignored.
α I = Combination threat. Being deliberately ignored.

	Peer Conflicts								
Client	B: Other self evaluation	Self self evaluations					Self other evaluations	C:Emotion	
Martin	He thinks I'm a waste of space	10	α I	6	10	10	He's a bastard	Anger	9
Cathy 3	She was accusing me of being lazy and incompetent.	10		0	7	9	You're a lousy mother.	Anger	9
Bill 1	Its like I'm not worth bothering with, just a wasted life.	8	I	4	9	9	Dunno really.	Angry	8
Nigel 2	What have I done? Perhaps looking over-anxious. Perhaps he's cross because of a comment I once made; perhaps they think I'm off my head - weird, pathetic.	5	α -	7	9	9	I don't say anything, but they're being really holier-than-thou.	Anxious	10
Den2	Calling me a druggie. Saying I have no self-respect.		α -	7	8	7	Thought highly of him.	Ashamed	7
Sandra 2	What are they thinking? Have they heard the gossip? Are they thinking I'm a tart?	10	α -				Stupid people, nasty misinterpreting people	Anxious	8.75
Cathy 1	I get the raw deal all the time. That means she's treating me with less respect than she should. Treating me like a nobody.	10	α I	4			She doesn't know what she is doing.	Anger	10 / 8.5
Cathy 2	Thought they were saying ' she's one of those ill people '. They think I'm worthless.	10	α -	10	10	10	No thoughts about them.	Anxious	10
Jack 1	She likes me and wants to know me; my mates are all really impressed	10	pos't v	2	10	7	My mates are nice blokes. She's going to be perfect, a good friend.	Happy	7
Jack 3	I felt they thought I'd been humiliated. Like I was weak in their eyes	8	α -	5		7	Cowards. Gutless swine.	Angry	7
Bill 2	He and my friends didn't want to know me	10	α -	5	5	2	I was wondering who it was. I was disgusted with him.	Angry	7
Pete 2	They didn't see who I really was, the real Pete. They saw me as ordinary, easy to get on with. Not forcing me to be something else, just didn't know me properly.	8	α +	8	8	9	At the time I thought they were ignorant, knew nothing.	Angry	9
Imran 2	They're saying I'm a good-for-nothing, I can't do anything right.	9	α -	9	9	10	They're not giving me a chance. They should be more considerate.	Anger	10
Rachel 2	He thought I was intruding.		α -	9	9	6.5	He's making a big deal out of nothing. I think he was over-reacting.	Guilty	6
Louise	He was treating me like I was a silly pathetic nutter, a silly kid, a fool, stupid.	10	α +	0	10	10	He's a bastard. How dare he, he's got no right.	Angry	10
Pat 2	She thought nothing of it. She picked my pocket and everything.					10	She was a right old trollop. She was disgusting. How could God let that happen?	Guilt	10
Elizabeth 2	They never insulted me, but they didn't give me enough respect. They were friends to me on their own level- not being ignored. They were happy to know me.	10	α +				I'm not going to bother with anyone. They're not good enough for me.	Angry	10

Map showing where in a typical 3 sequence conflict the columns detailed here would be



Key to symbols

α - = Negative alienation: imposed 'bad' self.
α + = Positive alienation: imposed self that other values but I do not.
I = Insecurity threat. Being ignored.
α I = Combination threat. Being deliberately ignored.

6.2.1.4 Interpretation

The first sequence shows the participants perceived threat to, and attempt to defend the constructed self (i.e. paralleling Bentall's concept of attributional biases as evidence of psychological defence; Bentall, Kinderman and Kaney, 1994). The angry response, rejection of criticism, and externalising of negative evaluation (external attribution) are consistent with the notion of the existential imperative - the psychological motive to have the desired self affirmed (constructed) and the undesired self disaffirmed (deconstructed). The first sequence, primarily exemplifies the operation of the existential imperative.

6.2.2 Second sequence

The second sequence starts where the first left off, that is, the consequence (C) of the first sequence is the activating event (A) for the second. It might be expected that the second sequence should embrace a second line of defence of the desired self if the first has not been successful. As shall be seen, there were two quite different types of second sequence - those reporting actual events, beliefs and consequences, and those reporting imagined events, beliefs and consequences.

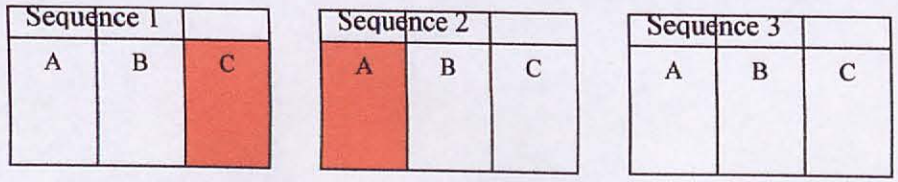
6.2.2.1 Activating events

The two types of second sequence (actual/ imagined) are immediately apparent in two types of activating events: those actual responses of the other when the client actually responded impulsively, and those responses of the other anticipated if they had *not* inhibited their impulse (table 6.2.2.1). Plainly, there was a large discrepancy in the majority of cases (89%) between what they would have liked to have done, and what they actually did.

Table 6.2.2.1 Table showing participant's desired actions at the end of the first sequence, and 2nd sequence Activating Events, including imaginary ones.

1st seq.	C: Action impulse	2nd sheet	Describe their reactions
Mick 1	Wanted to shout, use the F-word and tell them I was going to carry on doing it my way.	Imagine shouting angrily, etc.	Get even more angry: You're talking a load of rubbish/ must take notice.
Mick 2	I wanted to jump up and down, use the f- word; ' I don't have to take it'.	Imagine shouting 'I don't have to take the medication'.	More angry 'you've got to take it'. They'd say that now I was acting like a criminal.
Mick 3	Wanted to lash out with a hammer, jump up and down, struggle like crazy.		
Nigel 1	Impulse to shout 'I can't cope', "Give us a break". Looked angrily at him, stared at him.	Imagine shouting at him 'Don't be so bloody unreasonable'.	He would think I was a right waster. He would chuck me out of the house.
David 1	Refuse, tell her to piss off, tell her to bloody make it herself.	Imagining I said no- fetch the tea yourself.	She'd say "God aren't you a nasty sod?"
David 2	Say no, make her get it herself.	I wish I'd said no and didn't fetch that- make her get it herself.	She'd say "Aren't you a horrible person?"
David 3	Rack my brains, try to remember.	Realise she didn't ask for flour.	
Den1	Stay in bed and say "For God's sake I've not slept. SHOUT.	Imagine saying this	Angry "Do as you 're told, you little shit".
Sandra1	Impulse to shout very loudly, throw lamp shades round the room. Did actually scream.	Imagine doing the impulsive behaviour- shouting, throwing things etc.	Distressed, apoplectic.
Pete 1	Walk away, go to the next room.	This is how I feel if I were to answer back.	
Imran 1	If I could just lash it out "Just stop it, can't you see, it'll never happen again. I'm under a lot of pressure."	Imagining me saying 'I'm doing my best, please leave me alone'.	They would be very angry and upset. I'd be in even bigger trouble.
Imran 3	I want to tell her I can't do it.	What I imagine would happen if I expressed my anger.	
Ali 3	I let him carry on being angry. When he had gone I put a lock on my door.	I imagined myself saying 'I don't know why you are so bothered.'	Angry.
Rachel 1	I argued my case "look I didn't do anything wrong. I was just chatting/ lost track of time."	I thought 'stop treating me like a child. I do have a right to a life, etc.'	They think I 'm selfish, uncaring, untrustworthy
Elizabeth 1	I rang her up and really shouted at her , told her how I felt.	I felt like I had really achieved something, I felt a lot better. I put her in her place, told her that she's wrong and I'm right.	
Pat 1	I said 'that's what we are here to do'; pointed out they should read the scriptures too.	I did say something; I quoted scriptures at them.	They said there's no such place as hell. They threw it in my face, all that upbringing.
Matt N 1	I justified my stance, but I knew I wouldn't win.	How I felt after the interchange: Anger. I wanted a drink.	Get violent. Slag off mental health centre.
Matt N 2	Run away. Or alternatively to listen, to heed, to be quiet.	Imagining what would happen if I did run away from dad.	He'd come after me, give me a whack

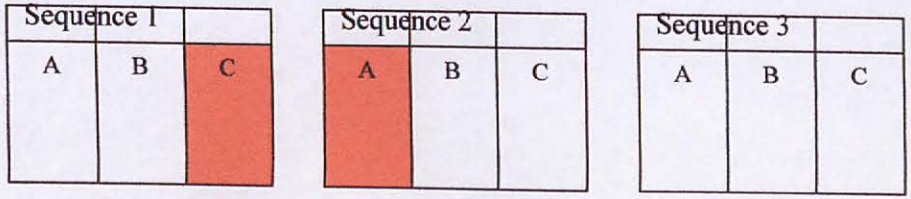
Map showing where in a typical 3 sequence conflict the columns detailed here would be



1st seq.	C: Action impulse
Mick O'C.	I actually told them about it. I spoke to them.
Martin	I wanted to do something bad that would make him sorry. so I went with a prostitute.
Cathy 3	I wanted to shout something about how I was going to do it.
Bill 1	I want to get really angry, make her take notice.
Nigel 2	Sit there and do nothing.
Den2	Impulse was to stop taking the drug, but I couldn't.
Sandra 2	Pain attack. Tense, agitated, muscle tension, facial grimacing, erratic breathing, pulse.
Cathy 1	Deck her one.
Cathy 2	To fly out of the pub immediately.
Jack 1	Ideally, I'd have danced with her, then got to know her. Not for sex, companionship.
Jack 3	I wanted to ask 'why me?'. I wanted to ask why no one had done anything to help. There were 10 of us/ 3 of them.
Bill 2	I hung up, walked away, took the dog for a walk.I wanted to say something to make him know I knew what he was up to 'Got the wrong number, have I?' -go knock on his door.
Pete 2	I wanted to shout at them.
Imran 2	I wanted to shout at them.
Rachel 2	Turn back the clock, apologise, make it up.
Louise	I actually hit him and screamed "give me the bloody key".
Pat 2	I had 3 AIDS tests, but I didn't think they were telling me the truth.
Elizabeth 2	I kept it to myself. I stopped seeing them. I didn't make any new friends except flatmate.

2nd sheet	Describe their reactions
She believed me, took it in. I think she understood what I was talking	She accepted it.
He would think I was a pervert.	Am I a pervert? I mustn't let him find out.
Imagining shouting at her.	She'd be even more angry and critical: "Don't shout at me".
Imagine shouting at her.	She'd be really angry.
Imagine saying: What the hell's the matter with you!	Reject me, tell me to get lost.
Was blushing strongly - others interpreted this as showing I was embarrassed about being a tart, diseased etc .	
Imagine; Challenge her and deck her one.	
Imagine leaving the pub.	
What actually happened was that I turned away from the girl, because I was scared and she went off.	I wouldn't know what to do/ might do the wrong thing, really hurt her or something.
What would have happened if I had said something:	
I wanted to say' I know what you're doing'. I 'd have just said 'fine'.	He'd say he'd found out that I had problems and that he thought a lot worse of me.
This is what would have happened if I had expressed my anger at them.	There would have been a LOT of very unhappy people there.
Imagine shouting at them	Its the end of everything, your whole life.
I went around with a rose.	Surprised. Back to normal.
I did actually hit him.	He went on about how I shouldn't want to top myself, about my kids, etc
Imaginary sequence- telling my friends I was special.	Some would be OK, some would be hostile.

Map showing where in a typical 3 sequence conflict the columns detailed here would be



6.2.2.2 Consequences

The 'existential imperative' having been thwarted in sequence 1, most clients had strong impulses to do something about this, but in the second sequence the majority do not in fact respond. What stops them acting are strong feelings of anxiety at C, in both parent and peer conflicts, (especially in peer conflicts). The anxieties are listed, along with the other emotional responses, in table 6.2.2.3 (on the same page as table 6.2.2.2). Most of the anxious consequences are the imagined results of purely imagined assertive action. It is interesting to point out that the only 2 'happy' emotional outcomes are from the only two real instances of acting upon the initial self-affirming urges. It is also apparent why so few clients actually act self-affirmingly- they are anxious about what might happen.

6.2.2.3 Beliefs

The form of these anxieties becomes clearer when the Beliefs behind the emotional consequences are considered (table 6.2.2.2). 70% of clients held beliefs that could be considered as catastrophic. It seems that the people who inhibited their angry impulses did so because they were scared of having their self constructed in an unpleasant way if they expressed their anger. The majority of clients not only felt that it would be unpleasant, but actually expected the results to be catastrophic. Those expected outcomes that we would rate as catastrophes are marked in bold in table 6.2.2.4; one or two of these outcomes may not immediately appear to be catastrophes but are when the client is known- for example, Sandra, feels that to be seen as a tart (in her second conflict, with her peers) is the worst thing that could happen to her. It is also interesting that 5/6 clients who showed guilt as their second sequence C showed a Self-Other belief that viewed the other positively; their guilt appears to reflect a belief of having wronged someone virtuous.

6.2.2.4 Second sequence interpretation

Taken as a whole, the second sequence shows that many clients have enormous fears of impending catastrophes which they feel may occur if they were to act on their existential *imperative* urges. Even without catastrophe, all but a few of the clients experience anxiety provoking beliefs are around themes of having their self constructed in an unpleasant way, and loss of social support. These beliefs therefore are consistent with the idea of the 'moral imperative'. It seems as if the moral *imperative* stymies the existential imperative, with the effect that the existential imperative is driven elsewhere. So what is the result of this 'double-bind'?

6.2.3 Third sequence

In what was predominantly the final sequence, clients told how they actually acted and how it left them feeling. 67% of participant's conflicts went to a third conflict; on the whole these were the people who had an imaginary 2nd sequence.

6.2.3.1 Activating events

The Activating Events of the third sequence were how the client actually responded at the time of the conflict. In most cases, what clients actually did was nothing. In table 0, 82% showed submissive or appeasing withdrawal responses, where the client apparently did what was required of them by the other, or remained motionless.

6.2.3.2 Consequences

Table 6.2.3.1 also shows how clients were left feeling at the end of the episode. It is interesting to note that the majority of the clients whose conflicts went to a third sheet felt depressed (62%). Without the benefit of knowing what emotions and beliefs had gone before in the previous sequences, these emotional responses appear as typical negative symptoms-

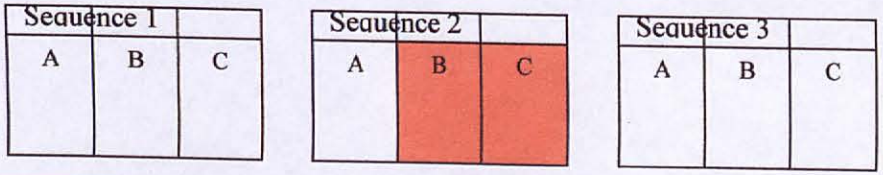
Table 6.2.2.2 Table showing beliefs bringing about Inhibition in 2nd sequence (moral imperitive)

Client	B: Other- to- Self evaluation	Type	Rate
	Parent Conflicts		
Mick 1	Implying they thought I was a fool (Couldn't see the obvious). Implying I was morally wrong- bad person.	α -	
Mick 2	Same as before, only more so, ie. I'm bad, morally in the wrong.	α -	7
Mick 3	They'd say that now I was acting like a criminal.	α -	
Nigel 1	Wouldn't think much of me if anything- good for nothing.	α -	10
David 1	She would hate me. She thinks I'm bad. She's right. I would 'feel'(experience myself) as a bad person.		
David 2	She hates me. She would be hostile and critical. She would think I'm bad.	α I	
David 3	She's setting me up, so she can have a go at me. How dare she! Treat me like a navvy AND deceive me- like a shit.		
Den1	She'd think I was a bad child. I'd feel terrible.	α -	9
Sandra1	Being burdensome for causing unnecessary pain- she's already fragile. Inconsiderate, uncaring daughter. Would be hurting a very virtuous person. Bad person.	α -	7
Pete 1	She wouldn't think I'm a fool, but I would. I'd think I was a fool. I'd be worse than I am now, mentally.	α -	8
Imran 1	I'm very ignorant. I don't know the truth.	α -	8
Imran 3	I'm good for nothing. I should be doing more. In the spotlight. I might get chucked out of the house.	α -	9
Ali 3	He'd say I was out of order. I'd done something really wrong. I needed hitting.	α -	10
Rachel 1	They think I 'm selfish, uncaring, untrustworthy, etc		
Elizabeth 1	She had to listen, she accepted it, couldn't ignore me. She accepted I was a warm and caring. person instead of just a machine who does things that she's told, does things by mother's power structure.		10
Pat 1	They acted like I was an idiot, like they weren't proud.	α -	5
Matt N 1	He'd be thinking I'm a waster, etc.	α -	9
Matt N 2	He would think I am a complete bastard. The idiot of all time. Can't hold down a job. Nothing goes in.	α -	10
Mick O'C.	They understood me, so not a prat.		

6.2.2.3 Table showing consequences (emotional) for 2nd sequen

C: Emotion:	Specific	Rate
Anxiety	shame	
Anxiety	anger	6
Anxiety	shame	
Anxiety	shame	
Anxiety	shame	
Depression	shame	
Angry		
Angry	shame	
Anxiety	guilt	
Guilty	foolish	
Guilt	suicidal	
Guilt		8.
Fear		
Guilt		
Happy		
Angry		
Depressed	victimised	
Fear	guilty	
Relief	Embrr'd	

Map showing where in a typical 3 sequence conflict the columns detailed here would be

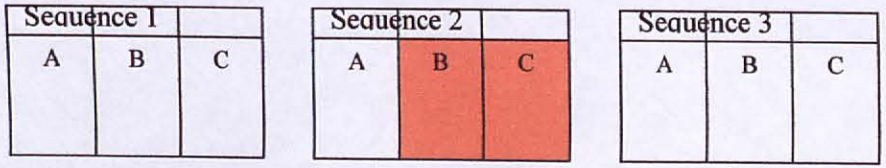


Key to symbols

α- = Negative alienation: imposed 'bad' self.
α+ = Positive alienation: imposed self that other values but I do not.
I = Insecurity threat. Being ignored.
αI = Combination threat: being deliberately ignored because I am bad.

Martin	He might think I was a pervert.	α -	10	Anxiety	Shame
Cathy	She'd think I was badly behaved and rude- worthless and useless.	α -	10	Anxiety	Shame
Bill 1	She'd say" Get a grip on yourself. You're showing yourself up, you're showing everybody up".	α -	10	Fear	Shame
	Peer Conflicts				
Nigel 2	I'm not worthy enough to know them (made worse by angry outburst).	α -	9	Anxiety	Shame
Sandra 2	They are thinking I'm a tart.	α -	10	Anxiety	
Cathy 1	Unprofessional nurse, trouble maker, moaner = bad.	α -/I	10	Guilty	Depressd
Cathy 2	They would definitely think there was something wrong with me. They'd think I was worthless, then.	α -		Anxious	Shame
Jack 1	She would have really hated me, if I had somehow messed it up.	α -	10	Anxiety	Fear
Jack 3	They were feeling guilty. They would have thought 'come on James, you're not being fair.' They'd sulk.	α -	7	Guilt	
Bill 2	He'd find out or would tell me he had found out I had problems and would tell me he thought worse of me.	α -		Anxious	
Pete 2	They'd be angry at me, they'd think I needed a break.	α -	8	Guilty	Depressd
Imran 2	They feel that they know better than me, I'm not all there, etc. I've succumbed.	α -	9	Guilty	Ashamed
Rachel 2	He thinks I'm not that bad after all.	α +	10	Happy	
Louise	He thinks I'm horrible; he's saying "you are very selfish, being a very bad person indeed.	α -	10	Shame	Depressd
Elizabeth 2	They might have been hostile if they knew I was clever.	α -	6	Depressed	upset

Map showing where in a typical 3 sequence conflict the columns detailed here would be



Key to symbols

α- = Negative alienation: imposed 'bad' self.
α+ = Positive alienation: imposed self that other values but I do not.
I = Insecurity threat. Being ignored.
αI = Combination threat: being deliberately ignored because I am bad.

Table 6.2.2.4 Table highlighting consequences that could be counted as catastrophic.

Name	Anticipated result	Other- Self Evaluation			Self-Self
	Parental conflicts				Negativity
Mick 1	They'd get even more angry "You're talking a load of rubbish. you must take notice".	Implying they thought I was a fool (Couldn't see the obvious).	α -		6
Mick 2	They'd get more angry 'you've got to take it'.	Implying I was morally wrong- bad person.	α -	7	6
Mick 3	They'd feel right in taking me away.	Same as before, only more so, ie. I'm bad, morally in the wrong.	α -		
Nigel 1	**He would chuck me out of the house.**	**Wouldn't think much of me if anything- good for nothing.**	α -	10	10
David 1	**She'd say "God aren't you a nasty sod?"**	**She would hate me. She thinks I'm bad. She's right.I would 'feel' (experience myself) as a bad person.**			9
David 2	**She'd say "aren't you a horrible person?"**	**She hates me. She would be hostile and critical. She thinks I'm bad.**	α I		10
David 3		Treat me like a navvy and deceive me- like a shit.			
Den1	She'd be angry: "Do as you are told, you little shit".	I'm a bad child. I'd feel terrible.	α -	9	8
Sandra1	**She'd be distressed, apoplectic.**	**Burdensome, causing unnecessary pain; she's already fragile. Inconsiderate, uncaring daughter. Would be hurting a very virtuous person. Bad person**	α -	7	9
Pete 1		She wouldn't think I'm a fool, but I would. I'd think I was a fool, I'd be worse than I am now, mentally.	α -	8	9
Imran 1	**They would be very angry and upset.**	**I'm very ignorant. I don't know the truth. I'd feel I was bad for leaving the house to rot.**	α -	8	8
Imran 3		**I'm good for nothing. I should be doing more. In the spotlight. I might get chucked out of the house.**	α -	9	9
Ali 3	**He'd be very angry.**	**He'd say I was out of order. I'd done something very wrong. I needed hitting.**	α -	10	8
Rachel 1		They think I 'm selfish, uncaring, untrustworthy, etc.	α -		7
Elizabeth 1		She had to listen, she accepted it, couldn't ignore me. She accepted I was a warm and caring person instead of just a machine who does things that she's told.		10	
Pat 1	They said tehre was no such place as hell.	They acted like I was an idiot, like they weren't proud	α -	5	10
Matt N 1	He'd get violent, and slag off all the staff at the mental health center.	He'd be thinking I'm a waster, etc. I would think I was absolutely crap and useless.	α -	10	8
Matt N 2	**He'd come after me, give me a whack.**	**He would think I am a complete bastard. The idiot of all time. Can't hold down a job. Nothing goes in- you can't discipline me.**	α -	9	9

Map showing where in a typical 3 sequence conflict the columns detailed here would be

Sequence 1		
A	B	C

Sequence 2		
A	B	C

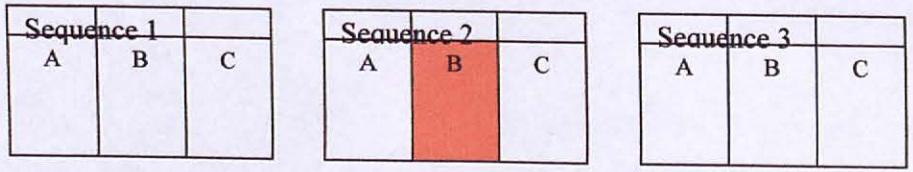
Sequence 3		
A	B	C

Key to symbols

α- = Negative alienation: imposed 'bad' self.
α+ = Positive alienation: imposed self that other values but I do not.
I = Insecurity threat. Being ignored.
αI = Combination threat: being deliberately ignored because I am bad.

Mick O'C.		They understood me, so not a prat			
Martin	**He'd think I was a pervert**	**The Police and Media are out to expose me, to put me away.**	α -	9	9
Cathy 3	She'd be really angry-"don't shout at me".	She'd think I was really badly behaved and rude- worthless, useless.	α -	10	9
Bill 1	She'd be angry	She'd say" Get a grip on yourself. You're showing yourself up, you're showing everybody up".	α -	10	9
	Peer conflicts				
Nigel 2	**They would reject me, tell me to get lost.**	**I'm not worthy enough to know them (made worse by angry outburst).**	α -	9	8
Den2					
Sandra 2		**They are thinking I'm a tart.**	α -/I	10	10
Cathy 1		Unprofessional nurse, trouble maker, moaner = bad.			10
Cathy 2		**They would definitely think there was something wrong with me, think was worthless.**	α -		10
Jack 1		**She would have really hated me, if I had somehow messed it up.**	α -	10	10
Jack 3		They were feeling guilty. They would have thought 'come on James, you're not being fair.' They would have sulked.	α -	7	8
Bill 2		**He'd find out or would tell me he had found out I had problems and would tell me he thought a lot worse of me.**	α -		8
Pete 2		They'd be angry at me, they'd think I needed a break.	α -	8	8
Imran 2		They feel that they know better than me, I'm not all there, etc. I've succumbed.	α -	9	10
Rachel 2	He would be surprised. Back to normal.	He thinks I'm not that bad after all.	α +	10	
Louise	He thinks I'm horrible.	He's saying "you are being very selfish, being a very bad person indeed."	α -	10	10
Elizabeth 2	Some would be OK, most would be hostile.	They might have been hostile if they knew I was clever.	α -	6	

Map showing where in a typical 3 sequence conflict the columns detailed here would be



Key to symbols

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anhedonia, depression, withdrawal, apathy. This is the prevailing picture for most of the time (i.e. the first two sequences are over very quickly, the third sequence extends in time to hours possibly days and is typically the 'presenting' picture). In these situations, the final feelings make more sense when the beliefs which are driving them are known.

6.2.3.3 Beliefs

Again to understand the link between A and C it is necessary to look at B, and B here for 65% of clients is typically of being useless and impotent. In other words they interpret their own submission as helplessness and are forced to finally endorse the negative self construction. The remaining 35% were left with the more extreme belief that they were bad people as a result of the submission and withdrawal.

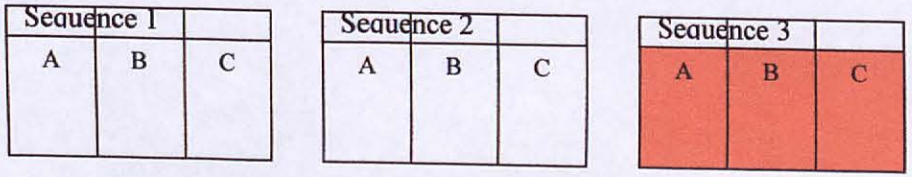
6.2.3.4 Third sequence interpretation

In most situations the client did not construct their desired self because of the fear of being reconstructed in extremely negative terms and ended up submitting to the lesser of two evils - submitting to the alien definition of self which they so angrily wanted to resist. Having being thwarted in their self-construction needs, and unable to do anything about this, they were left feeling depressed and, in their eyes, valueless selves. In effect, not being able to throw off the imposed self created for them, they are left 'wearing' it.

Table 6.2.3.1 Table listing complete 3rd (final) sequences: submission and entrapment.

	Client's Actual Action: Parental conflicts	Beliefs: Other to Self			C: emotion	
Mick 1	Sit quietly, say nothing.	They should have apologised. Felt insulted. I was being treated like a disobedient child.	α +	6	Down	7
Mick 2						
Mick 3	I just sat there and did nothing.	I've given in and feel trapped.			Despair	9
Nigel 2	Stayed quiet, said nothing.	You're being a good man, son. But I was reacting to the knowledge that he's bound to find out sooner or later and he'll revert to thinking I was a waster.	α +		Depression	10
David 1	I say "Sure, that's fine". I go fetch tea as asked.	She's pleased with me but it sticks in my throat. Treating me like a slave, worth nothing. and by doing what she wants, I'm being like one.	α +		Depressive	10
David 2						
David 3	I said "you didn't ask me" (to get any flour).	I feel like a failure. She thinks I am incompetent.			Depressive	
Den 1	I get up quickly	Treating me like a little schoolboy- doing what he's told- aargh!.	α +	9	Depressed	9
Sandra1	Held my breath, shut up, etc. Cope by keeping a distance so I can breathe.	She didn't want to admit the gossip was going on. Keeping a distance. Stuck with her dismissing and not valuing me.	I	8.5	Depression	9
Pete 1		If I don't say anything I feel a bit empty, quiet. She's treated me like a kid; I've had to act like a kid. Also satisfied - I've been honest with her.	α +	5	Depressed	8
Imran 1	As long as I don't continue, (ie cause a fuss) they'll leave me alone.	I feel like I've been very harshly treated, like being ignored and told I was bad.	I	10	Depression	10
Imran 3	I did what my mother expected, despite feeling ill. 'I thanked Allah'.	She thinks I'm OK because I did what she expected of me.	α -		Happy	
Ali 3						
Rachel 1	I thought 'leave me alone', went to bed, ending the interaction.	I'm inconsiderate, uncaring.	α I		Angry	6
Elizabeth 1	I didn't bother with them anymore.					
Pat 1	They didn't listen, so I had to go home.	I felt wronged.			Loneliness	10
Matt N 1			α I	6		
Matt N 2	I can't fight back, so he thinks he's won the argum't.	He still thinks I'm a scumbag. I'm still crap, I hasn't improved.	α -	10	Depressed	10
Mick O 1	They thought I'd gone barmy- phoning up strangers, ripping up clothes.	They put me into hospital because of this- they thought I'd gone barmy.	α -		Depression	10
			α -	10	Depressed	10

Map showing where in a typical 3 sequence conflict the columns detailed here would be



Key to symbols

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α+ = Positive alienation: imposed self that other values but I do not.
I = Insecurity threat. Being ignored.
αI = Combination threat: being deliberately ignored because I am bad.

Martin	Say nothing; he mustn't find out	I've covered my tracks but now he thinks I'm a waste of space again.	α I	9	Anger	9
Cathy 3	I said "I was going to do it", and did it.	She still thinks I'm useless because I didn't do it originally. I'm not totally useless.	α -	9	Depressed	8
Bill 1	I can't do anything but be ignored.	She's not interested. I'm just one bloke, with a problem, all on his own.	I	10	Alone	8
	Peer Conflicts					
Nigel 2	Still sitting there- same as before.	If he was angry about that comment I once made, it would mean I've lost a friendship. "You're too pathetic (AI) or a rotter (A-) to be my friend	α -	8	Anxiety	10
Den2						
Sandra 2						
Cathy 1	Simply getting on with my work.	She's treating me like a nobody and I'm agreeing with it			Depressive	10
Cathy 2	Staying in pub, talking.	they weren't thinking I was ill, but that I was a nurse			Anxiety	8
Jack 1	I turned away from the girl, and she went away. My mates really thought less of me.	She's disappointed in me; she thinks I'm an idiot. My mates think I'm a toss-pot.	α -	10	Ashamed	9
Jack 3		My friends felt sorry for me, which I don't like.	α -	8	Shamed	7
Bill 2	I just hung up. He doesn't want to know me now	He doesn't want to know me now. 'Its your fault- you deal with it.'	I	8	Angry	8
Pete 2	Not doing anything because of guilt.	They think pretty highly of me. They don't know I was angry, they thought I was OK	α +	8	Depression	8
Imran 2	I keep my head down, say nothing.	Its like they are saying "we are right and you are wrong". They're keeping me at bay. I've to be contained. My anger- that's to be avoided. At least I didn't get hit.	α -	10	Depression	10
Rachel 2		just quiet, which I am but it was like playing a role they value.				
Louise	I hugged him and told him I was sorry- so he won't condemn me as bad. Still want to get tablets.	He said "it's OK". Still treating me as a child, and I feel trapped. I'm helpless and powerless. Because he says it its got to be right/ I'm wrong.	α +	10	Depressed	10

Map showing where in a typical 3 sequence conflict the columns detailed here would be

Sequence 1		
A	B	C

Sequence 2		
A	B	C

Sequence 3		
A	B	C

Key to symbols

α- = Negative alienation: imposed 'bad' self.
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6.2.3.5 Whole conflict interpretation: summary of main themes

The activating events cover a variety of situations, but with the REBT paradigm, it is possible to make useful comparisons between conflicts in terms of the underlying beliefs and emotions. Conflicts can usefully be described in terms of self-constructions, failures and defences. As the initial conflict was to do with either ignoring the client's self- presentation, or steam-rollering it into an alien and unpalatable form, then the end product of the first sequence was the resultant angry and self-assertive urge, the "existential *imperative*".

However very few clients actually acted on this impulse, and therefore could not construct a desired or even more bearable self thereby. For the vast majority of clients there was an overwhelming fear of the consequences of self-affirming action; the consequences were all along the lines of being reconstructed as a terrible person and thereby losing one's social support, often to a catastrophic extent. The catastrophes were far more extreme than anything found in the brief student comparison study (Huber, 1997).

In the final sequence, therefore, the client was prevented from taking overt defensive action, and hence the majority were on the whole blocked from self construction, trapped in an alien construction and consequently depressed. They also showed - as the pathway to this fate - submissive and avoidant behaviours, of a sort which have been thought to be partially characteristic of post- acute schizophrenia. A conventional psychiatric view of this data would be that the clients are showing that particular manifestation of the underlying illness that commonly emerges after recovery from an acute episode and which is marked by negative symptoms and depression. However putting two of the findings together- that conflicts are initiated by abrasive communications and end with depression/ dysphoria- an alternative and

more psychological picture appears, namely that patients get depressed *because* of the style of communications and the calamitous self-constructions, and not because of any underlying illness.)

6.2.3.6 Function of the conflict as a whole

As a whole the conflicts generally represent a type of entrapment in which clients cannot self construct, either because they feel coerced into either abandoning the struggle for self construction or accepting an alien self imposed upon them or both. Most of these conflicts are either frequently occurring or infrequent 'defining moment' occurrences which set the precedent and pattern for future interactions. As such, a sense arises of how such conflicts perpetuated on a larger time scale could certainly contribute to the emergence of 'negative symptoms'- apathy, withdrawal, and anhedonia were all amongst the majority of end-products.

What is more surprising is the thwarting of the self-constructions themselves, and the alien selves sometimes taken on by clients (under perceived duress) also contribute to symptoms, but this time to the creation of the 'positive symptoms'. Section 6.5 looks for themes within the individual clients and reports in a more qualitative manner, using specific single cases to speculate about the formation of positive symptoms. Initially the issue of repression of anger and self-construction needs is considered, which looks more closely at those clients who are similar on these scores. Other clients do not have problems expressing anger, in fact they almost have a problem with being too angry; in these cases, the moral *imperative* seems to be the one awry. Finally some clients never get angry at all; these clients are then considered. Similarly, some of the conflicts were around specific themes and also contribute useful insights into those areas. A number of such themes are considered including symptom issues- relating to voices and

delusional characters, experiences of reference, and romantic issues, as another important area that is often overlooked. Before this, the data from the questionnaires are considered in the next section, to see what evidence they provide to show that the trends and instances reported here are in fact typical patterns and fit into the wider ongoing context of the relationships the client has with parents and peers.

6.3 Results part II

Quantitative data.

All 21 clients filled in most scales. A number of data-points were missing, for instance some clients did not have both parents, and therefore the PBI and Impact Inventory could only be used to assess the remaining parent. Other clients did not want their families interviewed, and so the LEE was used to judge EE instead of the CFI. It is probably this that causes the CFI and the LEE to be so poorly correlated, as can be seen in Table 6.3 which shows the intercorrelations between the various scales used. In all, 29 sub-scale categories were used, and each sub-scale was therefore compared to 28 other subscales. This means that a large number of comparisons were made, and that (statistically speaking), one in twenty of them could be expected to be significant by chance alone. Using a bonferroni correction on such a large number of comparisons is not practicable, as only five of the observed significant results can be said to be there with confidence. Hence the results should be treated as purely preliminary, pilot data, indicative of potential trends that may be explored in future research.

The CFI scale of Emotional Over-Involvement (EOI) correlated significantly with the LEE scale of Control, as would be expected because a high level of control is a major determinant of high EOI. Two measures were used to explore the relationship between self construction threat vulnerability and voices. The Beliefs about Voices questionnaire gives scores for whether the individual regards their voice(s) as malevolent or benevolent, and whether or not they resist any instructions their voice might give (obviously not all individuals heard voices). The Self and Other questionnaire measures whether a person is particularly vulnerable to either alienation or insecurity self construction threats. The prediction was that people who were particularly vulnerable to alienation threats were significantly more likely to rate their voice as

strongly malevolent, because they are used to seeing interactions as intrusive and undesired; this was indeed found to be the case.

Three of the questionnaires were relationship measures- the Parental Bonding Instrument, the Impact Inventory and the Level of Expressed Emotion scale. As predicted, people who were vulnerable to alienation threats were significantly likely to see their parents as controlling and irritable (on the LEE), although they were also significantly likely to see their mothers as submissive (according to the Impact inventory), which was not expected. People who were vulnerable to insecurity threats were significantly likely to not see their fathers as friendly (on the Impact inventory) and to see both parents as over-protective (on the PBI). They also significantly did not see their parents as being emotionally unsupportive (on the LEE).

To measure how unwell the client was currently, two symptom measures were used: the Manchester scale which is completed by the interviewer, and the SCL-52 which is completed by the client. It is interesting to note from table 6.3 that the two scales were not significantly correlated. Interviewers had doubts that the SCL-52 was particularly effective for measuring symptoms, because some clients who were plainly quite unwell gave themselves very low scores on this measure.

The PBI as mentioned above refers to how the client saw their parents throughout the first 16 years of their life. The "Care" and "Over-protection" subscales of the PBI were significantly inversely correlated, which was expected - those parents who were seen as caring were not seen as over-protective and *vice versa*. In this study the PBI Over-protection scales were significantly inversely correlated with the Manchester scale symptoms rating. Non-voice hearers tended to be less unwell on the Manchester scale, unsurprisingly since there are only a few items on the Manchester scale and hearing of voices is one of them.

	CFI	Critical	Hostility	EOI	Positive	Warmth	Voices Malevolence	Benevolence	Resistance	No voice	Self+Other Alienation	Insecurity
CFI	1											
Critical	**0.65**	1.00										
Hostility	0.44	**0.80**	1.00									
EOI	0.46	0.20	0.03	1.00								
Positive	-0.46	-0.40	-0.28	0.00	1.00							
Warmth	**-0.64**	**-0.50**	-0.35	-0.07	**0.70**	1.00						
Voices: Malevolence	-0.58	0.13	0.34	0.12	0.04	0.08	1.00					
Benevolence	0.27	-0.16	-0.04	0.40	0.69	0.62	-0.46	1.00				
Resistance	-0.37	0.22	0.11	-0.29	-0.64	-0.48	**0.62**	**-0.92**	1.00			
No voice	-0.41	-0.02	0.25	-0.18	0.11	0.09	-	-	-	1.00		
S&O: Alienation	-0.08	-0.10	-0.06	0.25	0.25	0.04	**0.73**	-0.45	0.59	0.04	1.00	
Insecurity	0.42	0.24	0.18	0.25	-0.15	-0.22	0.34	0.11	0.09	-0.11	**0.48**	1.00
Alienation- insecurity	-0.37	-0.29	-0.20	0.11	0.41	0.21	0.38	-0.48	0.46	0.12	**0.78**	-0.18
Manchester scale	0.12	-0.30	-0.39	0.25	-0.04	-0.07	0.14	-0.27	0.37	**-0.48**	-0.02	-0.04
SCL-52	0.18	-0.10	-0.08	0.40	0.42	0.02	-0.37	0.22	-0.22	0.07	0.37	0.38
PBI: Mum Care	-0.16	0.10	-0.03	0.22	0.04	0.48	0.07	-0.40	0.43	-0.09	0.06	-0.23
Dad Care	-0.21	0.01	-0.20	-0.04	-0.31	0.32	-0.25	-0.31	0.40	0.11	-0.25	-0.39
Mum Overprotection	0.27	0.40	0.46	0.05	0.01	-0.42	0.01	0.49	-0.41	0.32	0.31	**0.45**
Dad Overprotection	0.37	0.38	0.27	0.10	0.10	-0.25	0.27	0.13	-0.08	0.00	0.37	**0.57**
Impact: Dad Dominar	0.08	0.58	**0.70**	0.33	0.25	0.34	0.16	0.45	-0.28	0.41	0.14	0.27
Hostile	0.54	0.37	0.23	0.25	0.28	0.02	-0.17	0.54	-0.56	-0.20	-0.08	0.54
Submissive	-0.16	-0.16	-0.24	0.51	0.37	0.13	0.36	0.42	-0.33	0.28	0.39	0.00
Friendly	-0.09	0.11	0.40	0.11	0.05	0.24	-0.18	0.21	-0.22	0.17	-0.47	**-0.69**
Impact: Mum Domina	0.08	0.28	0.29	**0.64**	0.28	0.08	0.26	0.45	-0.32	0.44	0.49	0.41
Hostile	-0.07	-0.55	-0.32	0.16	**0.60**	0.49	-0.00	**0.78**	-0.67	-0.18	-0.12	0.35
Submissive	0.19	0.25	0.11	**0.62**	0.07	-0.23	0.03	0.08	-0.07	0.51	**0.66**	0.33
Friendly	0.20	0.48	0.45	0.54	-0.48	-0.35	0.22	-0.41	0.30	0.19	0.11	-0.14
LEE: Lack of support	-0.22	-0.16	0.14	-0.02	0.32	0.47	0.12	0.22	-0.23	-0.01	-0.20	**-0.71**
Control	0.35	0.36	0.12	**0.65**	-0.07	-0.27	0.36	-0.38	0.32	0.14	**0.67**	0.32
Irritability	0.08	-0.04	-0.34	0.37	0.36	0.02	-0.26	-0.16	0.15	0.10	**0.77**	0.45
EE LEE	0.17	0.16	0.35	0.32	0.53	0.36	-0.07	0.40	-0.47	-0.24	-0.13	-0.41

Table 6.9 Table giving matrix of inter-correlations for the 8 questionnaire measures (n=21)

All figures show correlation values (r).

Figures in bold indicate correlations significant at p=0.05 level (before bonferroni corections are applied).

Figures in bold and large font indicate significant at p=0.01 level, also before bonferroni corrections.

	Alien-inse	Manchester SCL-52		PBI Mum Care	Dad Care	Mum Overprote	Dad Overprote	Impact:Dad Dominant	Hostile	Submissive	Friendly	Impact: Dominant
CFI												
Critical												
Hostility												
EOI												
Positive												
Warmth												
Voices: Malevolence												
Benevolence												
Resistance												
No voice												
S&O: Alienation												
Insecurity												
Alienation- insecurity	1.00											
Manchester scale	0.01	1.00										
SCL-52	0.15	0.26	1.00									
PBI: Mum Care	0.23	0.20	0.04	1.00								
Dad Care	-0.01	0.19	-0.23	**0.63**	1.00							
Mum Overprotection	0.03	**-0.59**	0.26	-0.50	**-0.64**	1.00						
Dad Overprotection	0.02	**-0.56**	-0.01	-0.37	**-0.60**	**0.72**	1.00					
Impact: Dad Dominar	-0.01	-0.40	0.32	0.43	0.05	0.39	0.09	1.00				
Hostile	-0.45	-0.21	0.32	-0.08	-0.62	0.53	0.55	0.42	1.00			
Submissive	0.46	-0.26	0.00	-0.30	-0.34	0.54	0.39	0.01	-0.11	1.00		
Friendly	-0.10	0.20	-0.15	0.15	0.46	-0.47	**-0.72**	0.20	-0.46	0.12	1.00	
Impact: Mum Domina	0.29	-0.45	0.31	-0.20	-0.29	**0.68**	**0.61**	**0.81**	0.18	0.68	0.03	1.00
Hostile	-0.33	0.20	0.34	-0.16	**-0.62**	0.17	0.00	0.48	**0.77**	-0.08	-0.05	0.15
Submissive	0.52	-0.05	0.50	-0.04	-0.10	0.61	0.35	0.49	0.11	0.64	-0.22	0.65
Friendly	0.20	-0.14	-0.16	0.32	0.20	0.10	0.14	0.05	-0.38	0.51	0.20	0.32
LEE: Lack of support	0.22	0.17	-0.39	0.08	0.21	-0.49	-0.34	-0.05	-0.56	0.29	**0.90**	-0.13
Control	0.49	-0.37	0.23	0.23	-0.12	0.52	**0.57**	0.34	0.19	0.48	-0.35	**0.71**
Irritability	0.52	-0.27	**0.57**	0.08	-0.20	0.50	0.51	0.20	0.27	0.35	-0.53	**0.67**
EE LEE	0.11	0.03	-0.06	-0.05	-0.25	-0.12	0.02	0.36	0.02	0.23	0.74	0.29

Table 6.9 Table giving matrix of inter-correlations for the 8 questionnaire measures (n=21)

All figures show correlation values (r).

Figures in bold indicate correlations significant at p=0.05 level (before bonferroni corections are applied).

Figures in bold and large font indicate significant at p=0.01 level, also before bonferroni corrections.

	Mum Hostile	Submissive	Friendly	LEE lack support	control	irritability	EE LEE
CFI							
Critical							
Hostility							
EOI							
Positive							
Warmth							
Voices: Malevolence							
Benevolence							
Resistance							
No voice							
S&O: Alienation							
Insecurity							
Alienation- insecurity							
Manchester scale							
SCL-52							
PBI: Mum Care							
Dad Care							
Mum Overprotection							
Dad Overprotection							
Impact: Dad Dominar							
Hostile							
Submissive							
Friendly							
Impact: Mum Domina							
Hostile	1.00						
Submissive	-0.21	1.00					
Friendly	-0.48	0.47	1.00				
LEE: Lack of support	-0.11	-0.27	0.11	1.00			
Control	-0.37	**0.89**	**0.72**	-0.28	1.00		
Irritability	-0.15	**0.83**	0.18	-0.47	**0.74**	1.00	
EE LEE	0.31	-0.14	-0.04	0.72	-0.02	-0.16	1.00

Table 6.9 Table giving matrix of inter-correlations for the 8 questionnaire measures (n=21)

All figures show correlation values (r).

Figures in bold indicate correlations significant at p=0.05 level (before bonferroni corections are applied).

Figures in bold and large font indicate significant at p=0.01 level, also before bonferroni corrections.

Perceptions of past parenting were consistent with how the client perceived their parent currently, as demonstrated by scores on the Impact inventory: Over-protection (PBI) significantly correlated with Maternal Dominance (Impact), and significantly but negatively correlated inversely with Paternal Friendliness (Impact). There was a level of consistency between how clients viewed both mother and father as there were signs that they tended to view them similarly- mother and father measures of Care on the PBI correlated significantly, as did mother and father Dominance and Hostility measures on the Impact inventory. The few people who heard benevolent voices also significantly endorsed maternal hostility (Impact). Paternal care was linked negatively with Over-protection (PBI) and maternal hostility (Impact).

To tie the measures of the current relationship in with the EE paradigm, the LEE was used, as a self-report questionnaire version of the CFI. There was some correlation between the LEE and the impact inventory, as two measures of the current relationship. Both Dominant and Submissive mothers were significantly seen as controlling and irritable on the LEE. (Within the LEE, Control and Irritability were significantly correlated, suggesting a degree of overlap between these sub- scales.) Surprisingly, friendly fathers were seen as significantly unsupportive and not very good at helping with matters to do with being ill.

6.3.1 Discussion

The sample size is small, and the validity of the results is brought into question because there are a large number of comparisons, therefore it is unwise to read too much into these results. There is however, preliminary support for the main themes of the study in these data. In this study the PBI Over-protection scales were significantly inversely correlated with the Manchester scale symptoms rating, suggesting perhaps that clients valued parental involvement

when they were ill but found it annoying when they were more well. That client's perceptions of the parenting they received vary with how ill they are currently suggests that great caution is needed in interpreting PBI scores in studies using a psychotic group.

As predicted, people who were prone to alienation-type threats were likely to see their parents as controlling and irritable. Similarly, they were likely to see their voices as malevolent; this is interesting because it agrees with other current studies which have suggested that the way people relate to their family is very similar to and indicative of the way they relate to their voices. Birchwood, Meaden, Gilbert and Trower (1998) have shown that people who saw themselves as low rank in their interactions with their families also saw themselves as low rank in relation to their voices. Hence here it sounds like people who feel intruded upon and alienated by their family members also feel intruded upon and alienated by their voices. People who endorsed worries such as "If I'm getting too much attention it can feel like I'm being taken over" were also likely to say "My voice is persecuting me for no good reason" or that "my voice frightens me".

People who saw their mothers as submissive tended to be highly vulnerable to alienation threats; possibly they were similarly submissive themselves? Submissive mothers were also linked to high EOI scores, as was dominance in mothers and control in both parents. Only two clients had particularly over-involved mothers (rated as 4 or over on the CFI), and both these clients rated their mothers as both dominant and submissive. This surprising result seems to illustrate some of the confusion within psychosis-sufferers as to how to relate to EOI parents who have both submissive and domineering traits, and perhaps indicates why high EOI is so deleterious for clients. The two cases here are described in more detail as part of the next section, under the names of Den and Imran.

As predicted, individuals who scored highly on vulnerability to insecurity threats (S&O) were likely to see their fathers as unfriendly (Impact). Against prediction, they were also likely to

see both parents as over-protective (PBI); closer examination of the data revealed that for a large sub-group this was because they tended to have argued with their parents and moved out, and now lived in semi-isolation on their own. In a few cases, isolation-prone clients lived at home and were very dependent on their parents, needing instruction to do virtually anything, as if their parents were the originators of their selves. Furthermore, they seemed to massively resent their parents role somehow, presumably because of the absence of their own self-construction needs being met (hence both the isolation and over-protection scores); this resentment is studied in greater detail in the next section. Clients who showed low scores on insecurity vulnerability indicated their parents were unlikely to take their illness seriously and were fairly demanding (LEE; lack of support). It seems that fairly intrusive demands on the clients to perform acts they may not want to do may actually insulate the clients against loneliness and isolation.

Results Part III

6.4 Qualitative Account of Themes for Individual Clients

The results reported previously using the data from the ABC interview compared the underlying fundamental beliefs held by clients across a number of situations (section 6.3). In this section, clients are grouped by themes, each illustrated with prototypical case studies, including biographical information and symptom profiles. In looking for themes in the way clients functioned in terms of the self construction process, two broad groups appeared. In the first, majority grouping, despite wide variation between individuals, there was a broad theme of inhibition of self construction. In the second grouping there was an opposite theme of uninhibited self construction.

6.4.1 Inhibited Self: Anger Held In

As we saw in section 6.3, the largest group of clients (12/ 21) felt they could never get angry because they were too scared of the consequences. Since anger appears to be driven by thwarting of the existential imperative, it is proposed that this group are characterised by inhibition of self construction, because of fear of consequences. Some of these clients would rarely express anger, and when they did it was in tended to be in an extreme form, almost a rampage. The illustrative case studies that follow are described using a particular structure: how the client presented at first interview, then the content of their conflict with their parents. Some information about the parents from the CFI completes the dyadic picture, and finally the client's symptoms are described. This is followed by an interpretative summary of all the inhibited self cases (table 0)

6.4.1.1 David

6.4.1.2 Presentation

David presented as an affable white twenty-four year old dressed as a skinhead. He had been unwell for 6 years and was diagnosed as suffering from paranoid schizophrenia (ICD-10; section F20.0). He left school aged 16 and attended a local agricultural college for a year; he later worked in an abattoir for a year. He was first admitted to hospital aged 21, has had 4 re-admissions since then and has been unemployed since his first episode. He was the youngest child of three and lives with his Mum and Dad.

6.4.1.3 Family Background

From the Camberwell Family Interview, David's mother was rated as High EE. She was really very critical of him ("he really is bone-idle", "he is the most selfish person"), scoring 16 for Critical Comments and 1 for Hostility (generalisation of criticism from one-off instances to long-standing character traits). Both of these scores qualify for a rating of high EE. She scored 2 for Emotional Over-Involvement (this would be low EE, as the cut-off point for high EE is 3 on this scale; however, she was already rated as high EE on the basis of her critical comments and hostility scores); although she prompted him to do things a lot, and felt sure he couldn't exist without her, she fully accepted his right to his own life and to do independent things such as leave home (eventually). She rated as 3 for warmth, and 3 for positive comments, which are not used in the rating of EE.

6.4.1.4 Conflict

In conflict 1, David was asked by his Mum to make a cup of tea (Activating event or point A), and that the request was made in such a way that he took angry exception to this (Consequence or point C). David was angry because although his mum liked him in this role as dutiful son, he felt he was being treated like a slave (Belief or point B, coded α+), a self construction which he far from endorsed. Therefore his action impulse was to refuse to do such a thing and 'tell her to piss off' (point C). However, when he imagined the consequences of this in a second sequence, he experienced anxiety (point C), because he predicted that if he told her to 'piss off', she would define him as a bad person (point B, coded α-). If this imaginary outcome actually happened, he would have largely endorsed this definition (actual = 4/10; potential= 9/10), and he would have experienced shame (9). Hence in reality, in order to avoid this traumatic reincarnation, in the third and final sequence he said nothing and did as he was told (point A). Consequently, David felt depressed (point C) because he was trapped in a construction of himself which was demeaning and which by now he fully endorsed (10/10): 'She's pleased but it sticks in my throat' (point B, coded α+).

Conflict 1

Name: David Sequence No.: 1 Interviewer: PT

Activating event	Beliefs	Consequences
Describe: ***Mum said: "Go and make me a cup of tea".***	***Primary*** ***O-S: There she goes again. Using me - treating me like a slave, worth nothing. How dare she, the bitch.*** Categorise: *α* *α+* ***α-*** *αI* *I* *Other:* *Confidence:* ***9*** S-S Actual Endorsement: ***4*** S-S Potential Endorsement: ***9*** Negativity: ***9*** S-O: ***She's selfish*** ***Categorise:*** *α* *α+* ***α-*** *αI* *I* ***Other:*** ***Conviction:*** ***10*** ***Secondary*** ***Preferred Goal:*** ***No way I am going to be her slave*** ***Action choice:*** ***Refuse - tell her to piss off*** ***Want/ Ought*** ***Intensity (Preferred Goal):*** ***10*** ***Intensity (discomfort):*** ***10***	***Emotion*** ***General:*** ***Angry*** ***Specific:*** ***Insulted/hurt*** ***Intensity:*** ***9*** ***Action Impulse*** ***Describe:*** ***Refuse, tell her to piss off, tell her to bloody make it herself*** ***AcAc / InAc***

Conflict 1

Name: David Sequence No.: 2 Interviewer: PT

Activating event	Beliefs	Consequences
Describe: ***Imagining I said "no- fetch it yourself", and didn't get the tea.*** Category: Refusal Describe other's reaction: ***She'd say "God aren't you a nasty sod!"***	**Primary** O-S: ***She would hate me. She would be hostile and critical. She thinks I'm bad. She's right; I would 'feel' (experience myself) as a bad person.*** Categorise: α α+ α- αI I Other: *Confidence:* ***9*** *S-S Actual Endorsement:* ***7*** *S-S Potential Endorsement:* ***9*** *Negativity:* ***9*** *S-O:* *Categorise:* α α+ α- αI I Other: *Conviction:* *Negativity:* ***Secondary*** *Goal:* ***Not to do anything that would make her think I'm bad.*** *Want/* ***Ought*** *Intensity (Preferred Goal):* ***10*** *Intensity (discomfort):* ***10***	***Emotion*** *General:* ***Anxiety*** *Specific:* ***Shame apprehension*** *Intensity:* ***9*** ***Action Impulse*** *Describe:* ***Do as I am told- make the tea.*** ***AcAc*** */InAc*

Conflict 1

Name: David Sequence No. 3 Interviewer: PT

Activating event	**Beliefs**	**Consequences**
Describe last AcAc C: in brief: ***I say "Sure, that's fine." I go fetch a cup of tea like she wants.***	**Primary** O-S: ***She's pleased with me but it sticks in my throat. She's treating me like a slave, like I'm worth nothing. And by doing what she wants I'm being like one.***	**Emotion** General: ***Depression*** Specific: Intensity: ***10***
	Categorise: α ***α+*** α- α*I* *I* Other:	**Action Tendency** Describe: ***Give in and just do what I'm told***
	Confidence:	
Describe other's *re*action: ***Pleased with me***	S-S Actual : ***10*** S-S Potential: ***10*** Negativity: ***10***	
	S-O:	
	Categorise: α α+ α- α*I* *I* Other:	
	Conviction: Negativity:	***AcAc*** / InAc
	Secondary *Failed* Want Goal: ***Not being her slave***	
	Intensity (Want Goal): Intensity (discomfort): ***10***	

6.4.1.5 Symptoms

David's symptoms on acute admission included command hallucinations, episodic severe depression and suicidal urges, and ideas of reference. His voices were mainly expressing anger at his Mum, and others, sometimes commanding him to kill others, but also to kill himself, because 'everyone is against me'. There were periods of aggression, during one of which he was retained at a secure unit. At that time he kept a collection of knives, and there were also an incident when he trashed the late-night garage where his parents had got him a job. At other times he felt ashamed for this behaviour and became very low. At these times David was severely depressed, and was hospitalised after a number of suicide attempts. David's history then showed an oscillation between anger and aggression on the one hand, and low self esteem and depression on the other. The *interpretation* is that the command hallucinations function as a kind of 'solution' in allowing him to express the existential imperative (to be the person he wanted to be, i.e. macho) that was being thwarted by the moral imperative in his interactions with his mother, and which he was too anxious to express directly. In other words, the voice enabled him to be macho without the normal consequences. The conflict analysis described above and summarised in Table 6.4.1 helps to uncover the entrapment that David experiences and the role that the command hallucinations may play in 'resolving' the conflict.

6.4.1.6 Den

6.4.1.7 Presentation

Dennis was 19, and had been diagnosed as having paranoid schizophrenia with his first hospitalisation occurring only a few months ago. He became overtly unwell as he left school and

started working in a butcher's shop. He had also experimented with drugs such LSD and Ecstasy, but reported he was 'losing it' before that. At interview, Den presented as being very meek, shy and 'small', despite being a heavily built person; if anything his behaviour was reminiscent of a small child. He lived with his Mum and younger brother.

6.4.1.8 Family Background

Prior to his first acute episode, Den spent most of his time with his mates, experimenting with drugs and hardly ever at home. At this time his Mum felt she had "lost" him. After the acute episode this situation markedly changed and Den became very dependent on his mother. During the CFI, she expressly said that "I feel I have my 12 year old back, that *I* lost years ago. I've got my son back, and he's lovely. He's nothing like the child he was before, he was so self-centred and...obviously I don't want him as he is, but now he's so loving, so concerned. He was never concerned about anyone before. And this is what I always believed was inside him. Although it's really painful to see - I could cry sometimes, just weep and weep - I'm like a mother hen with him now, like he's 12 years old again". Whereas the self Den wanted for himself was trendy, fairly macho, unconventional and independent, the self his Mum wanted for him was of a good boy who respected and looked up to his mother. She rated for high EE on critical comments (scored 13: critical of nearly everything he initiates), Hostility (rated 1: generalisation of criticism: e.g. "He does nothing, now, absolutely nothing. I can't even get him to wash up after tea.") and Emotional Over-Involvement (rated 5: dramatising, self-sacrificing behaviour "there's no point me getting a job", "I say to him- 'yours isn't the only life ruined by this you know, Den'", wants to do everything for Den and knows everything he wants). She also scored a number of positive comments (3) and warmth (3). Of this conflict situation, she said "it was a real battle to make him do anything. It was a real shouting match".

6.4.1.9 Conflict

In his first conflict (conflict 2), Den reported an incident in which his Mum attempted to get him to get up, to get him to the hospital gym. He felt that he hadn't slept very well that night and did not want to get up (he liked to sleep a lot, and when he did get up he would mostly sleep in front of the TV). He said he resisted his Mum's attempts to get him up, until she got angry with him. In terms of the ABC sequence, in sequence 1 he says she urged him to get up, appealing to his sense of the moral imperative, that he ought to get up (point A). He felt that although she wanted him to be a 'good boy', he would find it as being a silly kid (point B, code α+). He himself certainly rejected this demeaning definition of himself (self self: 1/10), and felt really angry (point C: rated 8/ 10). Yet the second sequence showed that he felt very anxious about his angry impulses (point C), because he imagined (at point A) that if he acted on his anger his mum would get even more angry and label him as a little shit (point B; code α-). He would largely accept this definition of himself (rating 8/ 10), and would have felt great shame (rating 10/ 10). This anticipated consequence was what caused such anxiety, and because of this Den got up and did as she wanted. Finally, in sequence 3 he felt very depressed (point C; rating 9/ 10), because he had yielded to and become the "good little schoolboy" that he so despised. In sum, Den showed a very typical pattern of anger repression brought about by the anxiety he felt from how he imagined his assertive actions would go down.

Conflict 2

Name: Den Sequence No.:1 Interviewer: PT

Activating event	Beliefs	Consequences
Describe: ***I hadn't slept all night. Mum woke me and said "Get up, you have to go to the gym".*** ***I tell her I've had no sleep and don't want to get up.*** ***Mother: "Come on get up now! I don't care if you have had no sleep".*** Emotion: ***Angry***	**Primary** O-S: ***Undermining my views: Therefore treating me like a worthless child. What I say is bullshit.*** Categorise: *α* ***α+*** *α-* *αI* *I* Other: Confidence: *7* S-S Actual Endorsement :*1* S-S Potential Endorsement: *8* Negativity: *8* S-O: ***She is being unfair. Bad person*** Categorise: *α* *α+* ***α-*** *αI* *I* Other: Conviction: *7* Negativity: **Secondary** Preferred Goal: ***Refuse to comply to unreasonable demand. By refusing in effect refusing to be a silly little kid.*** Action choice: ***Stay in bed*** ***Want/*** Ought Intensity (Preferred Goal): ***10*** Intensity (discomfort): *8*	**Emotion** General: ***Angry*** Specific: Intensity: *8* **Action Impulse** Describe: ***Stay in bed and say "For God's sake I've had no sleep. SHOUT etc?*** AcAc / ***InAc***

Conflict 2

Name: Den Sequence No.: 2 Interviewer: PT

Activating event	Beliefs	Consequences
Describe: ***Imagine staying in bed and saying "I haven't slept".*** Category: Describe other's *re*action: ***She would say: "Do as you're told you little shit. Don't be babyish."***	**Primary** O-S: ***As a bad child, I'd feel terrible.*** Categorise: α α+ ***α-*** α *1* *1* Other: Confidence: ***9*** S-S Actual Endorsement: ***8*** S-S Potential Endorsement: ***8*** Negativity :***8*** S-O: ***None*** Categorise: α α+ α- α *1* *1* Other: Conviction: Negativity: **Secondary** Preferred Goal: Action choice: ***Obey her and get up*** Want/ ***Ought*** Intensity (Preferred Goal): ***10*** Intensity (discomfort):***8***	**Emotion** General: ***Anxious*** Specific: ***Anticpatory shame*** Intensity: ***8, 10*** **Action Impulse** Describe: ***Get up reluctantly but quickly***. ***AcAc***./ InAc

Conflict 2

Name: Den Sequence No.: **3** Interviewer: PT

Activating event	**Beliefs**	**Consequences**
Describe: ***I get up quickly***	**Primary** O-S: ***Treating me like a little school boy doing what he's told, again- aargh!***	**Emotion** General: ***Pissed off*** Specific:
	Categorise: α ***α+*** α- α*I* *I* Other:	Intensity: ***9***
	Confidence: ***9***	**Action Impulse** Describe: ***Carry on getting up; glum, slow, reluctant***
Category: ***Conform***	S-S Actual Endorsement: ***9*** S-S Potential Endorsement: ***9***	
Describe other's *re*action: ***She's shocked but pleased: "Good boy".***	Negativity: ***10*** S-O: ***She's wicked***	
	Categorise: α α+ ***α-*** α*I* *I* Other:	
	Conviction: ***9*** Negativity:	
	Secondary *Failed* Preferred Goal: ***Didn't ignore her and stay in bed. Gave in to her and became a little kid***	***AcAc*** / InAc
	Intensity (Preferred Goal):**10** Intensity (discomfort): ***9***	

It transpired that rebellious episodes such as this one happened every few months, and that usually he later become so ashamed of his earlier "outburst" (as defined by his Mum), that he set about "winning back her good opinion". He did this by doing things he thought his mother wanted him to- continuing from sequence 3 of conflict 2. Den was especially compliant and meek until he had another angry episode, which his Mum saw as a setback after a period in which he had been 'doing so well'; as she said to him to override his anger "Den, I'm doing everything in my power to stop you becoming a vegetable". But why was Den so vulnerable to being defined as 'bad'? The extent to which Den feels ashamed of himself if he incurs her wrath and how he spends months trying to win back her good opinion is unusual- if his behaviour is seen as typical of adolescents (Smetana, 1989), then it is only natural for people his age to be contrary and changeable and to exasperate their parents. It certainly should not be the cause of as much life-enveloping shame as it was. Den thought at these times that he was so worthless that everyone else was conspiring to sacrifice him to the devil.

6.4.1.10 Symptoms

Moral theme

The power that Den's anxiety sequence had over him is apparent in his symptoms. At times he was convinced that he was bad, that everyone hated him and was intensely ashamed. Den was obsessed with the devil, and at times feared everyone else was in league with the devil and about to sacrifice him. He told of how, while sitting in a pub he had seen the Devil's face reflected in his pint glass, about to sacrifice him. He also saw people as having one red eye, which meant they were half in league with the Devil. At night he could hear people chanting (preparing an alter for him), and said "I could see hoofprints and smell the goat". Earlier we considered David who heard angry voices against his mother, which we interpreted as being due to the existential imperative for self assertion. In contrast to David, Den's hallucinations seemed

to come from his sense of the moral imperative. Hence many of his delusions and voices came from the idea that he was awful and deserved punishment. For Den, the moral imperative was to both avoid being labelled as bad, and thereby preserve the social support of his Mum, because he was very dependent on her; he had to a large extent lost contact with his friends and was scared of them (see later). One function of the delusions was to squash any actions that might jeopardise her continued mirroring and validation.

Existential theme

Incongruent with Den's anxiety and shame behaviour was a story his mother told of a terrifying physical assault where Den actually threatened her with knives and picked her up by the throat (she weighed about 18 stone at this time). On this occasion, Den was speaking in a way that suggests he felt he had been taken over by the Devil. At interview, the most he would say about this was that it was something he feared; he was reluctant to talk about times when he got angry, but this incident suggests that he did have much anger. There is too little evidence to do more than speculate, but it is plausible that at this time he felt he had been taken over by the devil, and that this could be driven by his existential imperative. Den's existential imperative to self-assert therefore refuses to be quashed and manifests itself in hostility towards his mother and psychotic episodes along the themes of the devil. One might wonder why this might happen, but as Horney (1950) said, "There is simply nothing that may not be invested with pride...One person is proud of being rude to people, another is ashamed of anything that constitued as rudeness." (p93). It would seem unavoidable that a purpose of these themes would be to give him a tolerable level of power against his Mum. Den's Mum gave him a lot of consideration (in fact bent over backwards to accommodate him) when he was in this psychotic episode. In his role as the devil, he was very abusive, insulting and demanding; at one point he insisted she stay with him at all times. His Mum had to really wheedle him to be allowed out of the house.

The conflict shows that in the final sequence, Den was left feeling thwarted and impotent. This was reflected in his long term behaviour, because he withdrew as much as he could from interaction with his mum, although he didn't want her to know that he was withdrawing from the interactions because that too would be a source of shame (he preferred to be up at night, when there are no people about). If one was unaware of the power struggles involved, this social withdrawal, anhedonia, depression and perhaps 'bizarre behaviour' could only be explained by a disease model. But the alternative propsed here is that it is the entrapment created by the conflict of the imperatives, revealed in the analysis of the sequences, sequences and the subsequent thwarting of Den's efforts to construct a viable self that bring these behaviours about.

6.4.1.11 Discussion

These two cases are representative of a number of clients in that all these clients felt thwarted in their self-construction urges and yet repressed their anger. In table 6.4.1, 12 clients who fitted this pattern are shown, with an abbreviated account of their conflicts. An attempt is also made in each case to show a functional link to symptoms. This group all follow the same theme in that they repressed their angry impulses to assert themselves because of their sense of the moral imperative. As mentioned in the previous section, in many cases the moral imperative took the form of fearing catastrophic consequences, an especially common worry for clients (for example for Imran and Den, being chucked out of the house or sacrificed to the devil). The anxieties they experienced led them to feel trapped and unable to pursue their self-construction needs. As a result they acted submissively, allowing themselves to be constructed by the other, and they felt depressed. The anger repressed in these instances is driven underground, but it doesn't just disappear; instead it seems to reappear in symptoms.

For example, David (and possibly Den) heard voices expressing hostility towards their parents. Such voices might be described as malevolent (Chadwick and Birchwood, 1996), but a closer examination reveals that much of their malevolence was directed at their mothers or other people they felt controlled and defined by. In this context, even malevolent voices might be seen as supportive, if they are serving a need. Den heard voices that were hostile and critical of himself, which seem to partially reflect the moral imperative (i.e. their guilt and anxiety for asserting himself) and a need for some sort of mirroring of his self (as if the anger from sequence 1 gets directed at himself, to stop him being ignored and unconstructed). The methodology would perhaps need refining to take this aspect into account.

Most people will be able to empathise with the unstoppable nature of unexpressed anger, as most people will have had the experience of coming away from an argument and finding themselves ruminating about all the good argument lines that they wish they had thought of at the time, perhaps even saying them out loud or acting them out. (Bentall et al, 1994). In fact this 'rehearsal' is a popular coping strategy in normal people, for dealing with stress (Roger and Najarian, 1989). Rehearsal and efficacy of emotional coping have been shown to be positively correlated (Roger and Schapals, 1996). If this is the form that anger can take in normal people, it should not be surprising that held-in anger could take the form of uncontrollable thoughts or voices or acting out behaviour. In this instance, such thoughts might be a coping strategy, as they are in normals! One possibility by which the thoughts might become voices was discussed earlier and would depend on the attitudes the client has towards their own thoughts (for example if they felt that it wasn't acceptable to think angry thoughts against their parents). In chapter 7 the hypothesis is examined (and support found for it) that clients who heard voices were more likely to think that they ought not think bad thoughts against their parents. This is especially pertinent given that many clients are suffering in a state of *objectité*, which entails a feeling of transparency in which the other may be aware of and judging a person's thoughts.

Table 6.4.1 Table giving interpretative summary of all the conflicts which appeared to fit the category of **Inhibited Self**.

Name/ Parental EE	Sequence 1	Sequence 2	Sequence 3: Entrapment	Symptom
Martin *Father, high EE* Criticism: 7 Hostility: 0 EOI: 1 Warmth: 5 Positive Comments:7	Dad: "Not now son". "He thinks I'm a waste of space. He mustn't. He's a bastard! " (αI) Anger 9 "I'll do something bad - that will make him sorry". Goes with prostitute. (Existential imperative to reject αI by rebelling).	"He might think I'm a pervert" (α-). "Am I? I mustn't let him find out." Anxiety 9 Anticipatory shame 9 "Say nothing. Interrogate friends, check radio" (covers his tracks) (Moral imperative to conceal α-)	"I've covered my tracks, but now he thinks I'm a waste of space again. He mustn't ." (αI) Angry 9 "I'll do something that will make him sorry!" (Swings between existential and moral imperatives).	Believes there is a conspiracy to put him away. Police and the media are following him. Believes they will put him on trial as a pervert and it will be in all the newspapers. This exemplifies the moral imperative - punishment for his badness
David *Mother: high EE* Criticism: 16 Hostility 1 EOI: 2 Warmth: 3 Positive Comments 3	Mum: "Go and make me a cup of tea'" (α+) "She's treating me like a slave *again*. How dare she the bitch!" Anger 9 "Tell her to piss off and do it herself!" (Existential imperative to reject α+ by asserting macho self.)	"If I do that she'll say I'm a nasty sod. I would be." (Would become α- as defined) Anxiety 9 Anticipatory shame 9 "Sure, that's fine." (Moral imperative to avoid being α- by behaving submissively).	"By doing what she wants I'm behaving like a slave. That makes me feel I am one". (Yields to α+). Humiliation 8 Anger 9 Sullen withdrawal, goes to bedroom. Angry ruminations (trapped in α+ role by moral imperative).	Voices tell him to harm or kill his mother but doesn't tell her this for fear of hurting her feelings. (By attributing thought to voice, is released from guilt from moral imperative, allowing expression of existential imperative) i.e. desired macho and powerful self.
Den, *Mother,highE E* Criticism: 13 Hostility 1 EOI: 4 Positive Comments: 3 Warmth 3	"Mum tells me to get up." (α+) "Treating me like silly kid". Angry 8 "Want to shout for God's sake I've had no sleep!" (Existential imperative to reject α+ by shouting indignantly).	"She'd say 'do as you're told, you little shit. I'd feel terrible" (Would become α-). Anxiety 8 Anticipatory shame 10 "I got up reluctantly". (Moral imperative to avoid being α- by behaving submissively).	"I'm a good little school boy again- aargh" (yields to α+). "Pissed off" 9 Glum, obedient.	Delusions of Mother and others seeking to sacrifice him to the Devil as a punishment. (Exemplifies the moral imperative - punishment for his badness. Occasional delusions of being the Devil, which are possibly driven by the existential imperative.

Name/ Parental EE	Sequence 1	Sequence 2	Sequence 3: Entrapment	Symptom
Louise, Did not want CFI done on husband	Husband: "you're not having the tablets. Treating me like I'm silly pathetic nutter"(α+). Angry 9 Aggressive outburst - punches, kicks and shouts. (Existential imperative to reject α+)	"He thinks I'm horrible". (Becomes α-) Shame 9 Guilt 8 Hugs husband and says sorry. Husband: "It's OK". (Moral imperative to seek release from α-).	"I've given in. Still treated like a child,; helpless and powerless. I feel trapped". (Yields to α+). Depressed 10 Humiliated 9 Angry 9	Angry voices tell her to kill husband. (Command takes away guilt from moral imperative, and embodies expression of existential imperative to angrily reject marginalised self .
Mick *Mother: Low EE* Criticism:2 EOI: 1 Warmth 4	Policeman and Dad grab me by the arms. "They're treating me like I'm a criminal" (Define him as α-). Angry 9 "Wanted to lash out with a hammer, tell them to f... off". (Existential imperative to reject α- by being strong and indignant) .	"I'd be behaving like a criminal only worse." (Would justify their definition of him as α-). Anxiety 8 Anticipatory shame 4 Guilt 5 "I just sat there- did nothing." (Moral imperative to avoid being α- by being compliant).	"I've given in and feel trapped". (But still rejects α-) Despair 9 Humiliated 9 Hurt 6 Ruminates on 'real' self.	Delusions of grandeur (world famous songwriter) "I'm going to be due a Lot of money, soon, as I wrote all these famous songs. All these other people are trying to steal my thunder." (Substitution of rejected 'criminal' self by 'real' self by delusions of grandeur. Example of Poor Me paranoia).
Sandra, *Mother, High EE* Criticism:2 Hostility 0 EOI:3 Positive Comm's: 7 Warmth 5	Mum: "Nobody's talking about you, why should they? She's being casually dismissive of me. Felt unvalued and selfish" (defined as α-) . Angry 9 Hurt 9 "'Wanted to scream, throw lamp shades etc.'" (Existential imperative to reject I and α-).	"'I'd be hurting a very virtuous person" (Anticipates would be defined as nasty person α- by implication). Anxiety 10 Anticipatory Guilt 10 "Held my breath and shut up" (Moral imperative to avoid 'nasty person' α- by repressing anger and existential demands).	"Stuck with her dismissing and not valuing me" (But rejects 'unvalued and selfish' α-). Frustration 9 Depression 9 Subdued but agitated. Ruminates on valued grandiose self .	"The day will come when I will become the Latter Day Jesus Christ and my lover and I will tour the world doing good deeds." Communicate with lover telepathically." (Delusional substitution of rejected 'unvalued, selfish' self by grandiose self. This substitution is driven by the existential imperative.

Name/ Parental EE	Sequence 1	Sequence 2	Sequence 3: Entrapment	Symptom
Nigel, *Father high EE* Criticism:6 Hostility 0 EOI: 1 Warmth 3 Positive Comm's:0	"Dad assumes I'm looking for a professional job and coping OK." Asks if I am still looking. (Defined as α+) Angry-for-a-second 7 "'Want to shout 'I can't cope. Give us a break' ." (Existential imperative to reject α+ as unfair and demanding).	"If I did that he'd think I was a right waster. Would throw me out the house" (Anticipates being defined as would endorse α-). Anticipated shame 10 "Said nothing. Pretended I was coping." (Moral imperative to avoid α- inhibits any action, conforms to expectations.)	"He thinks 'you're a good son" (α+) but I'm not. He's bound to find out (α-) " (Endorses α-). Depressed 10 Helpless, hopeless Does nothing. Isolated. Ruminates on what others think of him.	Voices saying 'You're manure' .- amplifying the opinion he felt his Dad would and will have of him from the moral imperative. He generalised this paranoid belief to peers. Negative symptoms such as flattened affect, and avolition- could also be a consequence.
Cathy *Mother, Low EE,* Hostility:0 Critical Comm's:3 EOI: 1 Warmth:2 Positive Comm's: 2	"Mum asked me if I was going to do the dishes as I had said I would, when I got back from posting a letter - accused me of being lazy and incompetent - always criticising" (α-)." Angry 9 Hurt 8 "Want to shout something about how I was going to do it". (Existential imperative to reject α-)	"She would be even more angry and critical." (Would justify α-). Anxious 10 Anticipated shame 10 Behaves appeasingly, due to pressure from moral imperative.	"She's treating me like I'm useless and I've allowed it." (Endorses and becomes α-. Feels trapped in this 'always being criticised' role) Depressed 8 Frustrated 9 Socially avoidant, hypervigilant of others' conversations.	"I can hear people talking about me and being very critical of me. They actually say bad things about me. I became very reclusive". Delusion magnifies perceived critical labelling from mother - driven by moral imperative.
Pete Mother, Low EE EOI: 2 Criticism: 2 Hostility: 0 Warmth:4 Positive Comm's: 5	"Mum nags me to do things", "She's a nuisance, its unnecessary; she treats me like a kid" (α+). Anger, 8 "I'd like to just ignore her and walk away, go to the next room.". Existential imperative to avoid α+ by escaping scene.	"If I did walk away, she wouldn't think I am a ignorant fool, but I would. I'd be worse than I am now, mentally." (He would become α-) Anticipatory guilt, 8 "I do what she says." Moral imperative means Paul feels he has to pretend to agree and tries to agree.	"She treats me like a kid and by going along with I feel that way." (α+) (Paul loses confidence in own opinions, becomes dependent on his Mum's definition of him) Depression, 8 Social withdrawal. Ruminates about how he would like to be.	"I felt like I was much more important than everyone else. I began to hear these voices commenting on everything I did," (Grandiose delusions reflecting unappreciated real self - existential imperative. "Later on the voices started really picking on me."- echoing some perceived criticism in the interactions with his mother, reflecting moral imperative.

Name/ Parental EE	Sequence 1	Sequence 2	Sequence 3: Entrapment	Symptom
Matt N Did not consent to parents being interviewed	"My Dad had a go at me for finishing with my girlfriend". (First α-) "He thinks I'm useless, worthless." Anger, 9 "I wanted to defiantly run away from Dad telling me off." Existential imperative to avoid labelling α- by rebelling in the only way he dare.	"If I did that he would think I am a complete bastard. The idiot of all time. Nothing goes in." (Second α-). He'd come after me, give me a whack. Guilty (9), Fear, (9). "I can't fight back." Guilt caused by moral imperative means that escape is not an option; he has to accept the label (First α-).	"I can't fight back so he wins the argument. He still thinks I'm a scumbag- Matt hasn't improved." (First α-) (Remains caught between anger and the guilt that holds it in). Depressed, 10 Ruminates about being powerful and effective.	"I assaulted strangers in the street, who were in league with my Dad and hated me." By doing this he was throwing off Dad's demeaning construction (Conspiracy theory is motivated by the existential imperative to assert self and moral imperative to displace onto safer target).
Bill Mother, Low EE, EOI: 1 Criticism: 6 Hostility: 0 Warmth: 1 Positive Comm's: 1	"My mum is never interested in talking to me. She just watches her soaps. Like I'm a nobody". (I) Angry, 8 "I want to get really angry with her, make her take notice." Brian wants to be acknowledged (existential imperative).	"She would think 'Get a grip on yourself. You're showing yourself up, you're showing everybody up." (Would become α-) Fear, 8 "I try to get a grip on myself; I don't say anything". Fears of drawing attention to himself mean that he accepts being ignored.	"I can't do anything but be ignored" (Remains a nobody, i.e. remains I) Alone, 8 He remains angry about being ignored and ruminates on how he would like to be, and the lonely situation he perceives.	"I have these constant voices in my head always criticising everything I do. They really hate me. They have such power…and have threatened to kill me if I don't obey them." (Reflects moral imperative, how everyone dislikes him if he draws attention to himself. Flattened affect, social withdrawal. "I sometimes try to reason with them, in fact I'm quite assertive with them." (Reflects existential imperative as he plays the self he would like to be).

Name/ Parental EE	Sequence 1	Sequence 2	Sequence 3: Entrapment	Symptom
Imran, *Mother, High EE,* Critical Comm's: 6 Hostility: 0 EOI: 4 Warmth:2 Positive Comm's: 2	"Whenever I do something wrong, my parents never let me forget about it. They treat me as if I'm worth nothing, its like 'you should be nothing'." (First α-). Anger, 9 Suicidal, "I want to shout 'Just stop it can't you see, it'll never happen again'." Existential imperative wants to reject their α-definition of him by being indignant and asserting he's OK.	"They would be very angry and upset; I would be very ignorant, like I don't know the truth; I should be patient with my parents". (Would become second α-) Guilt, 8, "I have to put up with what they say, or else get into even bigger trouble. I have to do what they tell me. I try very very hard to". Moral imperative means that he feels unable to assert self and motivates him to work hard at appeasing.)	"My test is to get through all this and get through, with God's help. I'm not built to take this amount of torture, though. (Continues to be worth nothing, α+). Depression, 10 Anger is still there. Ruminates on criticism and how to win approval.	Delusions of reference- "people in the street, on TV, on planes are referring to me. I sometimes feel the Devil is after me, they hate me". Generalisation of perceived incessant criticism from parents: moral imperative "Sometimes I get possessed by something which I think may be the devil" (Existential imperative to assert self even if bad).

If it seems that even mild angry emotions would be followed by strong guilty and anxious thoughts, (perhaps self-critical ones like Imran's voices), then extremely angry thoughts would bring about intolerable guilt and anxiety, and yet the imperative is an unstoppable force. Hence the only way out for the client might be to attribute responsibility and ownership of the angry thoughts to something external to themselves. Furthermore, if the client's own anger is cause for shame, then clients might also vacillate from one emotion to the other (one imperative to the other) and back again, from anger to anxiety, in a self-perpetuating manner.

People with Obsessive Compulsive disorder have the common experience where the more they try to repress intrusive thoughts, the more impossible such repression becomes and the more likely the thought is to be intrusive (see Salkovskis and Campbell, 1994). The same principle may apply here- if a client has an angry thought about their mother, they may try to repress it, and this very act of repression may make it worse. Whereas OCD people deal with the guilt (and responsibility) by elaborate 'rectifying' thought rituals or compulsive behaviours, the clients here do it by attributing the thought to an external voice.

6.4.2 Clients who preferred not to talk about parents

A sub-group of clients never once spoke remotely critically of their parents; in fact they carefully avoided bringing up any issue involving a parent. Because of this, there are no conflicts from them involving parents, although there are conflicts around other issues. Clients are perfectly within their rights to not want to talk about a personal area, and during interview we took care not to pressure anyone into talking about something they didn't want to. We are within our rights to speculate whether clients avoided parental topics because they chose not to, or were unable to countenance such topics. The reader must decide for themselves but our interpretation

is that the majority of this group are on a continuum with the inhibited self first group. The current group are almost completely defined by their moral imperative. The repression that comes out of the moral imperative cuts right into the core cognitions that underlie self-construction needs, to such an extent that they are ashamed of even having such thoughts about self-assertion. See chapter 7 for an exploration in a larger group of clients of beliefs about getting angry with parents and idealisation scores.

In one of the previous examples, Den was very wary at first of expressing any criticism because he feared the interviewer being on the side of his mother. After much engagement he really opened up on these issues, and said how glad he was of the support. Given that the other clients needed such support to bring up parental issues, and that a feature of these parental conflicts was immense guilt and anxiety about ever thinking ill of their parents, it seems likely that there are similar inhibiting fears on the part of the clients who would not talk about parental issues.

It is difficult to report any data on this, because by definition it is a lack of data, but we estimate around 5 out of the 20 clients did not say a word against their parents throughout the interviews, and this probably reflects their behaviour with their parents- they have never said a harsh word to their parents at all. We suspect this reflects an idealised view of their parents (as in chapter 4). For example, towards the end of our study, clients were asked to name 3 good points and 3 bad points of their parents. Of 5 clients asked, only two could name a single fault their parents had, one of which was leaving the top off the toothpaste. The others were utterly surprised that we should ask such a thing, because their parents were obviously beyond reproach. In the CFI, none of the parents seemed as perfect as their offspring thought, (as indeed the interviewers aren't!). Jack's Dad seemed a very warm man, and yet when he found Jack drowsy

in their kitchen apologising for having just taken an overdose, all he (the father) could think of to say was how selfish Jack was to do this, and how he would never like him again after this, he would always hate him for it. Jack very unhappily told of how he sat in the ambulance, crying because he'd made his Dad hate him, and even 8 months later on, his main concern was worrying whether he would ever win back his father's good opinion; indeed this was the only aspect of the whole suicide attempt that he regretted). Jack's dad scored highly on warmth and positive comments in the CFI, and a son's attempted suicide must be unbearably stressful. Jack's Dad made a very understandable human, emotional response to the situation, but Jack did not have a sophisticated enough understanding of his Dad as a fallible human being to understand, and hence was far more hurt than he needed to be by the situation. Jack's primary symptoms were depression and grandiose delusions where he thought he was about to become "The Chosen One".

6.4.3 Self Uninhibited: Anger Expressors

Everyone is an anger repressor to some extent, as was found in the comparison study on students commented on earlier (Huber, 1997), but the clients above repress far more, and repress desired actions that most people would usually express. They suffer excruciating guilt and anxiety when they even think of standing up for themselves. At the other end of this continuum, there were 3 clients who had the opposite problem. They appear to experience no moral imperative whatsoever, and their existential expressivity appears to know no bounds. However this is clearly no solution as these clients probably have more severe problems and probably suffer more as a result of their marginalisation from family and peers.

In the following example, Elizabeth acted on her anger, and although her reaction was perhaps extreme, the result for her was a feeling of happiness. However the down-side to such

behaviour was that Elizabeth, being generally quite an angry person, was in trouble for beating her 4 year old daughter.

6.4.3.1 Elizabeth

6.4.3.2 Presentation

Elizabeth was 44 and had been diagnosed as suffering from schizophrenia since late adolescence. She had been in and out of various hospitals since her first acute episode at 21 and even living rough on the streets with her child for 2 years. She left school at 18 and studied hotel management at college. She was now in a much better state and hadn't been unwell for ages; she had been married for 13 years. She presented as affable but perhaps rather touchy.

6.4.3.3 Family Background

We never met Elizabeth's mother so we only have one side of this argument. Elizabeth had a very volatile relationship with her mother; in fact she had had cut her parents off to an extent, only having as much contact as she felt happy with. This situation worked well for Elizabeth, and she was very self-assertive, as is seen in conflict 3. Its tempting to see this as a blueprint for healthy expression of anger: although she was particularly nasty to her mother "I wish she was dead, I'd be better off and so would Gill", the second sheet seems like a much more satisfactory outcome than any of the others. In fact, this was one of the only conflicts with parents where the client expressed their anger- and Elizabeth really let rip with everything she felt- and said what they thought. The result was feeling happy (rating of 10), and beliefs of "Mum had to accept that I am a warm and caring person instead of just a machine who does what she's told; I Do matter".

6.4.3.4 Conflict

In her conflict (conflict 3), Elizabeth described how her mother wrote her some letters talking about how Gill should be brought up (sequence 1, point A). The letters made her angry (point C) because she felt they were implying that she was no good at anything (point B). Her action of choice was to ring her mother up and tell her exactly what she felt, and this is what she did (sequence 2). Sequence 2 is the final sequence because Elizabeth felt really happy afterwards (point C). "I felt I had really achieved something, I felt a lot better". "She had to accept I am a warm and caring person" (point B).

6.4.3.5 Symptoms

One of Elizabeth's main problems was really that she was too angry, too much of the time. Her symptoms were that she was very grandiose, and deluded; she felt she was very special and better than everyone else. She also suffered from paranoia and felt that people were out to get her, although she felt she hadn't really done much wrong. She heard a number of different types of voices, some of which were benevolent and others which were malevolent. They were usually voices of people she knew telling her secrets, advising her on what to do, and occasionally barracking her. She also heard God talking and saw signs from him in birds and cars, and on TV.

She described how she felt that her 5 year old daughter Gill wasn't doing the things that she was suppose to do, and that she felt "I have to do all the work", and "She wasn't doing things quickly enough". She "shouted at Gill, slapped her and ripped things up" (in fact she beat Gill quite badly on a number of occasions and even lost custody of Gill).

6.4.3.6 Discussion

The small group of clients who fitted the category of being anger expressors were angry to an extent that was problematic. It seems therefore that there are problems with some clients

expressing themselves fully, and that some clients may be right to hold in their anger somewhat. These clients were typically poor-me clients, who were sure that they were OK, and that the problem lay in other people (Trower and Chadwick, 1995). In the next example, Mick was so prone to blaming others and demanding that others don't ignore him and must validate his grandiose self presentations that that he became a monstrous tyrant to his family.

6.4.3.7 Mick

6.4.3.8 Presentation

Mick was 35 and had been diagnosed as suffering from schizophrenia since the age of 20. He lost his job as a trainee train driver at this point when he was first hospitalised, and had been unemployed since. He had been in hospital only once and lived in supervised group hostels for a while. He now lived alone, living within walking distance of his parents. He presented as scruffily dressed, and as very confident and magnanimous.

6.4.3.9 Family Background

Mick's mother was rated as high EE, and presented as completely exhausted and at the end of her tether from Mick's abusive behaviour. The CFI was virtually an hour and a half list of horrible things he had done when he was being grandiose and abusive (for example, he said hurtful things like " I can't wait 'til you are dead so I can spit on your grave"; he had also threatened to kill her and had assaulted both her and her husband on a number of occasions; usually after one of his frequent heavy drinking sessions). On the CFI his mother was rated 20 for Critical Comments, 1 for Emotional Over-involvement, 2 for warmth and 3 for positive comments. Hostility was rated as 2, because of a rejecting attitude ("I dreaded coming home because I was so scared of him", "For 2 pins I'd have put a pillow over his face". His parents blamed the stress Mick caused for his father's quadruple heart bypass (although his father was

Conflict 3

Name: **Elizabeth** Sequence No.: **1** Interviewer: CH

Activating event	**Beliefs**	**Consequences**
Describe: ***Mum wrote me some letters; they made me really angry because I felt Mum and dad were trying to take over Grace (8 year old daughter). She was saying that Grace needed bringing up properly.*** Emotion:	**Primary** O-S: ***She's shown me up in front of my husband. She's saying I'm no good at anything*** Categorise: α α+ ***α-*** α*I* *I* Other: Confidence: ***10*** ***I Am doing a good job. I do all these things***. S-S Actual Endorsement: ***0*** S-S Potential Endorsement: ***0*** Negativity: ***10*** S-O: ***I wish she were dead. I'd be better off and so would Grace.She's not a very nice person.*** Categorise: α α+ ***α-*** α*I* *I* Other: Conviction: ***10*** Negativity: ***10*** **Secondary** Preferred Goal: ***To sort her out*** Action choice: ***Want***/ Ought Intensity (Preferred Goal): ***10*** Intensity (discomfort): ***10***	**Emotion** General: ***Angry*** Specific: Intensity: ***10*** **Action Impulse** Describe: ***I rang her up and really shouted at her , told her how I felt.*** ***AcAc*** / InAc

Conflict 3

Name: **Elizabeth** Sequence No.: **2** Interviewer: CH

Activating event	**Beliefs**	**Consequences**
Describe: ***I put her in her place, told her that she's wrong and I'm right.*** Category: Describe other's *re*action: ***Don't know. I hung up.***	**Primary** O-S: ***She had to listen, she accepted it, couldn't ignore me. She acepted I was a warm and caring person instead of just a machine who does things that she's told, does things by mother's power structure***. Categorise: α α+ α- α*I* *I* Other: Confidence: ***10*** ***I Do matter; I haven't just let her walk all over me.*** S-S Actual Endorsement: ***10*** S-S Potential Endorsement: ***10*** Negativity: ***0*** S-O: ***I've done her a favour, really. Told her the facts of life. Its not just about being middle class. Even her own doctor says so, her conversation is very stupid.She tries controlling everyone, even my husband. She says he's stand-offish*** Categorise: α α+ ***α-*** α*I* *I* Other: Conviction: ***10*** Negativity: **Secondary** Preferred Goal: ***She was OK for a while and then she got all high and mighty, had to be put in her place again.*** Action choice: Want/ Ought Intensity (Preferred Goal): Intensity (discomfort):	**Emotion** General: ***Happy*** Specific: ***I felt like I had really achieved something.*** Intensity: ***10*** **Action Impulse** Describe: AcAc / InAc

still a heavy smoker), and his mother's depression, and hearing them relate Mick's tyranny this didn't seem totally unreasonable. The only people that Mick would act in such a derogatory manner with were his Mum, Dad and sister; when he met other relatives or strangers he was very quiet, almost too shy to speak. When in the street, or during his times in hospital he would run everywhere to protect himself.

6.4.3.10 Conflict

In Mick's conflict (conflict 4), he put himself in an embarrassing position, where his Mum found out that he had been wearing his little girl cousin's lingerie (sequence 1: point A). Mick was upset about this (point C) because he felt "They would think I was a right dirty-minded little prat" (point B), although his actual endorsement of this was 0. He felt confident enough to explain to his parents about the situation, and felt he had told them what the situation was (sequence 2: point A). This made him feel much better and happy (point C) because he felt "She believed in me, she took it in". To Mick's distress, this was the last in a line of odd behaviours and in sequence 3, his parents arranged for Mick to be sectioned. Even when sectioned, Mick felt sure that there wasn't anything wrong with him, and said "I wanted the truth brought out; I couldn't stand them thinking something was wrong with me when there wasn't" (point B). His actual agreement with their impression of him as odd was 0. Even at this stage, he still saw himself as high rank (whereas bad-me client would see themselves as low ranking). He reported some guilt and shame in sequence 2, but this doesn't refer to accepting the label; this arose because of the perceived rejection from his Mum and Dad.

6.4.3.11 Symptoms

Mick was very deluded and would talk for hours about space and cosmology in a way that didn't make sense. He seemed to see his subject matter as being very significant and

important. He wrote 'books' of philosophy and regarded himself as a prophet. Although he had a high opinion of himself, he also spoke of his parents in a very idealised manner, and to him at interview, they were the best parents of all time, who had no faults. His speech veered from one topic to another in a way that only made sense to him, and produced many neologisms and clang associations. He also spoke of many reference experiences such as TV and passers-by referring to him.

6.4.3.12 Discussion

Because he was hospitalised, and hence isolated and ignored, he lost a mirroring audience. Any doubts he had about his own behaviour came from having to accommodate that trauma. (Mick's behaviour was eventually modified by a behavioural program in which his rages were ignored until he had to accept certain ground rules, for example not coming home drunk and abusive.) This conflict shows the power of the existential imperative, in that when the existential imperative expresses itself so unrestrainedly, the moral imperative is completely disregarded. For example, in conflict 4, Mick must be ashamed in some sense because otherwise he would not be motivated to do anything about the situation. He is not reporting any self shame belief and instead simply demanded that everyone else change their way of thinking (a dominant strategy).

Conflicts that fit with this theme are in table 6.4.3.12. This group fit the second group mentioned in chapter 2 in that they seem to have individuated from their parents somewhat, but have lost contact with their peers and are possibly scared by them. Mick was dictatorial to his family but was very shy and withdrawn when anyone else such as wider family came to the door. Only when they had gone would he start being grandiose again.

Conflict 4

Name: **Mick O** Sequence No.: **1** Interviewer: CH

Activating event	**Beliefs**	**Consequences**
Describe: ***I was trying on my cousin's clothes and I tore them; I was scared my Mum would find out.***	**Primary** O-S: ***They would think I was a right dirty-minded little prat.*** Categorise: α α+ ***α-*** αI I Other: *Confidence:* ***10*** *S-S Actual Endorsement:* ***0*** *S-S Potential Endorsement: 10* *Negativity:* ***10*** *S-O:* ***They were good people*** *Categorise:* ***α*** ***α+*** ***α-*** ***α I*** ***I*** *Other:* *Conviction:* ***10*** *Negativity:* ***0*** ***Secondary*** *Preferred Goal:* ***To avoid it all; I shoved them back in the airing cupboard. I went into myself completely*** *Action choice* ***I had to say something to explain this, to be able to get on with things*** ***Want/ Ought*** ***Intensity (Preferred Goal): 10*** ***Intensity (discomfort): 10***	***Emotion*** ***General: Guilt, Shame*** ***Specific: Total embarrasment, shock*** ***Intensity: 10*** ***Action Impulse*** ***Describe:*** ***If anything happened to me, it happened there and then.*** ***I thought "Oh shit what the f... am I going to do about this?" It was almost time for me to go into The Ravens (inpatient unit).*** *AcAc / InAc*

Conflict 4

Name: **Mick O** Sequence No.: **2** Interviewer:

Activating event	**Beliefs**	**Consequences**
Describe: ***I talked to them about it. I was just myself, instead of acting myself.I told Mum about my sexual problem; this was why I was doing it. I think she understood.*** Category: Describe other's *re*action: ***She believed in me, she took it in.***	**Primary** O-S: ***She understood me, so Not a prat.*** Categorise: α α+ α- α *I* *I* Other: Confidence: ***10*** S-S ***I told her the truth, that's as much as I could tell them - what I'd done, why I'd done it.*** Actual Endorsement: S-S Potential Endorsement: Negativity: ***3*** S-O: ***I liked her*** Categorise: α α+ α- α*I* *I* Other: Conviction: ***10*** Negativity: **Secondary** Preferred Goal: ***Carry on as before*** Action choice: ***Want***/ Ought Intensity (Preferred Goal): ***7*** Intensity (discomfort): ***3***	**Emotion** General: ***embarrassed*** Specific: ***Relief*** Intensity: ***10*** **Action Impulse** Describe: ***I could carry on doing what I was doing before*** AcAc / InAc

Conflict 4

Name: **Mick O** Sequence No.3 Interviewer: CH

Activating event	**Beliefs**	**Consequences**
Describe last AcAc C: in brief: ***I carried on as I had been doing***	**Primary** O-S: ***They thought I'd gone barmy- ringing up strangers, ripping up clothes, etc.*** Categorise: α α+ α- α *I* *I* Other: Confidence: ***10*** S-S Actual : ***0*** S-S Potential: Negativity:	**Emotion** General: ***Upset, oh Jesus Christ, yes.*** Specific:***Depressed*** Intensity: ***10*** **Action Tendency** Describe:
Describe other's *re*action: ***Mum and Dad put me into hospital after this.***	S-O: ***10*** ***I was angry with them but I knew they'd misunderstood me, so I wasn't really angry with them.*** Categorise: α α+ α- α*I* *I* Other: Conviction: ***10*** Negativity: **Secondary** *Failed* Want Goal: ***I wanted the truth brought out. I couldn't stand them thinking something was wrong with me when there wasn't.*** ***Want*** Intensity (Want Goal): ***10*** Intensity (discomfort): ***10***	AcAc / InAc

The conflicts in table 6.4.3.12 are typically two-part conflicts because the client says exactly what they think and represses nothing; in fact the moral imperative seems to have no influence or be almost completely missing. Some of the clients in the previous group of anger inhibitors may well have originally been anger expressors but learnt through experience (perhaps through being sectioned like Mick was) to hold themselves in by conforming excessively or totally to the demands of the moral imperative. Conflicts reflected the difficulty of respecting a person's right to do what they want, and yet wanting to protect the client from harm as best they could.

Clients learn a certain pattern of relating to others with their parents that they then transfer into interactions with their peers. Conversely, they also evolve patterns with their peers which they can use with their parents. However, peers are generally less tolerant and more hurtful than parents, and other than closer friends have little investment or obligation in looking after the client's well-being. Clients who feel inhibited by their parents would be predicted to be even more inhibited by their peers. Similarly, anger-expressing clients would presumably be less tolerated by their peers than their parents.

6.4.4 Peer Conflicts

In assessing how clients got on with their peers, it became apparent that few of the clients had many peer friends who were not part of the psychiatric services. Clients without friends were asked about their relationships with their friends in late adolescence, as this was the time when clients crucially needed their peers' support and theoretically may not have found it. Often they detailed the last interactions they had and the reasons why contact ceased. Peer conflicts fell into two categories- 6 situations where the client perceived being evaluated negatively and rejected

by their peers, and 3 situations where the client grandiosely rejected their friends. Peer conflicts are detailed in table 6.4.4.

6.4.4.1 Rejection by Peers/ Non-family others

Three participants entered the company of strangers, and felt sure that the people there were laughing at them or talking about them. Imran related how he felt even complete strangers hated him when he passed them. Imran showed the same pattern of interaction with his peers as he did with his parents, as did most of other clients in table 6.4.4 However, even those clients who showed the same pattern showed some key differences from parental conflicts. For example, clients could usually only suspect what the criticism was, because it was rarely made explicit; sometimes a vague reason was given but even then it was fairly indistinct. It was common for participants to not really know why their peers rejected them (although this might be because they did not want to talk about why they were disliked at interview). The first 5 conflicts in table 6.4.4 show people who were rejected by their friends were rejected for no reason, or for vague and unlikely reasons. In Cathy's conflict, for example (3rd in table 6.4.4), she felt sure that everyone present knew about her psychiatric history, almost as if they could read it on her face, or as if everyone in the world knew anyway. Furthermore, the evaluative belief attached to being "one of those ill people" is instantly one of being worthless, an instance of stigma as a very real and very upsetting entity in Cathy's life.

Table 6.4.3.12 Table showing interpretative summaries of those conflicts that fitted the category of **anger expressors**.

	Sequence 1	**Sequence 2**	**I/A Entrapment**	**Symptom**
Elizabeth Did not consent to parents being interview'd	"Mum wrote some letters saying that my daughter needed bringing up properly. She's saying I'm no good at anything." (α-) Angry, 10 "I rang her up and really shouted at her, told her how I felt." Existential imperative to reject negative definition of her.	" I felt like I had really achieved something. She had to accept that I am a warm and caring person." (Succeeds in changing Mother's α-definition of her). Happy, 10 "I do matter; I haven't just let her walk all over me." *Absence of moral imperative.*	Catherine was equally assertive with her peers and had cut them all off (see later). Hence she was left without anyone. She now has no audience to express herself and be mirrored in front of (I). Depressed, ruminates about various arguments.	Anger, aggression, "I hear voices of people I know telling me what to do, advising me on things. I usually follow what they say. They tell me important secrets." Symptom serves existential need brought about by cutting ties with her family and her friends. Some paranoia- felt people were conspiring against her and would confront strangers about this. Socially phobic.
Mick O *Mum, High EE,* Hostility 2 Crit'sm:20 EOI: 1 Warmth 1 Positive Comm's: 3	"Mum found out I had been trying on my cousin's clothes." "I was worried she would think I was a right dirty-minded little prat". (α-). Guilt, Shame, 10 Total embarrassment "I wanted to put her right, couldn't bear her thinking I was perverted." But motivated to use existential strategy to achieve moral goal -to assert he	"I explained myself to her; I couldn't bear her thinking there was something wrong with me when there wasn't." Carried on with bizarre behaviour. Relief, 10 "She understood me, so I didn't feel a prat". *Absence of moral imperative.*	They put him in hospital, (I) and he experiences an unacceptable self (but still rejects α-). "Upset, depressed, oh Jesus Christ, yes." 10 Ruminates about how he can't bear them thinking there was something wrong with him when there wasn't.	Grandiosity, "I write short books on philosophy and astronomy- I think its fair to say I know more than anyone else about these things." Unbridled existential imperative. Drink problem, very demanding behaviour towards parents.

	Sequence 1	Sequence 2	I/A Entrapment	Symptom
	is normal.			
Pat Did not consent to parents being interview' d	"Mum and Dad were dismissive of my religious ideas. They said live a good life and you will be saved - you read too much of the scriptures. Its like saying 'we're proud of you, but we're Not proud of you"(α-) Angry, 8 Incredulous, "I wanted to persuade them, and quote the scriptures at them." Existential imperative to reject implied criticism, and assert grandiose self.	"I did quote scriptures at them." "They'd say there's no such place as Hell. They threw it in my face, all that upbringing." They acted like I was an idiot, like they weren't proud (Rejects α-) Angry, 8 Carried on arguing *Absence of moral imperative.*	"They didn't listen; I had to go home; I felt wronged."(αI) Upset (7) Depressed (7) Ruminates on argument, rehearses retorts.	Grandiosity, speaks at length about religious ideas and his philosophy of life. Hypochondria, "The whole world is against me, mocking me, laughing at a man on his death bed, I ask you. I believe I will be saved, I believe there's hope , 'Bring it to the Lord, lay it at his feet'. Its not as simple as that, the Lord wants u s to be happy but its not as simple as that, you've got to suffer." Unbridled existential imperative.

Cathy's immediate impulse was to flee the pub and escape, yet she felt that if she were to do this, yet again the people in the pub judging her so badly would be proved right, and she would be totally trapped in this self of "one of those ill people". So her situation was unbearable, because whatever she did she felt was being used against her by the people there, and there was no escape. Not only were these clients rejected for unclear reasons, but they could do nothing; if they did respond to it, then it would be the worse for them. They typically avoided or just keep quiet throughout the incident, hoping not to make things worse. Its interesting how the psychiatric label itself is seen as the thing that their peers hate or reject them for, when the label mainly refers to the sorts of behaviours they show in these cases when they are worried about the label. Its almost as if the client's own fear of madness brings about some of the 'mad' behaviours that they are worried about.

As well as being rejected for vague reasons, another group of 3 clients rejected their friends. Jack was in awe of his friends and preferred not to see them until he was well again (this transpired at interview although he did not want to complete a conflict around it). He was sure they had not thought ill of him, but was worried they might if they knew more about how he was now. He'd rather have them think well of him, and not see them again until such a time when he was better, rather than to have contact with them now and risk them knowing how badly he'd fallen). In the last two conflicts of table 6.4.4.4, the participants grandiosely rejected their friends for not being good enough or recognising the participants' worth. Pete's never once said anything to his friends, feeling that it would be enormously traumatic for everyone involved if he did. He preferred to just avoid his friends and not have them know he was so angry with them. Elizabeth also related a conflict in which her friends had not done anything specifically wrong, but she was very angry with them ("not so much at the time, but when I got home").

Table 6.4.4.4 Table showing interpretative summaries of conflicts involving **peers** or **non-family others.**

	Sequence 1	Sequence 2	Sequence 3	Symptom
Bill	"I rang my friend up to ask about a game of football. Someone pretended it was a wrong number." "It was my friends and they didn't want to know me". (α-) (I). Angry, 7 Disappointed. "I wanted to say something, let them know I knew what they were doing."(Existential imperative reflecting hurt, rejected feelings.)	"I was scared that if I said anything he'd say he'd found out that I had problems and that he thought a lot worse of me". (Would endorse α-) Anxious, 8 "I hung up and took the dog for a walk." Moral imperative means that he has to accept their actions.	"I was left feeling that they didn't want to know me anymore". (Endorses I) Depressed (10) Avoids peer group. "Angry at myself for having rung up. I started banging doors a bit, wanted to calm myself down". Angry ruminations and fantasised revenge and justification sequences.	Voices function as a substitute peer group? 'Socialises' with them, argues. Existential imperative to construct substitute group, however having a tendency towards the Moral Imperative his voices became very hostile and critical; he also suffered a very extreme case of objectite.. There was a similar pattern to how he interacted with his mum. He felt ignored but powerless to do anything about it with his Mum; he feels similarly helpless with his peers.
Imran	"People shout while I'm walking down the street- it seems like they're shouting at me". "I'm a good-for-nothing, I have to listen to them. I can't do anything right". (α-) Anger, 10 Insecure, shock, 10 "I want to shout back at them!" Existential imperative	"If I did that, it would be like I had made a fool of myself, I've succumbed, it would be the end of everything, my whole life. They know better than me". (α-). "Like I've made a fool of myself." Guilty, 9.5 Do nothing Moral imperative.	"I ignore them and say nothing. Its like they're keeping me at bay. I've to be contained- my anger is to be avoided." (α-) Ends up accepting 'good for nothing' definition. Depressed 10 Withdrawing, socially phobic, apathetic.	Imran is very socially phobic, withdrawn and anxious. He feels people are out to get him, and that they are trying to tempt him to do bad things (possibly violent). His religion means that these are trials he has to endure on the way to becoming 'pure'.

	Sequence 1	Sequence 2	Sequence 3	Symptom
Cathy	"I went into the pub scruffily dressed after badminton- people were looking at me". "I thought they were saying 'She's one of those ill people". They think I'm worthless." (α-) Anxious, 8 "I wanted to flee the pub immediately". Moral imperative	"If I did leave the pub they would definitely think there was something wrong with me. They'd then think I was worthless". (α-) Anxious, 8 "I stayed and talked about work with the person I was with". Monitored others really carefully." Moral imperative	"I couldn't leave because that would be proving them right. I couldn't stay. I was stuck. Anxious 8, Obsessively monitoring people's conversations.	"I could hear people talking about me, even when I was on holiday in a country where I didn't speak the language. They were saying things about me."
Nigel	"My friend looked at me out of the corner of his eye, sneered, looked away and shook his head". "I was wondering what I had done? Perhaps I was looking over-anxious? Perhaps he's angry about a comment I once made? Perhaps they think I'm off my head, weird, pathetic. (αI/ α-) Anxious, 10 Shame, 10 "Avoided doing anything to make it worse". Kept quiet. Moral imperative	"I didn't say anything but felt that they were being 'holier-than-thou'- trying to put me down ". (αI/ α-) Anger, 10 Shame, 0 "I wanted to say- what the hell's the matter with you?" Existential imperative.	"If I did say anything they would just reject me, and tell me to get lost". (α-/αI). "Its like 'you're too pathetic or a nutter to be my friend'". "I would think I wasn't worthy enough to know them". (would endorses α-) Anxiety, 10 "I sat there for ages without saying anything. I was trying to avoid them rejecting me".	"I felt as paranoid as this quite often, even when I was on my own in public. I felt sure people were talking about me and disliked me". Presented as passive, flat affect, very withdrawn and socially phobic. Occasionally heard a voice saying (in so many words) that he was worthless.

	Sequence 1	Sequence 2	Sequence 3	Symptom
Sandra	" I entered the hall and because I was late the people there were nudging each other, smiling, laughing." "They might be thinking I'm a tart." (α-). Anxious, 8 Panic, embarrassment, 9 Panic attack, facial grimacing, going red.	"People interpreted my reaction to the embarrassment as meaning that I was guilty". "They Are thinking I'm a tart". They don't want to know me (Rejects α-; experiences I?) Anxiety, 10 Want to escape. Moral imperative	"I can't win; because they think I'm a tart, I give this response, and because of this response, I prove them right and *am* a tart". (endorses α- or experiences I) Avoids peers, stays at home,	Sandra avoids her peers, and has an intimate relationship with a special voice character who she constantly converses with, moment by moment. This male voice character will one day arrive in the flesh, bestow special powers upon her and the two of them will travel the country giving lectures, doing good deeds and healing people.
Pete	"Sometimes when we were playing football I used to get really angry at my friends. They didn't see who I really was, not the real Paul. They saw me as someone ordinary, easy to get on with". (α+) Angry, 9 "I wanted to shout at them". Existential imperative	"If I had shouted something, there would have been a Lot of very unhappy people there." "They'd have been really angry at me, they'd think I needed a break".(α-) (Would endorse α-). Guilty, 8 Depressed, 9 Disappointed in myself "I'd need to apologise a lot". Moral imperative	"They think pretty highly of me but they get on my nerves. It was like playing a role they value, being trapped within that. I hated it". (α+). Loneliness, 9 Depression, 8 "I didn't go out, lost contact with my friends, spent all my time with my voices instead. Ruminated about letting them know how I felt"	Pete used to get angry at his Mum but never dared express it. Here he shows the same pattern with his friends.- he gets angry with them but doesn't dare say anything. He so hated conforming that he preferred to talk with his voices than go out with friends.

	Sequence 1	Sequence 2	Sequence 3	Symptom
Elizabeth	"At the start of my illness, I felt that my friends weren't good enough to know me. They were just silly kids" . "They never insulted me, but just didn't give me enough respect". (α+)	"If I had told them how I felt, they wouldn't have understood I was clever. They might have been hostile." (α-)	Doesn't bother with friends. Rejects α+ but trapped within it.	Elizabeth exploded at her Mum and decided never to have anything to do with her again. Here she doesn't explode at her friend, although she was angry, but she cuts them off just the same. "It might have done them some good; they might have been nicer to me. I also worried that if I let them know I was really clever, they might do it too and also be really clever".
	Angry, 10 "Not so much at the time but later". "I suppose I could have pointed out to them that they should treat me better". Existential imperative	Depressed, 10 It would just be bringing misery upon myself- its just not something you do. I'd be like a snail, a tortoise. I'd take refuge in my shell". Moral imperative. "I decided I wasn't going to bother with them anymore. They're not good enough."	Loneliness, 6 Depression, 10 Suicidal, 8	Elizabeth heard voices giving important messages from important people which contributed to her being very special. She was too depressed to get up many days. She lived rough on the streets for two years. She was very aggressive to people around her.

Again, she would never have dreamt of expressing how she felt to her friends "it would just be bringing misery upon yourself; its just not something you do".

In summary, some clients commonly felt rejected by their peers, often for reasons that were never expressed. These clients preferred to say or do nothing about the perceived rejection, for fear of making it explicit and thereby more real. Clients felt sure their peers on the whole disliked or rejected them, especially strangers. Another group of clients felt that their friends liked them, but rejected their friends for not being good enough, or acknowledging their grandiosity enough. The end result of peer interactions was nearly always loss of contact and isolation.

6.4.5 Romantic conflicts

The most crucial peer interactions are ones with potential romantic partners, and hence these situations also have the potential to be the most rewarding and also damaging. Few clients, especially the younger clients in this survey, had much experience with the opposite sex, if any. Hence real-life romantic conflicts were difficult to get. Instead, clients were asked to imagine a hypothetical situation in which there was the possibility of a romantic encounter (only a small number completed this task because this avenue was only explored towards the end of the study). 5 male clients completed conflicts around this situation: "Imagine you are sitting in a public place like a cafe and a pretty girl smiles at you in an encouraging way. How would you feel? What would you expect to happen? What would you like to happen?". As it happened, all 5 clients had never really had girlfriends, or even been out on a date. As Pete said "If you want to know the truth, I've never really got on with a woman, either physically or whatever." As the conflicts in this section are more exploratory than in previous sections, they follow a slightly less rigorous REBT format than the previous conflicts. In particular, the second sequence does not

chain from the first sequence as in previous sections. Instead the second sequence is the imagined best possible outcome, and the third sequence is the imagined worst possible outcome. For the 4 older clients, the situation did not contain any positive feelings at all, just anxiety, and fear. All 4 clients said that they would never make any sort of move on the girl, and would prefer to ignore her (most clients possibly would not have been sitting on their own in a public place).

Table 6.4.5 lists the 5 romantic conflicts. The themes running in these conflicts are very similar. Sentiments from one of the youngest clients, Jack (aged 18) reflect a common fear of every adolescent starting out with romantic relationships:

"I might not know what to do, I might do the wrong thing and really hurt her or something", "She would have really hated me if I had somehow messed it up".

These fears are probably familiar to everyone who has ever been an adolescent, exploring romantic situations for the first time. Jack had never had a girlfriend and admitted that it was something he wanted in principle but not in practice, because he was a little scared of girls. He also felt really inadequate and childish around his friends who had got girlfriends. He felt he had lost a lot of status with his friends through not having a girlfriend and it was one more arena within which he was now fairly crap in their eyes. His friends had all gone to University and successfully made the transition to independent living, whereas Jack was still living at home and if anything had regressed to a more childish, dependent state.

In summary then, clients showed a fear of the opposite sex in general, and romantic relationships in particular. Only a small number were asked, but of these, all clients asked were adamant that they would be very anxious about a possible romantic relationship and felt sure that the potential partner really disliked them, no matter what. None had much experience of dating and all saw this as terrifyingly important to them.

Table 6.4.5 Table showing Interpretative summaries of **romantic** conflicts.

"Imagining how I would feel if a pretty girl smiled at me in public".
(These conflicts follow a different format to the previous ones, being more exploratory. The first sequence is their initial response to the situation, the second is the imagined best possible outcome, and the third is the imagined typical worst outcome.)

	Sequence 1	**Best possible outcome**	**Worst possible outcome**
Imran	"She thinks I'm a load of old rubbish; how could she possibly think I'm normal. I get the feeling that she doesn't fancy me; she really hates me." (α-) Anxiety, 10 Dead Nervous, "Its out of the question"	"If I did chat her up, she'd give me a wicked eye and then look away. she'd suddenly snap." (α-). "I'm too dangerous, lots of stuff in me, rage, guilt". Relief, 10 "Its all to be avoided. Her being normal, me not being normal, makes me feel low. I'd leave it. Ignore her. Don't smile back."	"She was out to tempt me from my family and house and to another life; she's out to ruin me. She sees me as someone to control". (α-) Relief, 10 "God has saved me from the day. The lustful part of me is nulled. Its as if I get possessed by an entity that loves every girl in sight. She's out to try to ruin me, make me do bad things".
Pete	"She might not find me attractive, I'm not good enough, well-educate, intelligent." Anxiety, 5 Not happy. "I'd have to speak to her first, see if she was my type."	"I don't think I would really do anything because if you want to know the truth, I've never really got on with a woman, either physically or whatever. Anxious, 5 If my Mum didn't approve, I'd finish with the girl".	

	Sequence 1	Best possible outcome	Worst possible outcome
Jack	"She thinks I'm interesting , and have a good personality. Good looking." Happy, 9 "Smile back. Not go over though. We'd talk and perhaps go somewhere".	"If I did smile back ,and get chatting to her or whatever, I'd be worried that I wouldn't know what to do and might hurt her or something". "She would really hate me if I had messed it up somehow. She'd think I was a tosser". (α-) Anxiety, 7 "I wanted to get away because I might do the wrong thing- just get away without cocking it up".	"I'd do nothing, she'd be disappointed. My mind is filled with ideas about how she'd be the perfect woman". Depression, 8, "The truth is that I've never really been out with a girl, I'm not really bothered."
Bill	"She thinks I'm pleasant." "He'd be after a steady relationship". Fear, 7 Apprehensive, "I'd ask her if she wanted another cup, perhaps get her phone number".	"If I did do anything, she'd get up and walk away". "I'd get a slap in the face. She's just not interested in a relationship". Fear, 7 "It would never get this far".	"I couldn't do anything; she ignores me. Its like being kicked in the teeth when you are down". Depressed, 8 "I wouldn't ask her out."
Nigel	"She'd think 'What a weirdo!' "I'd have a full-blown panic attack". Anxiety, 10 Shame, 10 "I'd want to leave as quickly as possible".	"If I did go up to her and talk to her, she'd react like I was a weirdo. She thinks I'm stupid and weird." Anxiety, 8 Embarrassed, 8 "I'm going to have a panic attack".	

6.5 Discussion

Cognitive Behaviour Therapy has made great advances in recent years in understanding schizophrenia; current trials are showing it to be effective treatment alternative (e.g. Haddock and Slade, 1996). CBT practitioners have been successful despite many of them using fragmented, quasi-biological theoretical models, where the psychology is seen as an add-on extra. For example, Tarrier et al (1989) used pragmatic coping strategies and generic counselling skills; even the family interventions of the Expressed Emotion paradigms do not have any one explicit mechanistic model, and hence work in a "we don't know why it works but it does" manner. Such work originated from behaviour therapy as applied to learning disabilities (Haddock and Slade, 1996), and as behavioural approaches are specifically devoid of the concept of self, it is not surprising that the resultant treatments do not include any stated convincing theory of 'the person', despite the repeated calls for such a paradigm mentioned earlier (Chadwick, Birchwood and Trower, 1996).

6.5.1.1 Methodological considerations

A feature of the study has been demonstrating that REBT can be used to probe more deeply into what clients are thinking. Much of the detail of the study would not have been found without having a theory driven reason to probe. The study also shows the benefits of more extensive engagement with the client, and the potential benefits of using real-life situations and interactions with real people. Using hypothetical situations might be particularly unwise on a client group which divorces reality from fantasy quite often anyway. Similarly, a flavour is given of how research not only needs to respect the differences between clients, but also between the same clients over time- some clients symptoms change over time.

There is a striking difference between the traditional questionnaire data in the second part of the results section, and the rest of the results, in that the questionnaires really do not yield particularly interesting results. They show that the themes are consistent even when measured this way, and suggest that the same patterns extend into the client's past, as demonstrated by the relationship measures such as the PBI and Impact Inventory. The powerful exploratory techniques from the rest of the results section highlights glaring limitations in questionnaire designs.

The study has shown that there is much coherence in the thought processes of the clients. Even with the interviewer's questioning, the conflicts are still authentic, and in all places the quotes are genuine client quotes (except in the tables in 6 part III where the clients are paraphrased for brevity). The study shows very clearly that the client's cognitions are not bizarre and incomprehensible; they are certainly not "empty speech acts, whose informational content refers to neither world nor self" (Berrios, 1991, p12).

If anything the many situations covered are surprisingly mundane. The significance of the scenarios is more obvious to the clients themselves, because they cite these situations as being very important to them (although perhaps these situations are as controversial as they feel comfortable with, and they do not want to talk about bigger issues). The assumption that essential roots of the problem can be found in the minutiae of interactions was an important *a priori* stance ("Life is a filigree of tripwires" Goffman; 1971, p31). Much previous research has looked at instances such as these and see them as evidence of the wider problem (i.e. the disease or attributional bias) rather than being more directly responsible. This change is something that follows directly from the stance in chapter 5 where the self was defined as something being constantly created and re-created in interactions. By this definition the self is far less stable and

more transient than in other conceptualisations of the self. If the effects of these interactions build up over time and each had a small incremental effect in the same direction, this is consistent with the fact that psychotic delusions generally build up over time. Commonly about 2 years elapses between the first signs and a florid illness (Beiser et al, 1993).

Another merit of the study was that clients were asked what they would have ideally have wanted to happen or to act in the situation in very concrete terms. Typically work on 'ideal selves' or 'future selves' considers client's wishes in the abstract (Marcus and Nurius, 1986; Bannister and Fransella, 1966). In this study clients are asked which actions they would like to have taken (a very different sphere of operations from ticking statements about "how I would like to be..."). On the whole clients were shown to have wanted to be more powerful and assertive, although often just to defend themselves against perceived threats.

6.5.1.2 Conclusions

On the whole, it was shown that most clients did not act the way they would have liked to because they had crippling fears about what would happen if they did. These fears were often catastrophic and in most cases much worse than the interviewer would have judged the action to have merited. Although the literature demonstrates that families are often much more reactive than normal (for example a high EE family would be almost likely to react in a catastrophic manner like the client predicted; Vaughn and Leff, 1976), it seemed likely that the catastrophes imagined were grossly excessive.

The fears clients had caused them to be (on the whole) anger inhibitors, and to not express themselves. In normals, repressed anger has been linked to rehearsal and rumination as a

coping strategy, and it was suggested that clients show the same tendency to such intrusive uncontrollable automatic thoughts. Furthermore, there was evidence that the anxiety and guilt producing cognitions that led the clients to initially repress their anger might make clients feel afraid to own such thoughts, so they would have to experience them as voices. Future research might profitably look at any connection between repressed anger and voice hearing or voice content. This should be fairly simple to do as there are questionnaires to measure repressed anger. In chapter 7 the hypothesis is examined that clients have rules about what it is and isn't acceptable to think.

The Existential and Moral imperatives were cast as the prime movers behind many of the symptoms. Evidence was presented for this in the tables in part III. The two types of imperative illustrate the observation that a large proportion of the symptoms are concerned with themes "...which invariably reflect the patient's concern about his or her position in the social universe" (Sims, 1988). Many of the supposed symptoms of schizophrenia can be seen as meaningful and purposeful behaviour when the full situation is known- for example social withdrawal and the lethargy and depression of negative symptoms make more sense in the context of the entrapment sequence demonstrated here.

The study shows there appears to be two flavours of madness. They depend on which side of the existential-moral equilibrium the balance has shifted to. For the inhibited self group, the balance has shifted almost entirely to the moral imperative side. Their moral imperative-influenced symptoms are about being disliked and useless, and they feel compelled to accept threats to self-construction that the people in their life bring about. The other smaller group, the anger expressors were ruled mostly by the existential imperative. Although this group gets to pursue their grandiose needs, in the long term their behaviour is self-defeating because it annoys

other people and therefore separates them from them. This group was almost the most overtly disturbed of the two. A simplistic conclusion from the moral imperative group would be that all clients should be encouraged to express themselves more. However the anger expressor group need almost the opposite sort of encouragement as they need to give moral goals precedence and be more considerate.

There could be said to be a third flavour of psychosis in a third group which has both imperatives to excess. Some of the clients in the first group also showed strong existential symptoms, and hence had both grandiose existential themes and self-hating moral delusions. Here the two imperatives clash violently with each other to produce terrible conflict within the person themselves. These issues are discussed more completely in the final synthesis of the next chapter.

Chapter 7

7. An Exploratory Study of the Moral Imperative: how Clients perceive their own behaviour with their Parents

The analysis reported in the last chapter showed that while a minority showed unbridled self-construction, the majority were blocked from constructing a self by an abnormally powerful inhibitory process that has been called the moral imperative (see chapter 5). This majority show the clash of the two imperatives- the existential imperative to construct a self, and the moral imperative to subordinate the self to the other. This chapter further investigates the moral imperative.

Clients whose behaviour, emotions and possibly symptoms were driven by the moral imperative gave the impression that it crippled their self-construction capacities. It appeared to dominate their core cognitive self- schema. Part of the moral imperative is that people have a set of demanding or 'must' rules about how they themselves should behave towards other people (Dryden, 1995). It was speculated that such rules are so important to those people with a psychosis who are dominated by the moral imperative that they may find it catastrophic when they cannot conform to them. Hence if the existential imperative brings them to think angry thoughts about (for example) a parent, the moral imperative 'must' blocks this and the client is motivated to find another way out, such as denying responsibility for the thought. The client looks for alternative explanations as to where it came from, and decides someone else is responsible for it- perhaps it is a voice.

Hence it is suggested here that the moral imperative rule is vitally important in the formation of symptoms, both those symptoms that come directly from it, and those existential ones that the moral imperative represses. In the following study, a number of potential moral imperative statements were listed on a questionnaire, and a group of psychosis-sufferers were

compared to normal student controls. The study attempts to fill in a bit more context around the cognitions involved, for example, it was common for clients to speak very highly of their parents, but to spend most of their time avoiding them. One contention (from chapter 2, and confirmed in chapter 4) was that this was because in many cases they idealised their parents, and therefore wanted to make sure they reacted in an ideal way to their parent. Therefore it was expected that clients would endorse items about their parent's ideal qualities (e.g. "I have never known X to lie"), and also items about how important it was to comply with parents wishes and to not argue with them.

Part and parcel of the moral imperative are issues of morality and responsibility, essentially issues of what constituted good behaviour and a good person. One way of looking at these issues is to see them as power games; such judgements perhaps are commonly used to control another person's behaviour. For example, the person who can invoke the most amount of support from the community or authorities is likely to have more power, and can define 'the rules'. For the core of the questionnaire there were a lot of items derived from ideas as to what 'the rules', the syntax of arguments, should be. A rough theoretical outline was decided on thus: If a person is arguing with another person, very often there would be a demand along the lines of "do x", or "don't do x". If these demands failed, then the next line of argument would be to at least ensure that the person continues talking to the arguer- "listen to me when I'm speaking to you"-a person who can control the target with this line can at least continue to puts their point and make life difficult for the target by sheer stamina. Finally, it appeared that our clients often might feel compelled to listen but tried to escape the scene as soon as possible, having acquiesced in the short term for the sake of an easy life. The final rule might therefore be "Don't leave the room when your father wants to talk to you".

All these statements thus derived reflect an opinion or label on the behaviour of the target- from the observations of *objectité* (in chapter 5) it appears that this is likely to make the target very self-aware, and also prevent them entering the subject state where they would be able

to judge the other's behaviour (Duval and Wicklund, 1972), (which might explain their poor mentalising for other skills seen in chapter 4). It was likely therefore that if a client endorsed a lot of items indicating a set of strong beliefs about how they should act and behave, then they might be vulnerable to *objectité* types of experience. Hence even behaviours that the other person could not possibly have access to or knowledge of (for example, the client's own thoughts) might feel to the client like they were open to criticism. One of the hypotheses that has emerged during this thesis is that some voices may be the client's own thoughts that they dare not feel responsible for. If this was the case, then it could be predicted that the client would have a lot of beliefs about the types of thoughts it was acceptable to think, and what type of thoughts it wasn't, along the lines of "it would be terrible to ever think ill of Mum".

There were also a number of questions based around the idea of catastrophising, using the idea that clients can sometimes be scared of their parents and of the consequences of misbehaviour. Other questions were about more frankly psychotic experiences; in some cases, it seemed like the parents had become embroiled in delusional beliefs. It was difficult to find a format that would take these into account because delusions are so idiosyncratic, but it was decided that parents might be involved in delusion of control or reference, for example mind reading or thought broadcasting (e.g. "Sometimes it seems like Dad can control my thoughts").

7.1 Method

7.1.1 Participants

Participants were consecutive referrals to the study from psychiatrists and other mental health workers in South Warwickshire, Northern Birmingham and South Birmingham Mental Health NHS Trusts. In all 21 clients (of whom only 2 were female) completed the questionnaires; a further 10 declined to take part. All clients had an ICD-10 diagnosis of paranoid schizophrenia or delusional disorder. The average age was 31.9 (s.e.=2.5 years), and

the average number of years spent in education was 12.7 (s.e.=0.3 years). No clients were included who were currently misusing drugs or alcohol, or who had a primary organic impairment. All clients were in "regular and meaningful contact" with their parents. Interviews were completed in client's homes or in outpatient facilities. No one else was present during the interviews.

The controls were 20 students (10 were female) at the University of Birmingham. Their average age was 24.1 (s.e. 2.8), average number of years spent in education was 13.7 (s.e.= 0.18), although all were of college standard IQ. They were paid a nominal fee for taking part in a day of psychological experiments. They were not read the questions, but were left to fill our the questions themselves.

7.1.2 Measures

The *Communications about Behaviours Gauge* (CAB-Gauge; see appendix F) asks participants to choose how much they agreed or disagreed with 52 questions relating to various themes of idealisation, arguments, how the client should behave and how the client feels about the other. Statements were endorsed using a 7 point Likert scale, ranging from strongly disagree (0) to strongly agree (7). The statements were sentences containing a variable (e.g. "X is always right"); before starting, the participant nominated the person "X" who was the most influential in the their life- all chose a parent.

To see how the themes in the CAB-Gauge related to symptom issues, and particularly voices, clients also completed the *Beliefs about Voices Questionnaire* (Chadwick and Birchwood, 1994). This instrument differentiates primarily between clients who hear malevolent voices and those who hear benevolent voices, and gives a quantified score for each type. It has been shown to accurately classify 90% of individual's voices (Birchwood and Chadwick, 1995). Finally to check the validity of the CAB-Gauge, the *Parental Bonding Instrument* (Parker, Tupling and Brown, 1978) was used; this widely-used scale provides orthogonal scales of

perceived care and over-protection for both parents. This scale has been shown to be related to many aspects of psychopathology such as depression and bipolar disorder (Parker, Tupling and Brown, 1978).

7.2 Results

The scale as a whole was found to have excellent internal consistency (Cronbach's alpha= 0.85; split half reliability= 0.78). Analysis proceeded with questions being into a number of different *a priori* theoretical categories (see Table 7.1). T-tests were used to determine whether the schizophrenia group differed from the control group. As the variances were usually unequal, Levene's test was used, which adjusts for this (two-tailed tests were used, because this was more stringent, but as the directions were predicted in advance, one-tailed would also have been appropriate). As can be seen from table 7.1, clients were significantly more likely than controls to idealise their parents- they endorsed items saying they saw their parents as unlikely to have ever lied, to always be fair, to nearly always be right, etc. Clients were also more likely to feel that the contents of their thoughts were subject to moral standards imposed by the other- for example "I shouldn't think thoughts X wouldn't like" (category 3 in table 7.1). Clients who heard voices were not different from non-voice-hearers on the categories of type of thoughts, or origin of thoughts.

As can be seen in table 7.1, some of the items that might have been expected to differentiate best between psychotics and controls in fact showed no difference - fairly florid statements about the parent reading the clients mind and controlling their thoughts or body may well have been too transparent and socially undesirable for clients to endorse.

Table 7.1: Table showing how psychosis-sufferers differed from student controls on a *priori* categories of 'beliefs about one's own behaviours'. Levene's t-test for unequal variances was used, and statistically significant differences are in red. Key: '*' =p<0.05, '**' =p<0.01.

Category of Belief	Questions in this Category	T test score	p value
Idealising	10. X is always fair. 18. X knows better than me what is bad and what is good. 20. Most people agree with X. 26. I have never known X to lie. 35. I rely on X for my judgements about people; they are better than me at that sort of thing. 47. I would like to be like X. 49. X is nearly always right.	t= -1.99	p= 0.05 *
Type of Thoughts	11. I shouldn't think thoughts X wouldn't like. 29. X knows if I am thinking thoughts they wouldn't like. 46. Its terrible to ever think ill of X.	t= -2.95	p= 0.005 **
Origin of Thoughts	6. Sometimes, its as if X can read my mind. 14. Sometimes it feels like X controls my thoughts. 41. Sometimes, its as if X gives thoughts to me. 50. X can take away my thoughts.	t= 0.28	p= 0.78
Psychotic	14. Sometimes it feels like X controls my thoughts. 13. I often get confused around X, which I try to hide. 17. Sometimes, its as if X controls my body.	t= 0.96	p= 0.34
"Talk to me"	19. If I don't want to, I don't have to speak to X.(neg rate) 25. I would hate X to think I ever didn't want to speak to them. 33. I could never end a conversation with X, even if I wanted to. 43. I sometimes don't want to speak to X. (neg rate)	t= -2.19	p= 0.002 **
"Don't leave the scene"	21. I ought to be around X if I can be. 37. I avoid X if I can.(neg rate)	t= -2.21	p= 0.034 *
"Do y"	1. Its important to me to follow X's advice. 3. People who argue with X are awful. 40. X knows best; I should not go against their advice.	t= -2.69	p= 0.012 *
"Don't argue"	5. I can tell X if I think they are wrong.(neg rate) 9. I can't have my own opinions around X. 3. People who argue with X are awful 51. I never say things X may not want to hear.	t= -3.74	p= 0.0006 **
Fear	15. X doesn't want to hurt me. (neg rate) 28. X scares me, if truth be known. 30. I find it difficult to speak to X.	t = -3.94	p= 0.0005 **

Nearly all the other categories in table 7.1 differentiated significantly between controls and clients. Clients more strongly endorsed items about having to talk to the parent whether they wanted to or not. Clients were more likely than controls to feel they had an obligation to remain in the vicinity of the other. They were also more likely to feel they should do what they were told, and that they shouldn't argue with their parent. Finally they were more likely to be scared of their parent or feel that the parent might want to hurt them. Because of the highly significant statistical effects seen in these last two categories, especially considering that the sample size was so small, the data are looked at more closely in figure 7.1. Of the many clients who scored high on 'Don't argue', many were not voice hearers. In fact 6/ 7 non-voice hearers were in the high-scoring section of the sample for the 'Don't argue' category, significant using a Mann-Whitney U test (U=20.5, n=7,14, p=0.03). The same trend was seen for the 'Fear' category but this was not significant.

Clients who heard benevolent voices showed much lower fear scores than clients who heard malevolent ones (Mann Whitney U test: U=6, n=8,6 p=0.02). Benevolent voice hearers also scored higher than malevolent voice hearers on 'Do x' (U=8, n=8,6, p=0.043), but not on any of the either categories.

There was no evidence that those who heard malevolent voices scored higher than the rest of the group on any other category, including 'fear'. Similarly, clients who showed social withdrawal were not more likely to endorse any of the categories than clients who didn't. Some concurrent validation (that the categories were measuring something like that which they were intended to) comes from the Parental Bonding Instrument. The scores on this scale were consistent with the findings on the various categories of the CAB-Gauge (table 7.2). Splitting the sample into those who scored high on the PBI sub-scales such as 'Maternal Care' and those who had low scores, and measuring the scores that these two groups got on the CAB categories, it transpired that a number of relationships were significant.

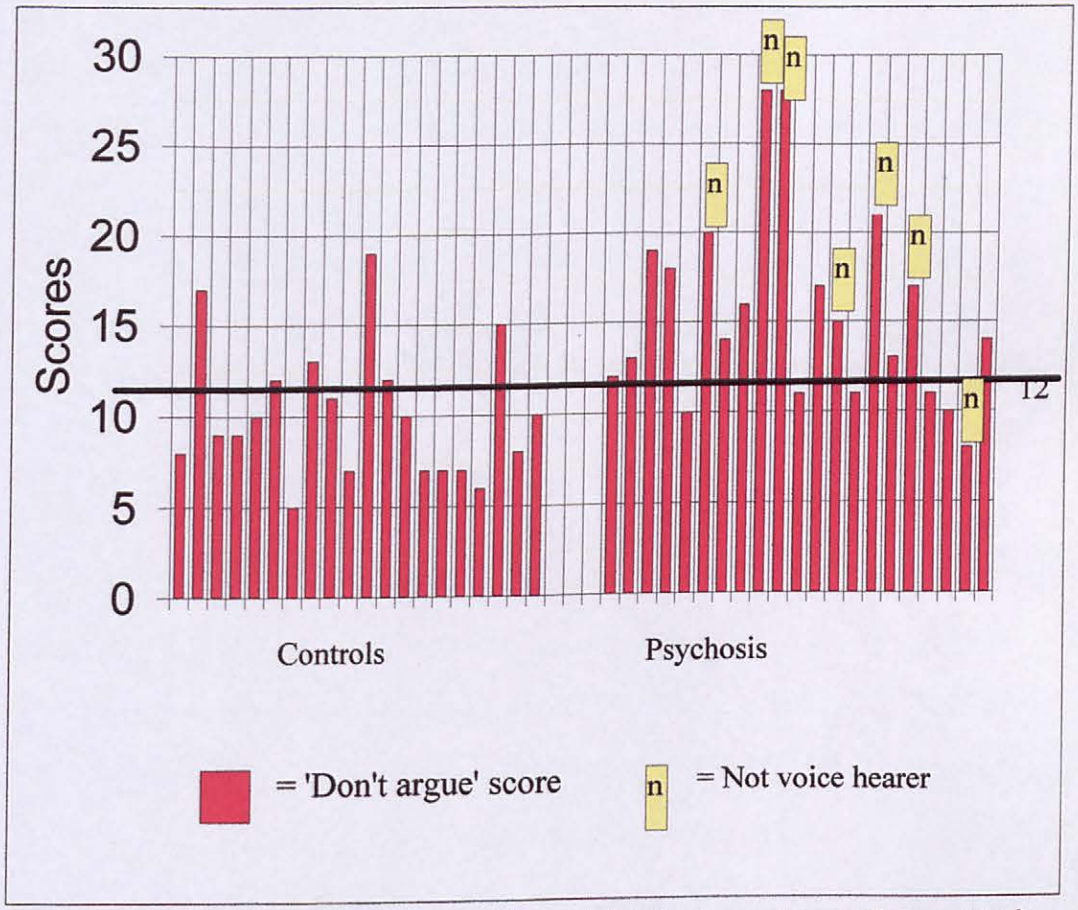

Figure 7.1 Graph showing the two different distributions observed for controls and psychosis-sufferers for the category of DON'T ARGUE. This category contained statements such as "people who argue with X are awful". Clients who were not voice hearers are labelled in yellow.

(The direction of the relationship is indicated in the table with any significant results- "high" means that high PBI score corresponded to a high score on the CAB-Gauge category.) Significant results are only reported as such when the corresponding p-value is significant after a Bonferroni adjustment, to correct for the fact that in some cases a number of tests were carried out on the same data. Clients who perceived their parents as caring were higher on idealising, and lower on fear, but also significantly high on obedience to Mum ("do y"), and not leaving Mum's vicinity (don't leave the scene"). Clients who perceived their parents as over-protective tended towards lower scores on idealising, and were significantly lower on "don't leave the scene" and "Don't argue" for fathers. They were high on Fear towards their fathers.

7.4 Discussion

The data here suggest that psychosis sufferers are far more likely than student controls to have extensive moral imperative rules as to how they should act. This is interesting because the man-in-the-street's conception of a 'schizophrenic' is that they are dangerous, unprincipled, and perhaps morally unrestrained. In fact, the data here show that the majority are much more inhibited by moral considerations than controls and if anything *far too moral*. The presence of strong rules as to how to behave was a better differentiator between the two groups than more typical psychotic features such as "they control my thoughts" or "I can't think straight".

Within the various categories of moral rules, a large sub-group of clients felt that their parents could somehow tell what sort of thoughts their offspring were thinking. These clients felt that they shouldn't think wrong thoughts (it would be interesting to investigate what sort of thoughts clients would see as 'wrong'). The result here confirms that these clients were suffering from *objectité*- that they felt so immensely self-conscious and under scrutiny from the other that they even felt their thoughts were transparent to others.

Table 7.2 Table showing how the psychosis group's scores on the PBI related to their scores on the CAB-Gauge using Mann-Whitney U-tests. Clients high on the PBI scale were compared to clients low on the PBI scale as to whether their CAB-Gauge category scores were different. The direction of the difference are shown beside any significant result - e.g. "high" means individuals high on that PBI category were also high on that CAB-gauge category. Significances were assigned after a Bonferroni adjustment.

Category of Belief (CAB)	PBI: Mum Care (p values)	PBI: Mum Over-protection (p values)	PBI: Dad Care (p values)	PBI: Dad Over-protection (p values)
Idealising	0.05 high	0.14	0.1	0.1
Type of Thoughts	0.5	0.7	0.8	0.4
Origin of Thoughts	0.5	0.5	0.4	0.8
Psychotic	0.5	0.1	0.48	0.1
"Talk to me"	0.6	0.5	0.53	0.6
"Don't leave the scene"	0.01 high	0.06 low	0.54	0.01 low
"Do y"	0.028 high	0.30	0.1 high	0.038 low
"Don't argue"	0.30	0.01 high	0.06 low	0.12 high
Fear	0.013 low	0.16 high	0.12 low	0.06 high

This category could not distinguish voice hearers from non-voice hearers, unfortunately, so there is no evidence here that such rules are specifically important in voice formation. However there was evidence that benevolent voices are a useful support against feeling scared of parents.

There was also evidence that non-voice hearers were likely to feel they weren't allowed to argue. This may reflect that people who believed they shouldn't argue were more successful in stifling argumentative urges even in their voice form. Voice hearers alone were still more likely than controls to feel they shouldn't argue, which still supports the idea that such beliefs are vital to voice formation.

The psychosis group were more likely to deny that they avoid their parent, and to say that they ought to be around their parents if they can- this is surprising given the high level of social withdrawal in the client sample. It possibly reflects that clients feel guilty for withdrawing as much as they do, or perhaps would like to withdraw more than they do but dare not.

Worryingly, many of the categories refer to quite a high level of control over the client's behaviour. Clients were more likely to say they have to talk to their parents, that should obey their parents advice and that they should not argue: "people who argue with X are bad". Most worryingly of all, the final category of fear contains items such as "They scare me, if truth be known", "I find it difficult to talk to them", and even "they do want to hurt me"; if anything the strongest difference between psychosis and controls was on this category. Endorsement of such controlling items was significantly linked to perceived over-protection from parents.

Similarly there was confirmation of the result from chapter 4 that clients are more likely than controls to idealise their parents. Such idealisation was statistically linked to high levels of perceived parental care on the PBI.

There are a number of obvious limitations to this preliminary study. The control group was not appropriately matched for age, amount of contact with parents, IQ, gender and ethnicity.

The sample is only small, but the PBI data that serves as a concurrent validation check suggests that if the sample size had been larger, more significant results would have been found. It is interesting that the categories corresponded to PBI scales because the CAB -gauge refers to only one parent; ideally this should have been filled in for both parents.

The data confirms that an important aspect of therapy for psychosis will be addressing the prohibitive and demanding rules of the moral imperative and REBT would seem appropriate given the focus on demanding thinking (Dryden, 1995). It also seems likely that in everyday interactions, guilt and shame based strategies for modifying a client's behaviour will be much more counterproductive than more positive reinforcements.

Chapter 8

8. Synthesis and Discussion

Most explanations of schizophrenia are on the level of the biological. There are partial psychological theories, e.g. in explanation of paranoid delusions (Bentall, Kinderman and Kaney, 1994), or voices (Chadwick and Birchwood, 1994), but it should be possible to develop a more complete explanatory theory at the psychological level. In the fullness of time there will be theories at each level (social, psychological, biological) which can be mapped one on to the other for a comprehensive biopsychosocial theory. So far there is incompleteness at all levels, let alone any real attempt at vertical integration. This thesis marks a step towards the goal of a more complete theory at the psychological level.

8.1.1 Biological versus Psychological

To set the scene for a psychological theory, it was necessary consider the relationship between the biological and psychological to show that the biological is not *a priori* necessarily pre-eminent. **Chapter 1** was written in conjunction with a neurobiologist (who may well yet fill out the picture at the biological level with his work on corticosteroids and psychosis; Mitchell et al, 1998); it was intended to be read by both biologists, biological psychiatrists and psychologists to find common ground between them. If there are three useful conclusions from this chapter they are 1) that the discovery of apoptosis means that there is no scientific need to look for brain injuries incurred during pregnancy or birth. This undercuts a large literature, and shows how an entire paradigm can be built up based on flawed assumptions (Crowe, 1994). 2) Although there are undoubtedly some biological differences between the brains of people with schizophrenia and normals, there is no evidence that they are there before the psychological symptoms or that they cause the symptoms. 3) Clients in an acute episode may be behaving in a fragmented way that justifies a brain-damaged or lesion-in-the-information-processing-systems approach, and can

be worked with in all the traditional manners, but theoretically this is still compatible with the condition being primarily psychological. That clients can descend to this biologically damaged position does not entail that when they are in remission their cognitions and experiences are unstructured and meaningless. Most of this thesis deals with the more coherent client who is in remission.

8.1.2 Part 1: Adolescent Development

Chapter 1 therefore provides the rationale for the rest of the thesis, which sees the psychological level as a crucial and neglected level to investigate. Any psychological approach to schizophrenia that would like to be more than a bolt-on to the biology has to deal with the fact that the scientific zeitgeist sees the old 1960's causal theories as discredited. The 60's work was seen largely as unscientific and blaming the family; however that was thirty years ago and psychology has made many relevant advances since then. **Chapter 2** details a fresh approach to investigating psychological mechanisms in schizophrenia valid by the criteria of philosophy of science and recently developed social-psychological qualitative methodologies. To briefly summarise, the theory draws on the current literature about what is known of normal adolescent development, and draws parallels with the current theories of psychosis, and what is known about schizophrenia. It concludes that there are such strong parallels between the theories that a compelling case can be made for late-adolescent onset schizophrenia being actually an extreme manifestation of the normal psychological turmoil associated with adolescence.

Such a theory is obviously ambitious and is best seen as another theory to be added to the clinician's repertoire; perhaps also one that will be more appealing to clients. Proof of such a theory (if ever possible; Popper, 1963) would be beyond the scope of a PhD thesis, but some corroboration is given in chapters 3 and 4. The data in **chapter 3** are consistent with the theory; they show that normal adolescents show high amounts of quasi-psychotic symptoms, and that such signs are intimately linked to their current level of autonomy development. Those who are

most advanced for their age in terms of autonomy are those who show the highest level of Schizotypy and Early Signs. It was concluded that this was probably because these teenagers were undergoing the stresses associated with attaining psychological maturity. The data for 17 year olds are probably the most convincing, consisting as they do of around 300 people. For young women, both autonomy measures, but particularly parental autonomy show robust relationships with schizotypy and prodrome scores. The same result was seen for young men, except here it is low peer autonomy that is related to higher schizotypy/ prodrome scores.

Interpreting these data is difficult. Conservatively, the most that can be said is that they show a quantitative relationship between psychosis-like symptoms, and the views individuals have of their parents and peers. The close relationship demonstrated in chapter two suggests that future research along these themes could make it possible to predict which teenagers are most at risk for a psychotic episode. It would be important for future research to explore further, for example later age groups could be studied. The teenagers in chapter 2 are still at school and when they leave school and try to work in the adult world, they might show more extreme levels of distress and symptomatology. A study of nineteen and twenty year olds might be much more revealing as to which students actually become psychotic. Alternatively, following the current students through longitudinally might be revealing. The study does suggest the exciting possibility of better tools for predicting who might be at risk, and potentially offers a clearer understanding of what actually precipitates a breakdown, and how it works functionally.

Apart from the exciting possibilities for earliest possible intervention, the data goes some way to corroborating the theory in chapter 2, which is an entirely fresh theoretical perspective on the etiology of schizophrenia. Much of the review in chapter 2 asserts facts that are verified in the following studies. For example, the data in **chapter 4** confirm the idea that clients are on the whole less autonomous and more idealising than controls (idealising was confirmed again in chapter 7). Clients are also much more extreme in their peer autonomy scores, even if their average peer autonomy score was similar to adult controls. The exception to this was clients

living away independently from their parents, who showed higher peer autonomy than either controls or psychotic clients living at home. This is particularly interesting given that in the rest of the thesis, losing contact with the peer group is seen as being the factor that really maroons the vulnerable late-adolescent. Normal young men show lower peer autonomy as they traverse adolescence. Clients living away seem to be very isolated from their peer group, a finding that was repeated in chapter 6 (quantatative data).

The two groups in chapter 6 part III, where clients are grouped into *inhibited self* and *anger expressor* categories, are roughly analagous to the two groups in chapter 2 – those who have not become autonomous from parents and those who have become autonomous from parents but not peers. It was because of the anomaly in the data in chapter 6 ("if they haven't yet individuated, how come some of them terrorise their families?") that the two groups in chapter 2 were hypothesised.

The majority of the psychosis group were also significantly lower than the two older groups of teenagers from chapter 3, and thus more similar to 12 and 13 year olds than the adult controls. That they are even below 12-13 year olds suggests that at least some of the autonomy difference has come about since psychotic breakdown, but it is still consistent with the notion that they were not particularly autonomous in the first place. Future research needs to refine the concept of autonomy; currently it is used rather nebulously as 'psychological development', and although it certainly comes close enough to that for the purposes of this thesis, future research may want to clarify what exactly psychological development is. This study sees Elkind's (1979) paradigm as particularly appropriate (the development that comes from a greater understanding of other people's minds- and therefore the development of such empathy could be an important tool in therapy), but more detailed accounts may be possible.

Another form of entrapment as demonstrated later in the thesis (in chapter 6) comes from the fact that clients are almost seeking validations in the wrong arena. Clients and parents are trapped in the parental conflicts shown because offspring should naturally be being more

independent of parents and standing up to them. Therapy could help clients to establish better peer relationships, because very few of them have any friends to speak of. Clients were generally even more cautious with their peers than with their parents and many of their symptoms could be understood as following perceived rejection or isolation from their peer group. It seems likely that peer relationships will be an important focus for future research, including employment as an useful means of fostering peer relationships (Shepherd, 1997). Similarly, the romantic conflicts showed that this is also an area that clients have great difficulty, almost terror, and as romantic relationships are of paramount importance to many clients this might also be a fruitful area for future research. This is especially true if the fears clients have are not just fears of intimate relationships, but fears of the opposite sex in general, as the data in chapter 6 implied. It cannot be helpful for clients to be scared of approximately half the population!

8.1.3 Part 2: Self-Construction

The theory in chapter 2 revolves around the idea of normal teenagers renegotiating the relationship they have with their parents; they have to establish their autonomy and adulthood while at the same time not rejecting the parents too abruptly. The urge to be one's own person (gaining autonomy) and the urge to remain supported and loved by those one is close to (affiliation) are two recurrent types of motivations in the literature. Such conflicting goals can create a lot of problems for both teenagers and parents: "The parental job is to be there to be left" (Coleman and Hendry, 1980). The same two themes are considered in more detail in **chapter 5**, as the 'Existential Imperative' and the 'Moral Imperative' (to reiterate, the choice of the term Imperative is meant to indicate the unstoppable nature of these goals, encapsulated in REBT as a demanding philosophy; Ellis, 1994, Dryden, 1995). Having set the scene as to the main arena where the battle for individuation takes place, the rest of the thesis looks in more detail at the actual mechanics of how this works and where it falters. The theory is based around the theory of

self construction (Trower and Chadwick, 1994). Chapter 5 sets out the theory and chapter 6 tests aspects of it.

The core theme of the self construction theory was the *existential imperative*: the need to construct a self is the psychological equivalent of the 'Darwinian' motive to survive and flourish. The need is compelling, and psychological survival depends upon it. For this reason, people continually attempt to construct their desired selves, experience joy, pride, satisfaction and other positive emotions when they achieve it, get angry when thwarted, anxious about having their self condemned or in some other way redefined, and dysphoric or depressed when they actually fail to construct their desired self, or even perhaps when they are coerced into constructing an undesired self. Why should people with a diagnosis of schizophrenia (or indeed any other diagnosis) be any different? The contention was that they are no different, that they have the same self construction needs as anyone else, and actually or potentially can experience the whole range of associated emotions, from joy through to depression, depending on the successes or failures of their self construction careers. The only difference, it was suggested, is that people with a diagnosis of schizophrenia experience much more failure than success - to such an extreme degree that normal psychological representations of reality breakdown and their experiences find expression in psychotic phenomena.

What is the evidence from **chapter 6**? The first aim was to see if people experienced the full range of negative emotions when their self constructions were under threat. Conflicts were chosen as the occasions when self constructions were most under threat.

1) Psychosis-sufferers got angry when thwarted. Most first sequences showed clients got angry because they saw themselves as being treated with indifference, being constructed as low ranking subordinates or coerced into such a role of what might be called a "bad or demeaned self" (Gilbert, 1993; Price et al, 1994). The majority of clients also experienced an angry impulse at point C to try to belittle or discredit the other, or compel the other to give them the recognition

they wanted. This angry response is no different from how anybody would respond. What is different in the client participants is what they do about it. Normally people would express their anger or assert themselves in some way, or they would, like adolescents who have successfully established a peer group, go elsewhere for their affirmations. However the participants rarely acted on this impulse with their significant relative, and they usually had nowhere else to go. They instead sometimes dealt with their need to construct a self by *inventing* it in a delusional world. This too is a mechanism that is part of our common psychology- in that people fantasise how they would like to be in an ideal world. However these clients seem compelled to invent and inhabit a fantasy world which they may believe is real. Many of the participants of this study not only constructed an imaginary self in this invented world, but also constructed the others who gave them affirmation. Usually the self was not just a desired yet ordinary self; it was an ideal, grandiose self, and the affirming others did not just affirm the presented self but were adoring of it. (Similarly, in chapter 7 there was evidence that benevolent voices go with people being less scared of their parents than those with malevolent voices or those who didn't hear voices.) Later in chapter 6, an explanation was offered for this leap into psychosis. This notion has some similarities with Laing's ontological insecurity (Laing, 1965).

2) They got anxious about having their self condemned or in some other way redefined by the other. Many participants anticipated receiving critical evaluations that would have the effect of objectifying them as shamefully bad and flawed. This, it was argued, using Sartre's notion of *objectité*, means being turned into an alien object, in the sense that their self becomes defined and constructed by the other and out of their control. They anticipated that they would feel ashamed and would experience many impulses to hide, avoid and escape. It was argued that this vulnerability to feeling like a shamed object before the other is also part of the human psychological inheritance (Duval and Wicklund, 1972), and that people also normally cope with it by avoidance strategies, either before the event when is anticipated, or by escaping after the

event after it has happened, or by reparations or giving justificatory accounts of an action that would change the way we were being defined. However in this study, participants were seldom able to successfully take these often subtle avoidant strategies; this was because they feared the consequences of such actions. Typically they feared being defined as 'even more bad' or worthless if they tried to assert themselves, and many feared actual catastrophe such as being thrown out of the house. Because they had nowhere to escape to, they were rendered unable to escape the shaming, defining look and intrusive, engulfing presence of the other; they were subject to extensive demands from the *moral imperative*. This often happened with the ever-present and omniscient voices (Chadwick and Birchwood, 1994). Consequently they suffer the *objectité* experience - they feel taken over, controlled to the core with the resultant symptoms of alogia, avolition, loss of the sense of willed action, thought insertion, thought broadcast, flattening of affect, possibly catatonia etc. In **chapter 7** it was shown that clients had more rules regarding their own behaviour than student controls; such rules regarded how they should behave and even what sort of thoughts they should think. It was shown that many clients virtually have a rule for every occasion, and are in fact fairly scared of their parents. The moral imperative is a particularly central set of 'musts'; according to Ellis (1994) and Dryden (1995), the primary irrational belief is the 'must'. This is the central component in dysfunctional core beliefs and the main thrust of REBT is to 'eradicate the must'. The existential imperative is also a set of 'musts'; in their most extreme forms (as was seen for some clients in chapter 6), the exaggerated imperatives clash against each other, and the client's ruminations oscillated between existential and moral goals.

3) Finally the participants got depressed through the experience of having no constructed self or an alien self. Again it was argued that everyone suffers dysphoria or depression as a result of the loss of their self (with varying degrees of severity, depending on how briefly, how important the particular self and associated role is, for example; see Champion and Power, 1995). Again this is

no different from "normal" depression, except that depression is extremely common in schizophrenia, and the loss of self is more severe, for reasons such as the fact that the diagnosis of schizophrenia is inescapable and severely stigmatising and entrapping (Rooke, and Birchwood, 1998). Evidence from this study showed that the outcome of the conflicts analysed most commonly resulted in dysphoria or depression, and resultant behavioural consequences of withdrawal, characteristic of a submission response (Price and Sloman, 1987). The structure of the conflict as a whole forms a total entrapment, a kind of double-bind which blocks self construction (but notably not a double-bind as the people who coined the phrase, Bateson et al, (1956) would recognise the term). A succession of overt and covert conflict-type interactions can build up over time to such an extent that self-construction becomes chronically impoverished and practically non-existent. Where this becomes a prolonged experience, this may lead into negative symptoms, such as anhedonia, apathy, poverty of speech.

8.1.4 Therapeutic Implications

The self construction analysis and formulation gives greater precision to cognitive interventions. Instead of blindly challenging the client's symptoms which the client may at that point in time be unwilling to relinquish, the self-construction formulation enables the symptoms to be utilised as a marker of the underlying beliefs, which then can be the target of the cognitive intervention.

There are three ways that this can be done: first, the dysfunctional beliefs underlying an all-engulfing moral imperative could be targeted, in those cases where clients self-constructions are profoundly inhibited. The case of Den from chapter 6 illustrates challenging the moral imperative: the formulation conceptualises his paranoid delusion of people intending to sacrifice him to the Devil as symptomatic of his underlying belief that he is inherently unlikeable, bad and evil. Having identified this belief, mainstream cognitive interventions would be employed (for example, Chadwick, Birchwood and Trower, 1996; Fowler, Garety and Kuipers, 1995).

Second, the dysfunctional beliefs underlying an unbridled existential imperative could be addressed in those clients who are totally lacking in any inhibition from any moral imperative. For example, Louise: the formulation conceptualises her command hallucinations as symptomatic of her underlying belief that her husband is wrongfully demeaning and marginalising her and must be killed.

However there are some slight dangers to this second approach, and hence the third scenario, which concerns the entrapment sequence more explicitly, where the moral and existential imperatives are in direct conflict, resulting in the self-construction entrapment. The purpose of the formulation here would be to identify the dysfunctional beliefs underlying both imperatives, and target them in tandem in a cognitive intervention. Louise can be used as an example again: the fact that Louise's aggression against her husband appeared as a voice suggested- and she confirmed in interview- that she had issues of massive shame and guilt around having such thoughts, indicative of a strong moral imperative. The formulation therefore would direct the clinician to challenge both her shame and guilt beliefs (moral imperative) and her murderous anger beliefs (existential imperative).

Effectively this approach is not doing that much that clinicians are not doing all ready in terms of actual CBT techniques - for good reason because this theory strongly stresses that we are dealing with ordinary human emotions and beliefs. What is new about this approach is that it gives a strategy for deploying therapeutic resources at the right targets. It is also genuinely person-centred because it is working with the client's own self-construction goals, and not against them which can be the case in a narrow symptom-focused approach. The symptoms should in any case be at least weakened by this approach which is designed to undermine the psychological needs and vulnerabilities which maintain them. The symptoms can then be more effectively targeted. The emphasis here is similar to the emphasis in preferential REBT which targets the irrational evaluative beliefs first, in the expectation that this will weaken the distorted

inferences, since the evaluative beliefs maintain the distortions (Ellis, 1994).

8.1.5 Limitations of Thesis

Throughout the thesis, limitations have been addressed where appropriate, in particular in the discussion sections of the empirical chapters (Chapter 3, 4, 6 and 7), for example limitations such as small sample sizes, innovative techniques and validity of findings. However it is worth re-iterating some of the wider issues that the thesis addresses. First is the problem of inclusivity. It is common for theories to address more than they can sensibly aspire to. It would be tempting to use the adolescence angle (of chapter 2-4) to account for all psychoses, but this would be unwise. It is valid for those people whose psychosis arises during late adolescence, but although this is a sizeable group, only 50% of people with a psychosis had their first hospitalisation before they were 25 (Sartorius, 1986). It could also be said that the same adolescent issues apply to the 80% who are under 35 (Sartorius, 1986), because adolescent-type problems don't only apply to those who are chronologically adolescent. It is plausible that some people managed to soldier on into adulthood and stave off psychosis for a few years (for example Brian had many friends after leaving school until they all started having families and children and had less time for him; his first admission at 28 came after a number of years of struggling). However it would be inappropriate to expect the adolescence theory to explain (for example) the statistical increase in post-menopausal women among psychosis sufferers (Hafner et al, 1993b), which almost certainly has much to do with life-roles and identity (Hassett, 1997), deterioration in health, and a rapid drop in oestrogen levels (Mitchell, 1997). Similarly post-natal psychosis, steroid-induced psychosis and other biological psychoses may be more biological in origin. However it has not been shown that these types of 'psychoses' are the same as the types addressed here; in fact it seems likely that they are substantially different. For example, the 'psychosis' commonly thought to be concomitant with Huntington's Disease is actually very rare indeed, and when manifested is more akin to a stubborn, aggressive insistence on ritual and sameness (Garron,

1973). Other psychoses with a known organic origin show untypical psychotic symptoms such as a feeling of imminent catastrophe befalling someone else nearby (Cutting, 1987) or visual hallucinations, which are still comparatively rare in schizophrenia.

A second limitation might be that the theory does not address why more males than females are vulnerable to psychosis, although perhaps it should and could. A speculative argument would be along the lines such as how males are expected to take the dominant role in courtship (in Western cultures at least) and thus females would find it easier to establish romantic relationships. Alternatively, generally speaking female gender roles give them closer peer relationships and more scope to be emotional (Griffin, 1953), as opposed to males who have pressure to appear as strong and powerful (a very common fantasy amongst the male clients). The reader might also feel that the adolescence issues in chapter 2-4 are fairly global and could apply to any condition- therefore why psychosis and not, for example, anorexia? As regards anorexia, there is a good degree of overlap between many of the major psychopathologies, and perhaps as anorexics are mainly female this may be just a more culturally appropriate way for women to channel their psychological distress. There may be various different solutions to unsolvable conflicts.

A third limitation might be that no attempt has been made to apply the adolescence theory to why there are such cultural differences in schizophrenia in terms of onset and relapse (Birchwood et al, 1992), but the theory could as easily be applied here. For example Asian culture is far more hierarchical than white European culture and as such it may be more difficult for offspring to debunk their parents and assert jurisdiction over their own lives. Different religions place different emphasis on the importance of correct behaviour, and such emphasis can be seen as a difference in the moral imperatives; hence some religions predispose individuals to be more vulnerable to a overwhelming moral imperative than others. Different cultures also have different norms regarding romantic relationships and marriage, all of which reflect different pressures and supports for vulnerable people (Cochrane, 1983).

In conclusion, it is hoped that the thesis will aid many new research projects and inform new approaches to therapy with people with a psychosis.

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