AUTOBIOGRAPHICAL MEMORY, DISSOCIATIVE SYMPTOMS AND EMOTIONALLY TRAUMATIC PAST EXPERIENCES IN ADULTS WITH BORDERLINE PERSONALITY DISORDER (BPD)

RESEARCH PORTFOLIO

PART I

Joy Airlie

Trainee Clinical Psychologist

Department of Psychological Medicine

Faculty of Medicine

University of Glasgow

1st August, 2001

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Acknowledgements

I would like to take this opportunity to thank Dr Kate Davidson for her support across my training. Many thanks to Dr Paul Flemming for his time and support regarding my single case study. Thank you to all of my family and friends for all of their support and patience throughout my training.

Most of all, my thanks goes to all of the participants who kindly donated their time and accounts of their experiences in order to provide us with the information necessary to help us improve our understanding of personalities. Without their help and co-operation this study would not have been possible.

Contents of Research Portfolio – Part I

(This bound copy)

Contents of Research Portfolio – Part II

(Separately bound)

SMALL SCALE SERVICE EVALUATION PROJECT

Waiting List Initiative:

An Evaluation of Referrals to A West of Scotland, NHS Trust, Psychology Department

AUTHOR: Joy Airlie, Trainee Clinical Psychologist.

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Address for Correspondence: Joy Airlie

The University of Glasgow

Department of Psychological Medicine

Academic Centre

Gartnavel Royal Hospital

1055 Great Western Road,

Glasgow, G12 0XH

Prepared for submission to *Journal of Mental Health*

(Appendix 1.1 for contributors' notes)

Abstract

As the result of a large waiting list (N=460), a Psychology Department in the West of Scotland proposed a waiting list initiative in the form of screening assessment clinics scheduled to take place during the first two weeks in February 1999. Analysis of the referrals being made to the department was proposed. This information would be used to inform service development in order to promote a more referral-based service.

At the time of assessment the length of time patients had been waiting for an appointment ranged from two weeks to nine months. The majority of referrals were received from GPs (74%). Anxiety (40%) and depressive (26%) symptomatology were the most common reasons for referral. Sixty seven percent of referrals experienced more than one clinically significant presenting problem. 'Caseness' on the Brief Symptoms Inventory (BSI) was associated with the level of intervention required (chi-square=18.1, df=3, $p<0.05$). Results indicate that the screening assessments have been a successful exercise in reducing the waiting list (currently N=194).

Introduction

A perennial problem faced by adult mental health psychology departments is that of ever lengthening waiting lists (Cawley & Read, 1999; Westbrook, 1995). Extensive waiting lists have led to a multitude of problems. Claxton & Turner (1997) discuss dissatisfaction felt among referral agents, as their demands for an accessible service appear to remain unmet. It has also been suggested that client confidence in the service may reduce as waiting lists grow (Murray & Walker, 1996). This has been indicated in attendance rates where studies have shown that the likelihood for a patient to DNA at their first appointment increases the longer he/she has to wait (Anderson & White, 1996). Non-attendance is a significant problem for the NHS, as wasted resources contribute to increased waiting periods and staff frustration (James & Milne, 1997).

The Professional Practice Guidelines for Clinical Psychology (1995) discuss the possibility of patients' distress increasing as a result of treatment being withheld. Also acknowledged is the sense of responsibility, and subsequent drop in morale that some clinicians may feel for the length of their waiting lists, regardless of the actual resources available to them. The Guidelines advocate that every effort should be made to improve response times, ensuring that waiting times do not exceed the standards set for the service (Professional Practice Guidelines for Clinical Psychology, 1995).

In efforts to improve client access and reduce the pressures felt by health care professionals, waiting list initiatives have been the source of interest for many carrying out clinical audit (Dawson, 1997). Various hypotheses have been posited in attempts to understand the occurrence of, and subsequent implications resulting from, extensive waiting lists, as well as the various methods proposed to reduce them (Newnes, 1993; Westbrook & Kirk, 1993 and White, 1993, cited in Westbrook, 1995). More complex referrals (Cawley & Read, 1999; Crowley & Advi, 1999), referral rates exceeding the rate by which patients are being discharge and limited resources have been postulated as pressures affecting the effectiveness of the psychology service.

Inappropriate referrals can affect attendance rates (Farid & Alapont, 1993) as well as the implications this may have on the efficiency of the service provided. The Management Advisory Service to the NHS (MAS) (1995) discuss the range of psychological skills possessed across various disciplines, ranging from level one (basic psychology/supportive counselling) to level three (specialist/complex multi-theoretically based psychotherapy). According to the MAS, it is the skills at level three that distinguish the clinical psychologist from other disciplines. Promoting a more effective use of the specific skills of the clinical psychologist, and other psychology service providers must be encouraged in order to improve the effectiveness of Primary Care Psychology Services. This would enable patients to be targeted to the most appropriate professional for his/her specific needs.

This Psychology department was experiencing increasing pressure as referrals were being received at a rate which far exceeded that of discharge and the numbers contracted to be seen per annum. This resulted in dissatisfaction from referrers as the waiting list increased to as long as nine months for some patients, far exceeding the departmental aims to see patients within nine weeks of referral.

A waiting-list initiative, in the form of an initial screening assessment (Denner & Reeves, 1997; Westbrook et al, 1991), was proposed. Its purpose was to enable patients to be screened for allocation to the most appropriate intervention for his/her needs. In addition to this, an overview of the department's referrals would yield information of interest to the department in its descriptive value.

This study aimed to provide a descriptive overview of the referrals received by the department. Such information might include the types and severity of presenting problems being referred, sources of referrals, attendance/attrition rates of the sample, the appropriateness of referrals and the number of patients requiring to use the service following an initial screening exercise. It is hoped that this information will provide a springboard for service development in order to provide a more appropriate referral-based service.

Method

Participants

Patients on the waiting list referred prior to 1st February 1999 were included in the study. The waiting list consisted of 460 patients, 268 females and 192 males. The age range was from 17-74 years (mean=37, sd ± 11.3).

Measures

- Patients' scores on the Brief Symptoms Inventory (BSI) (Derogatis, 1993) were used to assist the description of the types of referrals being received by the department.

- An Assessment Proforma **[Appendix 1.2]**, designed by the clinical psychologists within the department, was completed for each patient assessed. Demographic details, the source of referral and the patient's attendance status were among the details recorded. The main presenting problems and contributory factors were recorded using EPPIC Formulatory Categories **[Appendices 1.3 & 1.4]**. The problem category and the level of intervention required, according to the MAS levels (MAS, 1995), were also detailed on the Assessment Proforma.

Design & Procedure

Assessment clinics were scheduled for the first two weeks in February 1999. Fifteen psychologists ran the clinics across 10 clinics within the Health Board area. The aims were to establish the nature and intensity of the individual's problems and provide patients with sufficient understanding of, and information about, their problem in order that they could begin working on resolving their difficulties themselves whilst waiting for intervention (Denner & Reeves, 1997). Additionally, the screening assessments enabled patients requiring only a single session or an alternative service to be screened out or referred to another service for his/her needs.

An opt-in letter (Yeandle, 1999) **[Appendix 1.5]** was sent to all patients. A return slip **[Appendix 1.6]**, a BSI and a stamped addressed envelope were provided. Patients were asked to return the slip, indicating their intention to attend, and completed BSIs within two-weeks, on the understanding that failure to do so would result in the appointment being reallocated. Inaction was to be accepted as an indication that the patient no longer wished to make use of the appointment and such patients were instructed to follow the normal referral procedure should a further appointment be needed in the future.

On receipt of completed questionnaires, the BSIs were scored by an assistant psychologist and inserted into the patient's file along with an Assessment Proforma, which was also completed for each patient assessed. The assistant psychologist then entered the data on to a SPSS database, compiled for the nature of the study.

During the assessment a number of options were considered. For example, no further appointment required, referral to a revised waiting list for treatment or referral on to another agency. Assessing psychologists were asked to record, according to their clinical judgement, the appropriateness of referrals and, if intervention was required, which context was considered appropriate, e.g. individual, group or family. Patients were placed onto the revised waiting list according to high or medium priority, and again the assessors' clinical judgement was employed.

Referrers were notified of the assessment procedure and on completion of the assessment a copy of the patient's Proforma was forwarded with a standard cover letter **[Appendix 1.7]** to the referrer.

Missing Data

Due to a departmental administrative error, 197 cases (those who failed to complete a BSI) were lost from the database immediately after initial descriptive analyses of the whole sample had been performed, thus placing some restrictions on the data analysis.

Statistical Package for Social Scientists (SPSS) for windows, Version 7.5, was used for data analysis. Descriptive analyses were used to report demographical data and chi-squared tests were used to compare particular aspects of the categorical data.

Results

Length of Wait

At the time of the study, the length of time patients had been waiting for an appointment ranged from two weeks to nine months.

Waiting List Figures

The waiting list consisted of 460 patients who were contacted and offered an appointment. Table 1.1 illustrates that 53% of patients attended, 12% cancelled and rearranged an alternative date, nine percent cancelled with no further appointment required and 26% DNA'd. The DNA group consisted of 108 patients who failed to respond (yielding an overall response rate of 77%) and 12 who opted-in for their appointment, yet did not attend.

(Insert Table 1.1 here)

Outcome of Assessment

Forty-six percent of the patients were removed from the initial waiting list, no longer requiring to make use of the service. Table 1.2 illustrates the reasons for removal from the waiting list. Nine percent cancelled, 11% were assessed & discharged and 26 DNA'd. A further 12% awaited rearranged appointments and 42% were allocated to the revised waiting list.

(Insert Table 1.2 here)

Of the patients who had been assessed and discharged, table 1.3 indicates the reason for discharge.

(Insert Table 1.3 here)

Thirteen felt that their problem had resolved prior to the assessment, ten required a single session only, 18 were referred to another service and ten were discharged for 'other reason'.

The revised waiting list enabled patients to be targeted according to the degree of urgency and the level of therapeutic intervention that was considered appropriate for their needs **[Table 1.4]**.

(Insert Table 1.4 here)

Approximately one third of the assessed patients required to be seen by a counsellor. Sixty-five patients were considered to be 'high' priority and 129 were considered to be 'medium' priority.

Source of Referrals

The majority of referrals (N=336) were referred by their GP, 108 were referred by Psychiatrists/CMHT staff and 16 from other sources (e.g. physiotherapist, occupational therapist) **[Figure 1.1]**.

(Insert Figure 1.1 here)

Table 1.5 illustrates the rate of attendance and the assessor's opinions of appropriateness of the referral by the referrer. Neither the attendance rates (chi-square=0.3, df=2, $p>0.05$) nor the appropriateness of the referral (chi-square=5.5, df=2, $p>0.05$) were affected by the referral source.

(Insert Table 1.5 here)

Characteristics of Referred Population

Presenting problems were classified using EPPIC categories. Problems with less than a 4% incidence were grouped together as 'other'. Therefore the EPPIC categories were condensed to present the following six categories. Appendix 1.8 illustrates the problem categories grouped into the 'other' group. Figure 1.2 illustrates the results.

(Insert Figure 1.2 here)

The most commonly experienced presenting problems were anxiety related (40%) and depressive (25%) symptomatology.

Table 1.6 illustrates that the majority of the assessed population experience more than one clinically significant presenting problem.

(Insert Table 1.6 here)

Brief Symptoms Inventory (BSI)

Of the 460 patients who were offered an appointment, 263 completed and returned their BSIs, representing a BSI response rate of 57%. Therefore questions regarding the relationship between 'caseness' and specific descriptive factors will be carried out on patients who completed the BSI.

A BSI T-score of ≥ 63 is considered to be an operational definition of 'caseness'. Table 1.7 represents the percentage of cases considered to meet 'caseness' for psychiatric disorders.

(Insert Table 1.7 here)

Thirty-five percent presented with life transitional problems, 39% of the psychological disorder group and 70% of the severe and enduring mental illness group reached 'caseness'. 'Caseness' was not affected by problem category (chi-square=4.0, df=2, $p>0.05$). Fifty percent of patients assessed to be 'at risk' on a positive risk assessment reached 'caseness'. Thirty-eight percent of high priority and 46% of medium priority patients, reached 'caseness', yet 'caseness' was not found to be affected by prioritisation (chi-square=0.6, df=1, $p>0.05$). Thirty-nine percent of appropriate referrals and 40% of inappropriate referrals reached 'caseness'. 'Caseness' was not affected by appropriateness of referral (chi-square=0.0, df=1, $p>0.05$).

Eleven percent (N=2) of cases requiring no further intervention, 40% requiring supportive counselling, 35% requiring circumscribed therapy and 63% of those requiring complex psychotherapy reached 'caseness' **[Table 1.8]**. 'Caseness' was significantly affected by the level of intervention required (chi-square=18.1, df=3, $p<0.05$).

(Insert Table 1.8 here)

In a comparison of the department's two most frequently applied interventions, CBT and counselling, 36% of those requiring counselling and 45% of those requiring CBT reached 'caseness'. 'Caseness' was unaffected by the intervention required (chi-square=0.9, df=1, $p>0.05$).

Of the two most frequently reported problems, 23% reporting symptoms of anxiety reached 'caseness' for the anxiety dimension on the BSI. Of the anxiety group 42% obtained a global score reaching 'caseness'. Twenty-one percent of the depressed group reached 'caseness' for the depressive symptomatology dimension, and 47% of this group obtained a global score which reached 'caseness' **[Table 1.9]**.

(Insert Table 1.9 here)

Discussion

The waiting list for the psychology department, on 1st February 1999, consisted of some 460 patients. Jones & Cochrane (1981) report that women may be more likely to seek professional help for mental health problems than men and that GPs may be more likely to refer women to mental health services. Such findings were supported as the rate of female referrals slightly exceeded that of males.

Given that this department has been, to date, a Primary Care, Direct-Access Psychology Service it was not surprising to find 74% being referred by GPs.

Farid & Alapont (1993) suggest that attendance can be affected by inappropriate referrals. An examination of the attendance rates and considered appropriateness, by referrers, was carried out. Attendance rates were unrelated to referral sources. Similarly, the appropriateness of referrals was little affected by the source of referral. It would have been useful to have assessed the direct relationship between appropriateness of referrals and attendance rates, however this information was incomplete due to the loss of data.

The most commonly experienced presenting problems were anxiety (40%) and depressive (26%) symptomatology. McPherson, Watson & Taylor (1996) report a higher incidence of anxiety disorders and depression amongst GP referrals. Additionally, Cawley & Read (1999) report a high incidence of anxiety related disorders. The psychology department is predominantly of a 'Cognitive-Behavioural' orientation. Cognitive Behavioural Therapy has been successfully employed in the treatment of anxiety (Chambless & Gillis, 1993) and depressive disorders (Blackburn et al, 1986). Therefore, it is possible that referrers, who are aware that this is a Cognitive-Behaviourally orientated department, may feel that this is the most appropriate referral choice for such patients. Alternatively it is possible that referrers may feel that psychology is a recognised referral route for anxious or depressed individuals. Such reasons might explain the high incidence of these problems within the assessed sample, and further research could include an analysis of referrers reasons for referral.

Studies show that more complex referrals have a significant impact on the length of waiting lists (Cawley & Read, 1999) and the demand posed on clinicians (Crowley & Advi, 1999). The number of presenting problems was taken as an indication of complexity. Approximately two thirds of the assessed population experienced more than one clinically significant presenting problem.

The initial assessment appointment enabled patients who did not require or no longer wished to use the service to be screened out. Forty-six percent of the sample was removed from the waiting list in this way. Failure to remove these patients from the waiting list acts only to maintain the high numbers of patients being held, unnecessarily, on a waiting list. Therefore the screening of such patients, and allocation of those requiring to make use of the service to a revised waiting list, enables the waiting list to be managed more efficiently. The revised waiting list would therefore consist only of those requiring to use the service. This reduces the length of waiting lists and subsequently the lengths of time patients wait to be seen. DNA rates contributed greatly to the screening out of such patients accounting for 26% of the sample. This supports the findings of Gerhand & Blakey (1994) that suggest 20% of patients referred to clinical psychology will DNA. However research has shown that the likelihood for patients to DNA at their first appointment increases the longer he/she has to wait (Anderson & White, 1996). It would have been interesting to have evaluated the relationship between the length of waiting time and attrition/attendance rates, however again, due to the loss of data, this was unable to be done. Given that some patients were waiting up to nine months for an appointment it is possible that DNA rates were affected by the length of wait. However, a further survey of patients who do not attend their first appointment may provide valuable information regarding common reasons for non-attendance and consequently inform initiatives to reduce DNA rates.

Of the sample only 11% required a single session. This was due to their problems having resolved themselves prior to the appointment, patients being referred on to another service, a single session (where self-help materials were provided if necessary) being sufficient or an 'other' reason. Further research might assess the profiles of such patients in more detail in order to identify characteristics of

patients requiring a single session, thus informing waiting list initiatives. Applying an Assessment Triage approach in the future would enable such patients to be seen quickly, thus preventing an unnecessary contribution to already lengthy waiting lists.

Only 42% of the original waiting list were allocated to a revised waiting list, this being a significant improvement in length to the previous waiting list. The revised waiting list enabled patients to be targeted according to the assessor's opinion of the degree of urgency. Prioritisation was unstructured, as guidelines for high or medium classifications were not provided in advance, rather the assessor was requested to allocate according to his/her clinical judgement. A retrospective account of clinician's reasons for prioritisation was carried out, which identified certain criteria most often used **[Appendix 1.9]**. A further study might provide these criteria in advance in order to standardise responses. Such criteria may also be useful in terms of informing referrers of suitable criteria for referrals to the department. The department aims to see patients on the revised waiting list within nine weeks. 'Medium' priority patients who have not been seen within eight weeks automatically become 'high' priority patients therefore developing the need to be seen as quickly as is possible, depending on departmental resources.

Clinicians were asked to allocate patients to the level and type of therapeutic intervention considered appropriate for their needs. According to the MAS (1995), efficient use of the clinical psychologist's skills can be achieved by optimising working at level three. An evaluation of the effectiveness of the clinical psychology service could thus be based on such criteria. The secondary waiting list indicated that approximately one-third of patients required level one intervention. This could be considered an inappropriate use of a clinical psychologist's time and skills, where some of these cases would appear to be more suitable for referral to counselling. Many GPs within this area do not have practice-based counsellors and in those who possess this facility it is restricted to their patients. It is understood that until such facilities are more widely available GPs within this area feel restricted as to where these patients could be referred. It is hoped that future developments, of e.g. skill-mixed departments, might

promote a more efficient use of therapists' skills throughout the range of professionals offering psychological support.

The remaining two-thirds of patients require interventions at level two or three. Some of these patients may require more intensive and long-term psychotherapy, thus affecting the rate of through-put as brief interventions may not be appropriate for their needs. This exercise has proved useful in indicating the potential restrictions within the current service in terms of meeting the needs of the referred population. Such information may assist in enabling the funds, due to be received by the department as part of the Mental Health Strategy, to be channelled most efficiently, on a needs-led basis, in purchasing additional therapists who will be available to this group.

It was hoped that the BSI would assist in a more detailed description of the presenting population, providing an operational definition of 'caseness' for psychiatric disorders, globally as well as in individual dimensions. As anxiety and depression were the most frequently reported presenting problems an evaluation of the severity of cases was carried out. Twenty-three percent of those reporting symptoms of anxiety reached 'caseness' on the anxiety dimension of the BSI. Forty-two percent of the anxious group obtained a global severity index (GSI) which reached 'caseness'. Similar figures were found for the depressed group with 21% obtaining 'caseness' within the depression dimension and 47% obtaining a GSI score considered 'caseness'.

'Caseness' on the BSI was not affected by the problem category, prioritisation, appropriateness of the referral or intervention required (CBT compared to counselling). These results proved surprising as it was anticipated that certain subgroups of this sample might be seen to reflect some degree of increased severity as indicated by 'caseness' on the BSI, e.g. the different severity of cases referred to counselling and clinical psychology. Further research could investigate the psychologists' reason for deciding to place patients within certain categories. However, a greater proportion of those requiring level three interventions reached 'caseness' on the BSI.

The lost data, as a result of a departmental administrative error, has restricted the level of analyses performed within this report. It was decided that, given the nature and time constraints of this study, the length of time it would have taken to regain the missing data would have far exceeded those constraints. However, for the nature of this report, the information available has enabled the types of cases being referred to the department to be described. This enables the department to consider its current resources and evaluate the demands being made upon the service in order to consider possible solutions to the current management of waiting lists and future targeting of resources where most needed. It also provides some indication of areas that might be targeted in future departmental research, which may inform service development.

In conclusion, it may be that the assessment triage has been a successful exercise in reducing current waiting lists and as a result of this continued assessment clinics are being run within this department in an attempt to manage waiting lists more efficiently.

References

Anderson, K. & White, J. (1996). Evaluation of an Opt-in System in Primary Care Psychology. *Clinical Psychology Forum,* **93**, 28-30.

Blackburn, I.M., Eunson, K.M. & Bishop, S. (1986). A Two-year Naturalistic Follow-up of Depressed Patients Treated With Cognitive Therapy, Pharmacotherapy and a Combination of Both. *Journal of Affective Disorders,* **10**, 65-75.

Cawley, J. & Read, N. (1999). Waiting List Strategy Number...? An Evaluation of an Interim Measure. *Clinical Psychology Forum,* **130**, 29-31.

Chambles, D.L. & Gillis, M.M. (1993). Cognitive Therapy of Anxiety Disorders. *Journal of Consulting and Clinical psychology,* **61**, 248-260.

Claxton, T. & Turner, A. (1997). Clinical Psychology and Counselling: A Retrospective Analysis of GP Referrals to a Clinical Psychology Service. *Clinical Psychology Forum,* **106**, 15-18.

Crowley, A.E.L.. & Advi, E. (1999). The Impact of Complex Cases in an Adult Mental Health Speciality. *Clinical Psychology Forum,* **130**, 13-17.

Dawson, D. (1997). Changing a CMHT Assessment System: Separating From Treatment. *Clinical Psychology Forum,* 11-12.

Denner, S. & Reeves, S. (1997). Single Session Assessment & Therapy For New Referrals to CMHTs. *Journal Of Mental Health,* **6**, 3, 275-279.

Derogatis, L.R. (1993). BSI Brief Symptom Inventory: Administration, Scoring and Procedures Manual. National Press Computer Systems, Inc. Minneapolis.

Farid, B. & Alapont, E. (1993). Patients Who Fail To Attend Their First Psychiatric Out-Patient Appointment: Non-Attendance or Inappropriate Referral? *Journal of Mental Health,* **2**, 81-83.

Gerhand, S. & Blakey, R. (1994). An Investigation Into Early Discontinuation of Clinical Psychology Contact By Clients. *Clinical Psychology Forum,* 12-14.

James, I. & Milne, J. (1997). Opting Into Treatment: Increasing the Rate Of First Appointment Attendance With A Community Addiction Team. *Journal of Mental Health,* **6**, 3, 281-288.

Jones, L. & Cochrane, R. (1981). Stereotypes of Mental Illness: A Test Of The Labelling Hypotheses. *International Journal of Social Psychiatry,* **27**, 99-107.

McPherson, F.M., Watson, P.J. & Taylor, V.J. (1996). Audit of an Adult Mental Health Outpatient Clinical Psychology Service. *Clinical Psychology Forum,* 26-28.

Murray, A. & Walker, G. (1996). Anxiety Management "While You Wait": Input from an assistant psychologist. *Clinical Psychology Forum,* **89**, 33-36.

The Management Advisory Service To The NHS. (1995). National Review of Clinical Psychology Services Report Digest. Gloucester.

The Professional Practice Guidelines. (1995). *Division of Clinical Psychology,* Leicester: BPS.

Westbrook, D., Kirk, J., Whitehead, L. & Kennerley, H. (1991). Different Waiting List Procedures For a Psychology Out-patient Clinic: does early assessment help? *Presented at the Annual Conference of the British Association for Behavioural Psychotherapy; manuscript in preparation.* Cited in Westbrook, D. (1995)

Westbrook, D. (1995). Patient and Therapist Views of Different Waiting Procedures. *Behavioural and Cognitive Psychotherapy,* **23**, 169-175.

Yeandle, J. (1999). Outcomes from an opt-in waiting list initiative in a community psychology service for children and families. *Clinical Psychology Forum,* **130**, 18-21.

TABLES

Table 1.1: **Waiting List Figures**

	(N)	(%)
ATTENDED	245	53
CANCELLED (rearranged an alternative appointment)	54	12
Cancelled (no further appointment required)	41	9
DNA	120	26
TOTALS	**460**	**100**

Table 1.2: **Outcome of Assessment**

	N	%
Cancelled (no further appointment required)	41	9
Assessed & discharged:	51	11
DNA	120	26
Placed on revised waiting list	194	42
Awaiting rearranged appointment	54	12
TOTAL:	**460**	**100**

Table 1.3: Reason for Discharge

SEEN AND DISCHARGED:	N	% of sample
a) Problem resolved prior to assessment	13	3
b) Required single session only	10	2
c) Referred to another service	18	4
d) Other reason	10	2
TOTALS	51	11

Table 1.4: **Targeting and Prioritisation of Patients on Second Waiting List.**

LEVEL OF INTERVENTION REQUIRED (MAS)	HIGH PRIORITY (N)	MEDIUM PRIORITY (N)	TOTALS (N)	%
LEVEL ONE: Supportive Counseling	20	41	61	31
LEVEL TWO: Circumscribed therapy	19	43	62	32
LEVEL THREE: Complex Psychotherapy	19	40	59	30
OTHER: e.g. Group work	7	5	12	6
TOTALS:	**65**	**129**	**194**	**100**

Table 1.5: **Attendance Rate & Appropriateness of Referral by Referrer**

	GP	PSYCHIATRY / CMHT	OTHER*
ATTENDED (%)	54	51	50
APPROPRIATE (%)	85	76	75

(* Including Addictions Service, self referral, psychiatric nurse, physiotherapy, neurologist, occupational health, general medicine practitioner).

Table 1.6: Complexity of Cases

N° PRESENTING PROBLEMS	N	% OF SAMPLE
1	58	32
2	77	42
3	34	18
4	12	7

Table 1.7: **Percent of Cases Reaching 'Caseness' on BSI by Problem Category, High Risk, Priority on Secondary Waiting List and Appropriateness of Referral**

CATEGORY	N	REACHED BSI CASENESS (%)
PROBLEM CATEGORY		
Life Transitions / Life events	34	35 (N=12)
Psychological Disorder	151	39 (N=60)
Severe & Enduring Mental Illness	10	70 (N=7)
RISK ASSESSMENT		
High Risk	6	50 (N=3)
PRIORITY FOR SECONDARY WAITING LIST		
High	47	38 (N=18)
Medium	101	46 (N=46)
APPROPRIATENESS OF REFERRAL		
Appropriate	173	39 (N=69)
Not Appropriate	87	40 (N=35)

Table 1.8: **Percent of Cases Reaching 'Caseness' on BSI by Level and Type of Intervention Required and Context of Therapy Appropriate.**

CATEGORY	N	REACHED BSI CASENESS (%)
LEVEL OF INTERVENTION REQUIRED		
No further intervention required	19	11 (N=2)
Supportive Counseling	53	40 (N=21)
Circumscribed Therapy	62	35 (N=22)
Complex Psychotherapy	54	63 (N=34)
INTERVENTION REQUIRED		
Cognitive Behavioural Therapy	92	45 (N=42)
Counseling	58	36 (N=21)
ACCEPTABLE CONTEXT OF THERAPY		
Individual	160	42 (N=67)
Group	6	50 (N=3)
Family	3	100 (N=30)
Group or Individual	14	50 (N=7)

Table 1.9: Percent of Cases Reaching 'Caseness' on BSI by Most Frequently Experienced Presenting Problems.

CATEGORY	N	REACHED CASENESS FOR OWN DIMENSION IN BSI (%)	REACHED BSI CASENESS (%)
Anxiety Disorders & Phobias	124	23 (N=29)	42 (N=52)
Depression	114	21 (N=24)	47(N=54)

Figures

Figure 1.1: **Source of Referral**

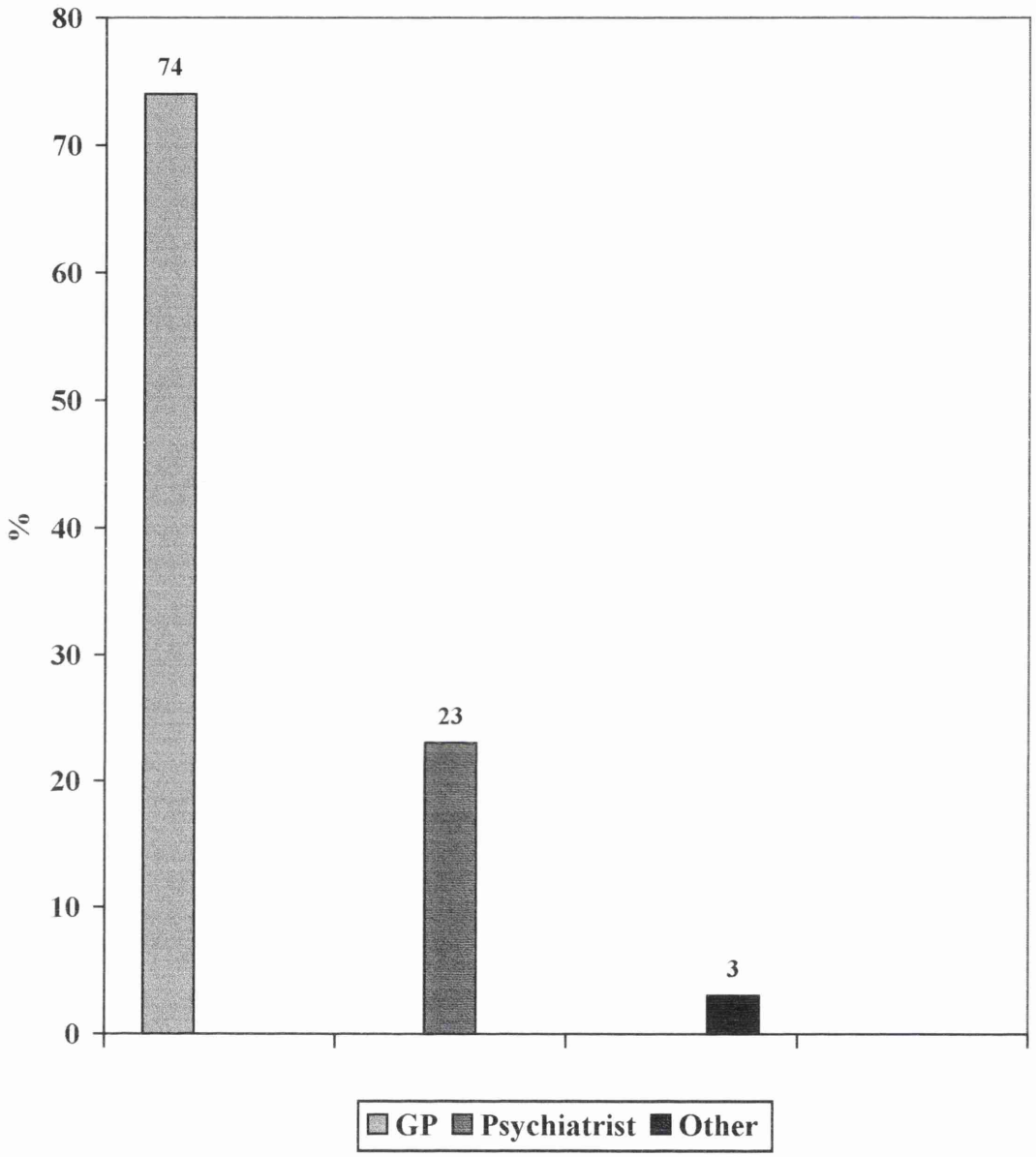
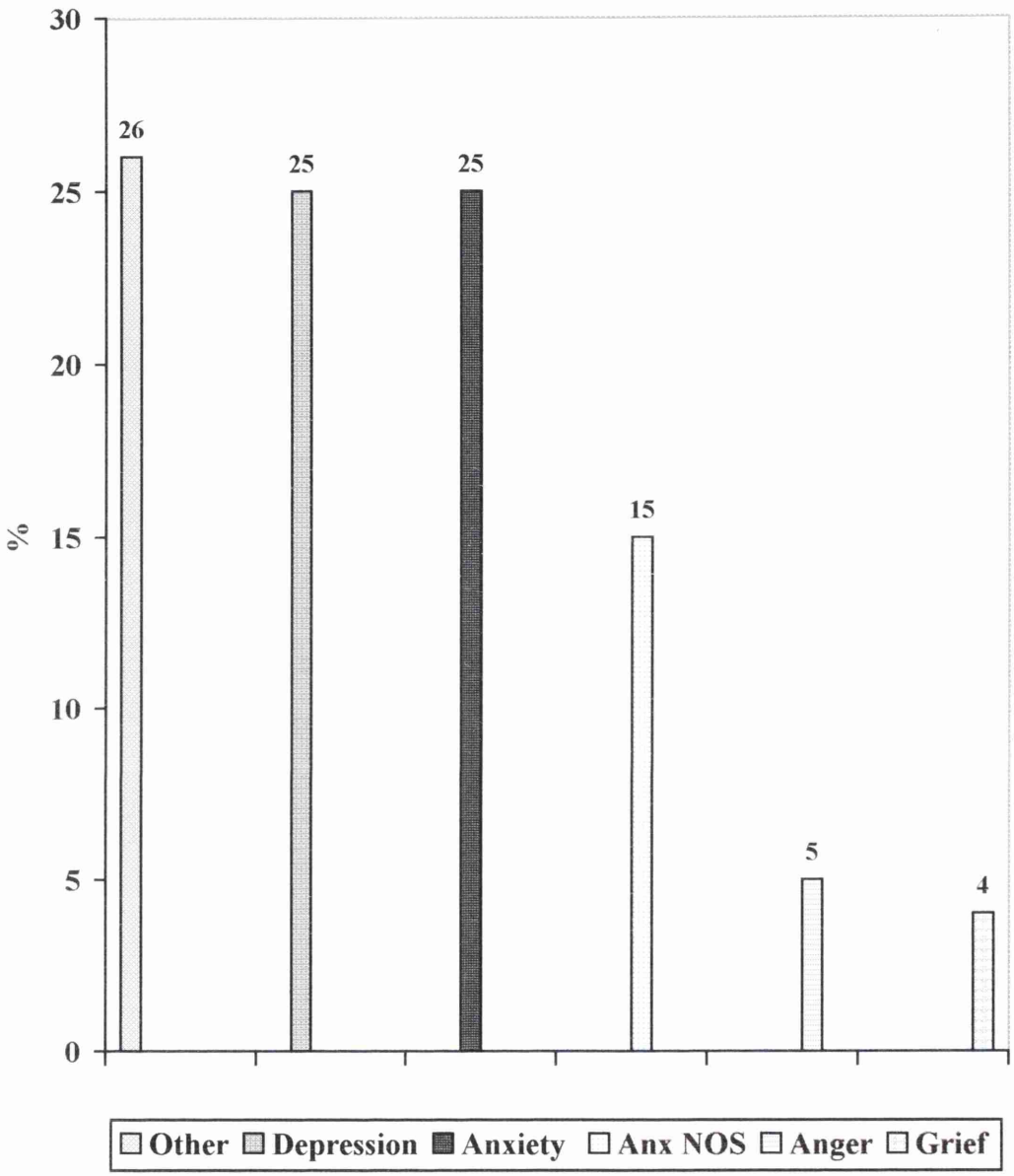


Figure 1.2: **Types of Problems**



MAJOR RESEARCH PROJECT LITERATURE REVIEW

Autobiographical Memory, Dissociative Symptoms and Emotionally Traumatic Past Experiences in Adults with Borderline Personality Disorder (BPD):

A review of the existing literature.

Submitted in partial fulfillment of the requirements for the degree of

Doctorate in Clinical Psychology

Word count: 4812

Prepared for submission to the *British Journal of Clinical Psychology*

(Appendix 2.1 for contributors' notes)

Author:	Joy Airlie, Trainee Clinical Psychologist*
Running Title:	Autobiographical Memory, a review of the literature
Address for correspondence:	The University of Glasgow Department of Psychological Medicine
	Gartnavel Royal Hospital
	1055 Great Western Road,
	Glasgow G12 0XH
Telephone number:	0141 211 3920
Fax Number:	0141 357 4899.
E-mail address:	joyairlie@yahoo.co.uk

* author for correspondence

Objective

The purpose of this review is to examine the existing autobiographical memory research literature with a view to considering its applicability in Borderline Personality Disordered (BPD) patients. Due to the paucity of literature on autobiographical memory in patients with BPD, the existing literature, pertaining to populations which are of clinical relevance to the Borderline Personality Disorder population, is considered. This review aims to make recommendations for future autobiographical memory research, with BPD patients in particular, and aims to highlight the clinical implications for understanding autobiographical recall in psychologically disordered populations.

Method

The relevant published material was identified through computerized literature searches of Medline and PsychInfo (to June 2001) using the following key words: Autobiographical Memory, Depression, Childhood Trauma and Borderline Personality Disorder.

Results

A number of studies have reported that clinical groups may be characterised by a more over-general style of autobiographical recall, however, the process behind the development of such a style of recall is not yet fully understood. Several studies have indicated the role that depression plays, although a lack of consistency between the methods used to determine current depressed states prevents firm conclusions from being drawn from the available literature. There is some evidence to suggest that early traumatic experiences may play a role in over-general recall, yet little work has been done in this area. To date, only one study has assessed autobiographical recall in patients with Borderline Personality Disorder. Although this study indicates that BPD subjects demonstrate an over-general bias in their recall, methodological considerations prevent conclusions, with regards to the correlates of this deficit, from being established.

Conclusion.

Further studies, ensuring tighter and more consistent control over the effects of depression are necessary. In addition, studies investigating the role of early traumatic experiences may help to clarify the origins and clinical implications of these reported deficits.

Running title: Autobiographical memory, a review of the relevant literature.

Introduction

Borderline Personality Disorder (BPD) has more recently become the subject of intense theoretical and clinical investigation (Herman, Perry & van der Kolk, 1989). These patients have been found to be high users of mental health services (Swartz, Blazer, George & Winfield, 1990) yet, it is generally agreed that individuals diagnosed with BPD are particularly difficult to treat (Herman *et al*, 1989). A notable feature of this particular group is their somewhat complex presentation as depression (Pope, Jonas, Hudson, Cohen & Gunderson, 1993), dissociative symptomatology (Jones *et al,* 1999), and recurrent parasuicidal behaviour are particularly prevalent, (Keherer & Linehan, 1996). In addition, over the past decade, numerous studies have highlighted the frequent occurrence of trauma and neglect in the childhood experience of patients with BPD (Sabo, 1997).

Over recent years knowledge about autobiographical memory in the emotional disorders has steadily accumulated and this construct has been associated with depression (Williams, 1996), dissociative symptomatology (Jones *et al,* 1999), parasuicide & problems solving abilities (Evans, Williams, O'Loughlin & Howells, 1992) and a past history of traumatic childhood experiences (Williams, 1996). Yet, many questions remain unanswered and future research is needed in order to improve our understanding of the causes and potential implications of such recall deficits.

Due to the multifaceted presentation of BPD, an investigation into the inter-relationships between these variables may be possible and this may provide further insight into the understanding of autobiographical memory and its correlates. However, to date only one such study exists (Jones *et al,* 1999). Although this study indicates some interesting results, which will be discussed later in this review, the paucity of existing literature, regarding autobiographical memory in BPD, would imply the need to draw from studies across a wider range of clinical disorders. Therefore, this review aims to systematically examine the available autobiographical memory literature and make recommendations for future autobiographical memory research in patients with BPD in particular. The clinical implications for understanding autobiographical recall in psychologically disordered populations will also be considered.

Autobiographical Recall

'Autobiographical recall' refers to memory of information relating to oneself. It provides knowledge of who we are and what our experiences have been, and it is upon this that we base our predictions for the future (Brewer, 1995). Brewer (1995) suggests that when an individual recalls a 'specific' episode from his/her past experience the memory recalled contains information about place, actions, persons, objects, thoughts and affect.

Earlier studies of autobiographical memory investigated latencies to respond to positively or negatively valenced words. Williams & Broadbent (1986) were the first to describe a more qualitative aspect of autobiographical recall, namely 'response specificity'. In comparison to hospital controls, they found that a group of parasuicide patients' relatively longer latencies to respond to positively cued words, in particular, was associated with their tendency to produce more over-general responses. This study has been described as being instrumental in drawing researchers' attention towards 'response specificity' in autobiographical memory (Wessel, Meeren, Peeters, Arntz & Merckelbach, 2001), and subsequent research has indicated that retrieval style is more consistently reported across studies than retrieval latency (Kuyken & Brewin, 1995).

Subsequent studies of autobiographical recall have classified response styles as being either 'specific' or 'over-general'. Specific memories are described as memories containing an explicit description of a 'one-moment-in-time event' (Rubin, 1995). Williams & Dritschel (1992) have subdivided over-general responses into 'extended' over-general memories, referring to descriptions of events over an extended period of time, such as 'during my undergraduate days, or 'categoric' over-general memories, describing generic summaries of events such as 'drinking in pubs' (Kaney, Bowden-Jones & Bentall, 1999). Over-general recall has been described as a normal developmental phase preceding the development of 'specific-event' memory, said to emerge around the age of 3–4 (Williams, 1997). During this initial phase children tend to provide over-general responses to questions about events, even when an event has been quite out-with the normal day to day experiences.

Existing literature indicates that patients suffering from a variety of psychological disorders, display similar autobiographical deficits. When asked to recall a specific memory from their past, in response to a positive, negative or neutral cue word, participants from such groups tend to experience difficulties retrieving 'specific' autobiographical memories, instead they tend to respond with more 'over-general' memories when compared with control groups (Williams, 1996). In attempting to understand what may link these different patient-groups, attention is drawn to the considerable evidence suggesting that autobiographical memory disturbance is associated with depression (Williams & Broadbent, 1986; Brittlebank, Scott, Williams & Ferrier, 1993; Kuyken & Dalgleish, 1995).

Autobiographical memory deficits in depression

Existing literature now provides substantial evidence to suggest that autobiographical recall disturbance is associated with depression (Moore, Watts & Williams, 1988) and some suggest that such deficits may be a symptomatic feature of depressive phenomenology (Wessel *et al*, 2001). Throughout this literature, two main arguments exist. Some authors argue that autobiographical recall deficits are associated with the individual's present mood state, whereas others suggest that such deficits reflect a more stable trait. It is argued that this may indicate individuals who may be more vulnerable to emotional disturbance. The evidence for both will now be discussed.

1. Over-general recall as a marker of current mood-state.

There is some evidence to suggest that over-generality is simply a correlate of current depressed mood. When presented with emotionally valenced words and asked to provide a specific memory in relation to that word, depressed individuals have been found to respond with a more over-general recall style (Moore *et al*, 1988; Evans *et al*, 1992). These individuals tend to be more likely to respond with over-general 'categoric' (Williams & Dreitschel, 1992; Kuyken & Dalgleish, 1995), rather than 'specific' autobiographical memories, and some authors suggest that this is particularly true in response to positively valenced cue words (Moore *et al*, 1988; Merkelbach, Muris & Hoselenberg, 1996).

In a study by Kuyken & Dalgleish (1995), patients who met DSM-III-R criteria for a current major depressive episode had significantly more difficulty accessing specific autobiographical memories than non-depressed controls. Fourteen of the controls who, when retrospectively assessed, met criteria for a past episode of major depression did not display any deficits with regards to recall. The authors therefore concluded that such findings refute the idea that over-generality reflects a stable trait. Instead, they argue that the deficit observed in the depressed individuals appeared to reflect a state-effect of depression, as indexed by a current diagnosis of a major depressive episode. Although severity of current depressed mood was assessed using the Beck Depression Inventory (BDI), this variable was not included in any of the analyses, thus preventing any conclusions being drawn with regards to the association between 'severity' of current mood state, as reflected by self-report measures.

Wilhelm, McNally, Baer & Florin (1997) studied autobiographical recall in patients diagnosed with obsessive compulsive disorder (OCD). This study provided further evidence supporting the role of depression in over-general recall. They found that, as a group, patients who met DSM-III-R criteria for OCD demonstrated an over-general bias in their responses when compared to a normal control group. The authors then divided the OCD patients into two sub-groups: medicated versus non-medicated patients. Initial analyses indicated that medication status played a significant role in over-generality as the medicated group were significantly more over-general than the non-medicated group. However, the results from the Structured Clinical Interviews for DSM-III-R (SCID), used to screen for primary and co-morbid diagnoses, indicated that the medicated group were significantly more depressed than the non-medicated group. A subsequent comparison was made between the medicated OCD patients who fulfilled criteria for the diagnosis of a major depressive disorder with the medicated participants who did not meet criteria. The former group were found to be significantly less specific than the medicated OCD patients who did not meet criteria for major depression. Furthermore, having compared the non-medicated (therefore non-depressed) group with the normal control subjects, no significant differences were observed between these two groups. The authors concluded that such evidence strongly suggested that over-generality was attributable to the presence of comorbid major depression in the patient group and not to the diagnosis of OCD or medication status *per se*. As with the previous study, self-report measures of depression severity

were only used as an initial screening measure to reflect the differences between the two original groups. Clinical diagnoses were relied upon for the main analyses.

Goddard, Dreitschel & Burton (1997) were interested in investigating whether the recall deficits reported among clinical samples, could be found among a non-clinical group of participants who reported depressive symptomatology and these authors decided to make use of the BDI, a self-rating questionnaire assessing current severity of mood. Thirty-two student volunteers were recruited for this study, comprising two groups. The 'non-clinical' depressed group comprised individuals with BDI scores ≥ 15 and the control group comprised individuals with BDI scores ≤ 7. These authors found that an over-general response bias, previously associated with clinical depression, was demonstrated by a non-clinically depressed sample. Thus supporting the association between current mood state and over-generality. This study indicates that severity of current mood state, as indexed by a self-report measure, is associated with reported recall deficits.

Until this point, the studies mentioned above have based their analyses on either a clinical diagnosis for major depression or a self-rating measure of current depression severity. More recently, Wessel *et al* (2001) assessed autobiographical memory style in participants recruited from local anxiety and mood disorders clinics and decided to make use of both clinical diagnoses and self-report measures of depression severity. The initial analyses identified a clear association between a current diagnosis of major depressive disorder and reduced recall specificity in their sample. No association was reported between remitted depression and over-general memories, from which the authors concluded that this absence of an association between remitted depression casts doubt on arguments that over-general autobiographical memory reflects a stable trait (Wessel *et al*, 2001).

In order to investigate to what extent depression severity predicts autobiographical memory specificity, the contribution that the participants' self-report measures of depression made to the variance in scores on the AMT was assessed. Self-reported depression severity failed to significantly contribute to the variance in scores on the AMT. Only a current clinical diagnosis of MDD significantly predicted performance on the

AMT, thus contesting Goddard *et al*'s (1997) findings concerning the association between current severity of mood state and over-generality.

Taken together, these studies would appear to suggest that autobiographical recall is related to current mood as indexed by either a clinical diagnosis or a self-report measure of depression. However, further investigation is needed in order to clarify which measure of current mood may be the most appropriate, this way the promotion of a more consistent measure of current mood state can be established.

2. Over-general recall as a stable-trait marker, indicative of emotional vulnerability

Despite the findings from the aforementioned studies, the existing literature also provides a respectable body of evidence to suggest that a lack of specificity is not necessarily mood-dependent but may reflect a stable trait in individuals who are considered vulnerable to emotional disturbances, such as depression (Williams, 1996).

Three main studies assessing autobiographical recall in parasuicide patients reflect similar results. Sidley, Whitaker, Calam & Wells (1997) demonstrated that parasuicide patients were more over-general in their recall style, similar to depressed and other clinical samples. However, consistent with the suggestions that this particular style of recall could be attributed to a more stable trait, as opposed to reflecting the individual's current mood state, these authors found no association between over-generality and current levels of depression, as indexed by participants BDI scores. Williams & Dritschel (1988) also reported that over-generality was not associated with transient mood levels in an early study of autobiographical memory in parasuicidal patients. Such findings were supported by Brittlebank *et al* (1993) who assessed 13 parasuicide patients across three different time periods, initially on admission following their self-harm incident and then at 3 and 7 months follow-up. No control group was used in this study, instead a within-subjects repeated measures design was employed. The authors concluded that, despite a gradual reduction in self-reported depression scores, as measured by the Hamilton Rating Scale for Depression (HRSD), this group were seen to display significant difficulties in retrieving specific autobiographical memories across time. They argue that such findings support the theory that over-generality reflects a stable trait rather than

a state of mind marker. In addition, the authors found that performance on the AMT at baseline predicted recovery from depression at 7 months follow-up and argued that assessment of autobiographical recall style may help to identify individuals who may be more vulnerable to emotional disturbance, such as depression. Again, no clinical diagnoses of current depressed state were made, and reliance was made solely on self-report measures of depression severity.

Merckelbach *et al* (1996) studied autobiographical memory in 194 undergraduate university students. Their results produced no evidence to suggest a positive association between over-general memories and current self-reported levels of depression. Similarly, Kuyken & Brewin (1995) reported that the severity of current levels of depression, as indexed by self-reported BDI scores, was unrelated to any aspect of memory performance. This study assessed autobiographical recall in 56 patients who met DSM-III-R criteria for a major depressive episode, although their diagnosis was not used as part of the analysis. However, further investigation highlighted the number of previous depressive episodes and the tendency to be over-general was significantly associated with this. Taken together, these results would suggest that rather than reflecting the individual's current mood state, the tendency to be over-general may be related to a more stable trait. However, it may have been interesting to include current diagnosis into the analyses.

The above studies highlighted that the over-generality observed across the different samples, appeared to be unrelated to current depressed state, as indexed by self report measures of depression. Such findings would lend support to the suggestion that the tendency for emotionally disturbed individuals to be over-general may be due to a pre-morbid (*i.e.* trait) cognitive style and current life crises (Brittlebank *et al*, 1993; Williams & Dritschel, 1988).

However, across each of the aforementioned studies, investigating the association between autobiographical memory and depression - state or trait, there appears to be an inconsistency in the measures used to assess depression, thus preventing clear conclusions from being drawn at this time. Further investigation is therefore needed in order to clarify which measure of current mood may be the most appropriate. This may be achieved by making use of both current clinical diagnoses and self-report

measures of depression levels within studies in order to clarify the relationship between autobiographical memory and depression.

'Over-general' autobiographical recall as a particular cognitive style

Consistent with the suggestion that over-general recall style may reflect a stable trait in individuals who may be more vulnerable to emotional disturbances, attention is now drawn to the evidence which implies that over-generality is a particular cognitive style. Williams & Dreitschel (1992) propose that 'over-general' memories are the product of a certain cognitive style. According to this view, negative life events lead to a cognitive style that focuses on the affective dimensions of experiences (Merckelbach *et al*, 1996), the peripheral details of which are not memorized, resulting in 'over-general' recall. An inability to retrieve 'specific' memories would then permit avoidance of affectively charged, unwanted memories (Harvey, Bryant & Dang, 1998). Williams, Watts, MacLeod & Mathews (1997) suggests that avoidance of 'specific' memories following adverse life experiences leads to an over-elaboration of 'categoric' (generic) summaries of past events (Kaney *et al*, 1999).

Williams (1996) proposes that individuals, who suffer negative events in childhood, continue to retrieve in 'generic' form as a means of controlling their affect, rather than progressing to the next developmental phase which would facilitate the retrieval of more specific information (Williams,1997). However, Morton (1990) argues that memories for more specific details of an event are present and can be elicited with careful questioning. Such a view is supported by van den Hout, Merckelbach & Pool (1996) who argue that while patients may be unable to explicitly recall autobiographical details, objective tests may reveal that the pertinent information is in fact stored in memory. This idea, that over-general recall style facilitates the avoidance of certain 'unwanted' memories, is not dissimilar to what might be expected of dissociative symptomatology.

Dissociation and over-general autobiographical recall, two related constructs?

As mentioned at the outset, dissociation is not an uncommon correlate of BPD. It has been conceptualized as being an initially adaptive response to traumatic events (*e.g.* Putnam,1989) by promoting the

compartmentalization of traumatic experiences, thus reducing their impact (Merckelbach *et al*, 2001). Memory problems have been implicated in relation to dissociative disorders (van den Hout *et al*, 1996), and more specifically, the main aspect of memory functioning affected in dissociative disorders is indeed autobiographical memory (Kihlstrom, Tataryn & Hayt, 1993; van den Hout *et al*, 1996). The presence of a dissociative disorder is believed to preclude access to certain autobiographical memories (Bryant,1995; Schacter, Kihlstrom, Kihlstrom & Berren, 1989) and a history of trauma is associated with this impeded retrieval (Kuyken & Brewin,1995). Numerous clinical studies have highlighted that elevated levels of dissociation are significantly associated with histories of traumatic experiences (Putnam *et al*, 1996) and there are now some indications that over-general autobiographical recall may also be present in individuals who have suffered some form of psychological trauma.

A common link between these two constructs appears to be the supposition that individuals may fear certain emotions and may strive to avoid thoughts, memories or situations that they expect to elicit their emotions. This would suggest that, by facilitating avoidance of such thoughts or memories, these two constructs might indeed share a similar role. One might therefore expect measures of over-general autobiographical recall and levels of dissociation to be associated and there is some evidence to suggest that they are (Jones *et al,* 1999).

Over-general autobiographical memory in relation to past trauma

Existing literature highlights the relationship between difficulties in recalling 'specific' personal memories and a history of past trauma (McNally, Prassas, Shin & Weathers, 1994; McNally, Lasko, Macklin & Pitman, 1995; Kuyken & Brewin,1995; Kaney *et al*,1999), suggesting that over-general retrieval style might represent a specific response to traumatic events. Self-reported trauma is therefore not only relatively high in subjects suffering from dissociative disorders but also in subjects with other psychiatric diagnoses such as depression, eating disorders (van den Hout & Pool, 1996) and BPD (Sabo, 1997).

McNally *et al* (1994) and McNally *et al* (1995) studied autobiographical recall in a group of Vietnam veterans suffering from PTSD. This group was reported to have demonstrated an over-generality in their

recall, independent from the effects of depression. Similar results were found by Harvey *et al* (1998) in a study of acute stress disordered (ASD) participants. These subjects reported fewer specific memories to positive cue words, again, even when the influence of depression, as indexed by self-report measures, was controlled for. However, it may not be possible to completely rule out the possible effect of depression on these patients' performances, as the previously highlighted questions regarding the association between self-report measures of depressed mood and autobiographical recall may well raise questions about the use of self-report measures of depression severity. Only one study, to date, has indicated an association between self-reported measures of depression and over-generality (Goddard *et al,* 1997), the remaining studies having either reported no such associations or failed to investigate this relationship. Further research should aim to clarify this question.

Harvey *et al* (1998), also reported that non-specificity in recall was reported to be a significant predictor of PTSD symptomatology at 6 months post trauma, consistent with earlier suggestions that over-general memory could predict failure to recover from depression (Brittlebank *et al*, 1993). The authors explain that their findings support McNally *et al*'s (1994) earlier conclusions that over-generality causes vulnerability to emotional disturbance and maintenance of the post traumatic disturbance. They propose that it would be expected that individuals who develop pathological trauma reactions would have impaired ability to access and integrate positive specific memories.

Existing evidence suggests that exposure to trauma in childhood may result in over-general autobiographical memory. For example, in the study mentioned earlier by Kuyken & Brewin (1995), when studying a group of women who met DSM-III-R criteria for a major depressive episode, over-general memories were found to be especially over represented in patients who had reported childhood sexual abuse in comparison to a group of depressed patients with no such reports. This was said to be true even after the effects of depressed mood, as indexed by the BDI scores, were controlled for. Again, these authors' previous findings of over-generality were associated with patients' clinical diagnosis and no such association was investigated with regards to their BDI scores. It may therefore be possible that if there is no such association between self-reported depression severity and over-generality, it would be inaccurate

to consider that this is an appropriate method of controlling for the effects of depression. Especially when 'depression' was originally accounted for by an alternative measure, namely the clinical diagnosis of current depression. The use of the two measures might imply that two slightly different phenomena are being measured and indeed it appears that the clinical diagnosis is a somewhat more objective evaluation of current mood state, whereas self-report measures tend to be more subjective. Further research is required in order to clarify the association that over-general recall has with depression.

Consistent with the association between autobiographical recall and past trauma, Kaney *et al* (1999) found that a group of participants, who met DSM-III-R criteria for a diagnosis of delusional disorder, were significantly more over-general than a normal control and depressed group. The authors discussed the possibility that early adverse experiences may have contributed to this recall style. Such findings concur with Williams' (1996) argument that traumatized children might adopt and persist in a general retrieval style in order to avoid memories of intensely adverse experiences.

Taken together these studies lend support to the possibility that 'over-general' retrieval style might represent a stable trait in patients who have experienced severe traumatic life events. However, the effects of depression cannot be completely ruled out due to methodological considerations, and in addition, two recent studies cast doubt on the association between childhood trauma and over-generality. In a study, previously mentioned, by Wilhelm *et al* (1997), these authors investigated the association between over-generality and past trauma in their group of OCD patients. No such association was found and the authors concluded that, contrary to previous findings, childhood trauma may not be a necessary antecedent to over-general memory in adulthood. Similar findings were found in a recent study by Wessel *et al* (2001). They too conclude that the lack of association between over-generality and past trauma casts doubts on theories emphasizing the role of childhood trauma in over-general autobiographical recall. Further research is recommended in order to clarify whether these two variables are associated, and stricter control over the effects of depression is necessary to ascertain more reliable results.

Clinical implications for assessing autobiographical recall

It has been argued that over-general recall appears to be a phenomenon of general clinical importance and may possibly underpin the problem solving deficits found in parasuicide, and perhaps other clinical samples (Sidley & Calam, 1997). Another implication for assessing autobiographical recall is its potential prognostic value. The evidence to support these suggestions will now be considered.

1. Over-general recall reflecting a problem solving deficit

Beck (1979) discussed the implications that over-general statements have on problem solving, in his early theoretical work. This association has since been demonstrated in studies of autobiographical memory as 'over-general' recall has subsequently been explained as a problem-solving activity and some authors have argued that the main consequence of over-general recall is compromised problem-solving abilities (*e.g.* Williams & Dreitchel, 1988). Evans *et al* (1992) studied the relationship between autobiographical recall and problem solving abilities in a group of parasuicide patients. Consistent with previous findings (Williams & Broadbent, 1986; Williams & Dreitschel, 1988), this group were more likely, than matched controls, to retrieve over-general autobiographical memories, significantly in relation to positive cues. In this study it was hypothesized that, during a crisis, access to specific positive events would be impaired and the generation of useful problem-solving strategies would be affected. A significant correlation between low effectiveness of problem solving strategies and over-general recall in this group supports this hypothesis, and Evans argues that the definition of a problem and the generation of alternative solutions demands an ability to address adequately the memory 'database'. Williams & Dreitschel (1992) argue that over-general response bias may therefore make it harder for patients to remember both experiences of mastery and techniques used to overcome difficulties, resulting in a need to prioritise problem solving training techniques.

2. Over-general recall determining outcome

The importance of 'specificity' in predicting intervention outcome has also been demonstrated in a number of studies. Wahler & Afton (1980) discovered that women who had persistent difficulty in recalling specific incidents of parent-child interactions failed to demonstrate significant improvement

throughout a Parent Training Programme. In terms of its prognostic value, difficulties accessing specific personal memories has been related to emotional disturbance (Williams, 1996) and is said to strongly predict failure to recover from depression. The more over-general the patient's memory tends to be, the more unlikely it is that he or she will improve (Brittlebank *et al,* 1993). This has been supported throughout recent cognitive models of responses to trauma, suggesting that disrupted retrieval processes, reducing optimal recall of traumatic memories, may mediate post-traumatic adjustment. Foa & Hearst-Ikeda (1996) present an information-processing model which holds that trauma adaptation requires the processing of traumatic memories in a manner that permits habituation to the associated distress and integration of new information. Impaired access to autobiographical memories of trauma may impede this therapeutic process.

Implications for investigating autobiographical memory in borderline personality disorder

The existing literature indicates a number of correlates with over general recall style, including depressive phenomenology, histories of past trauma, dissociative experiences, and ineffective problem solving abilities. However, equivocal and often conflicting findings leave many questions unanswered. In order to understand autobiographical recall further, it may be useful to assess a clinical group in which the aforementioned variables are common and one such group, whose psychopathology has been described as multifaceted (Jones *et al,* 1999), is borderline personality disordered (BPD) patients.

In a recent study by Jones *et al,* (1999) it was hypothesized that, due to their complex presentation which involves many of the variables in which autobiographical recall has been associated, BPD patients would demonstrate similar recall deficits, as have been identified in other clinical populations. The possible relationship between autobiographical recall deficits and dissociation was also investigated. The results from this study suggested that BPD subjects tended to respond in an over-general style and that this appeared to be associated with their tendency to dissociate. From this observation the authors suggested that over-generality might facilitate avoidance of emotional information as a means of controlling their affect. However, despite evidence that over-general recall and dissociation may be related to self-reported histories of emotional trauma (DiTomaso & Roth, 1993), Jones *et al* did not formally evaluate such a

relationship.

These authors made use of a self-report measure of depression, and due to poor associations with the tendency to be over-general, the authors concluded that response specificity was not related to depressed mood. However, bearing in mind the previous argument regarding the use of self-report measures, this would suggest that Jones' conclusions must be interpreted with caution. Despite higher affect scores in the clinical group, Jones *et al* did not control for the effects of depression on recall and, given the available literature on the potential relationship between over-generality and depression, this would seem to be an imperative consideration in such a study.

Conclusions & Recommendations

The existing literature demonstrates that research on autobiographical memory highlights various potential correlates to over-generality. To date, findings suggest that some individuals, in particular depressed patients and/or those who have previously experienced trauma, may be at risk of developing an over-general recall style.

(Insert Figure 2.1 here)

Figure 2.1 illustrates the main studies reflecting the movement and convergence of findings regarding the relationship between autobiographical recall deficits, depression and past trauma. As can be seen from this illustration the origins to the development of this retrieval style are not yet conclusive and therefore future research is recommended.

Understanding auto-biographical recall may be of general clinical importance as the evidence suggests that over-generality may underpin problem solving deficits (Sidley & Calam,1997). Effective problem solving may be reliant on satisfactory retrieval of specific autobiographical memories as Williams (1996) argues that such memories are likely to provide a helpful and varied database from which to construct solutions to important real life problems. Poor problem solving abilities are frequently indicated among patients with BPD, reflected in their high rates of parasuicidal behaviours. Therefore a better understanding of this phenomenon may be of clinical importance with regards to helping understand and

treat this group. The multifaceted presentation of borderline personality disorder may provide researchers with an opportunity to investigate the inter-relationships between the various variables previously implicated in the existing literature. Although one such study exists, methodological considerations prevent definitive conclusions from being drawn and further research is therefore warranted. Tighter control over the effects of depression are needed as well as an evaluation of the two methods for assessing current mood state (diagnosis and self-report data). A measure of childhood trauma would facilitate the investigation of the hypothesised relationship between the tendency to be over-general and past traumatic events.

References

Beck, A.T. et al. (1979). *Cognitive Therapy of Depression.* Guilford:Guilford Press.

Brewer, W. F. (1995). What is Recollective Memory? In D. Rubin (ed.) *Remembering our Past: Studies in Autobiographical Memory,* pp.19-66. Cambridge: Cambridge University Press.

Brittlebank, A. D., Scott, G., Williams, J. M. G., & Ferrier, I. N. (1993). Autobiographical memory in depression: state or trait marker? *British Journal of Psychiatry,* 162, pp.118–121.

Bryant, R. A. (1995). Autobiographical memory across personalities in dissociative identity disorder: A case study. *Journal of Abnormal Psychology,* 104, pp.625-631.

DiTomaso, M. J., & Roth, D. K. (1993). Recall of abuse in childhood and three measures of dissociation. *Child Abuse and Neglect,* 17, pp.477-485.

Evans, J., Williams, J. M. G., O'Loughlin, S., & Howells, K. (1992). Autobiographical memory and problem solving strategies of parasuicide patients. *Psychological Medicine,* 22, pp.399–405.

Foa, E. B., & Hearst-Ikeda, D. (1996). Emotional Dissociation in response to trauma: an informatin-processing approach. In L. K. Michelson & W. J. Ray (Eds), *Handbook of Dissociation: Theoretical and clinical perspectivies (pp.207 –22).* New York: Plenim Press.

Goddard, L., Dritschel, B., & Burton, A. (1996). The role of autobiographical memory in social problem-solving and depression. *Journal of Abnormal Psychology,* 105, pp.609–616.

Harvey, A. G., Bryant, R. A., & Dang, S. T. (1998). Autobiographical memory in acute stress disorder. *Journal of Consulting and Clinical Psychology,* 3, pp.500–506.

Herman, J.L., Perry, C., & van der Kolk, B.A. (1989). Childhood Trauma in Borderline Personality Disorder. *American Journal of Psychiatry,* 146: pp.490-495.

Jones, B., Heard, H., Startup, M., Swales, M., Williams, J. M. G., & Jones, R. S. P. (1999). Autobiographical memory and dissociation in borderline personality disorder. *Psychological Medicine,* 29, pp.1397–1404.

Kaney, S., Bowen-Jones, K., & Bentall, R. P. (1999). Persecutory delusions and autobiographical memory. *British Journal of Clinical Psychology,* 38, pp.97–102.

Keherer, C. A., & Linehan, M. M. (1996). Interpersonal and Emotional Problem Solving Skills and Parasuicide among Women with Borderline Personality Disorder. *Journal of Personality Disorders,* 10(2), pp.153-163.

Kihlstrom, J. F., Tataryn, D. J., and Hoyt, I. P. (1993). Dissociative Disorders. In P. B. Sutker & H. E. Adams. *Comprehensive Handbook of Psychopathology* (2nd ed.). New York: Plenum Press.

Kuyken, W., & Dalgleish, T. (1995). Autobiographical Memory and Depression. *British Journal of Clinical Psychology,* 34, pp.89–92.

Kuyken, W., Brewin, C. R. (1995). Autobiographical Memory Functioning in Depression and Reports of Early Abuse. *Journal of Abnormal Psychology,* 104, pp.585–591.

van den Hout, M., Merckelbach, H. & Pool, K. (1996). Dissociation, Reality Monitoring, Trauma, and Thought Suppression. *Behavioural and Cognitive Psychotherapy.* 24, pp.97–108.

McNally, R. J., Litz, B. T., Prassas, A., Shin, L. M., & Weathers, F. W. (1994). Emotional Priming of Autobiographical Memory in Post-Traumatic Stress Disorder. *Cognition and Emotion,* 8, pp.351–367.

McNally, R. J., Lasko, N. B., Macklin, M. L., & Pitman, R. K. (1995). Autobiographical Memory Disturbance in Combat-Related Post-Traumatic Stress Disorder. *Behaviour Research and Therapy,* 33, pp.619–630.

Merckelbach, H., Muris, P., & Horselenberg, R. (1996). Correlates of Overgeneral Memories in Normal Subjects. *Behavioural and Cognitive Psychotherapy,* 24, pp.109–115.

Moore, R. G., Watts, F. N., & Williams, J. M. G. (1988). The Specificity of Personal Memories in Depression. *British Journal of Clinical Psychology,* 27, pp.275-275.

Morton, J. (1990). The Development of Event Memory. *The Psychologist,* 1, pp.3–10.

Pope, H. G., Jonas, J. M., Hudson, J. L., Cohen, B. M., & Gunderson, J. G. (1993). The Validity of DSM-III Borderline Personality Disorder. *Archives of General Psychiatry,* 40, pp.23–30.

Putnam, F. W., Carlson, E. B., Ross, C. A., Anderson, G., Clark, P., Torem, M., Bowman, E. S., Coons, P. H., Chu, J. A., Dill, D. L., Laewenstein, R. J., & Braun, B. J. (1996). Patterns of Dissociation in Clinical and Non-clinical Samples. *Journal of Nervous and Mental Disease*, 184, pp.673–679.

Putnam, F. W. (1989), Pierre Janet and Modern Views of Dissociation. *Journal of Traumatic Stress,* 2, pp.413–429.

Rubin, R. C. (1995). Remembering Our Past: Studies in Autobiographical Memory. Cambridge University Press: Cambridge.

Sabo, A. N. (1997). Etiological Significance of Associations between Childhood Trauma & Borderline Personality Disorder: conceptual and clinical implications. *Journal of Personality Disorders,* 11(1), pp.50-70.

Schacter, D. L., Kihlstrom, J. F., Kihlstrom, L. C. & Berren, M. B. (1989). Autobiographical Memory in a case of Multiple Personality Disorder. *Journal of Abnormal Psychology,* 98, pp.508-514.

Sidley, G. L., Whitaker, K., Calam, R. M. & Wells, A. (1997). The Relationship between Problem Solving and Autobiographical Memory in Parasuicude Patients. *Behaviour and cognitive Psychotherapy,* 25, pp.195–202.

Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the Prevalence of Borderline Personality Disorder in the Community. *Journal of Personality Disorders,* 4, pp.257-272.

Wahler, R. G., & Afton, A. D. (1980). Attentional Processes in Insular and Non-insular Mothers: Some differences in their summary reports about child problem behaviours. *Child Behaviour Therapy,* 2, pp.25-41.

Wessel, I., Meeren, M., Peeters, F., Antz, A., Merckelbach, H. (2001). Correlates of Autobiographical Memory Specificity: the role of depression, anxiety and childhood trauma. *Behaviour Research Therapy,* 39, pp.409-421.

Wilhelm, S., McNally, R.J., Baer, L., & Florin, I. (1997). Autobiographical memory in obsessive-compulsive disorder. *British Journal of Clinical Psychology,* 36, pp.21 – 31.

Williams, J. M. G., Watts, F. N., MacLeod, C., & Mathews, A. (1997). Cognitive Psychology and Emotional Disorders, 2nd Ed. London: Routledge.

Williams, J. M. G. (1996). Depression and Specificity of Autobiographical Memory. In D. Rubin (ed.), *Remembering Our Past: studies in autobiographical memory,* pp.244 – 267. Cambridge University Press: Cambridge.

Williams, J. M. G. (1997). Cry of Pain: Understanding Suicide and Self-Harm. London: Penguin Books.

Williams, J. M. G., & Broadbent, K. (1986). Autobiographical Memory in Suicide Attempters. *Journal of Abnormal Psychology,* 95, pp.144 –149.

Williams, J. M. G., & Dreitschel, B. H. (1988). Emotional disturbance and the specificity of autobiographical memory. *Cognition and Emotion,* 2, pp.221–224.

Williams, J. M. G., & Dreitschel, B. H. (1992). Categoric and Extended Autobiographical Memories. In M. A. Conway, D. C. Rubin, H. Spinnler, & W. A. Wagenaar (eds.), Perspectives on Autobiographical Memory. London: Kluwer.

Williams, J. M. G., & Scott, J. (1988). Autobiographical Memory in Depression. *Psychological Medicine,* 18, pp.689–695.

Williams, M. D. & Hollan, J. D. (1981). The process of Retrieval from very Long Term Memory. *Cognitive Science.* 5, pp.87–119.

Figure

Figure 2.1: An illustration reflecting the movement and convergence of findings regarding the relationships between Autobiographical Memory (AM), Depression and Past Trauma.

Figure 2.1 Illustration of the main studies reflecting the movement and convergence of findings regarding the relationships between Autobiographical Memory (AM), depression and past trauma.

Autobiographical Memory Research

Earlier studies investigated latencies to respond to positively or negatively valenced words and indicated that clinical groups took longer to respond to positive cues in particular than control groups. Such findings were not consistently reported and **Williams & Broadbent (1986)** were first to describe 'response specificity' in relation to autobiographical recall. They discovered that a group of parasuicide patients' relatively longer latencies to respond to positive cues was associated with their tendency to produce more over-general responses. This study was considered instrumental in drawing researchers' attention from response latencies towards 'response specificity' and subsequent research has indicated that retrieval style is more consistently reported across studies than retrieval latencies (**Kuyken & Brewin, 1995**).

Overgenerality in Relation To Depression

Considerable evidence suggests that AM disturbance across the various clinical groups may be associated with depression (**Williams & Broadbent, 1986; Brittlebank *et al*, 1993 and Kuyken & Dalgleish, 1995**). The literature highlights 2 main arguments concerning overgeneral recall. One line of thought suggests that overgenerality is associated with the individual's present mood state whereas the other suggests that such deficits reflect a more stable trait.

State: **Kuyken & Brewin (1995)** found that patients who met DSM-III-R criteria for a current major depressive episode had significantly more difficulty accessing specific memories than non-depressed controls. Fourteen of the controls, who when retrospectively assessed met criteria for a past episode of major depression, did not display any deficits with regards to recall.

Wilhelm *et al* (1997) also found that a group of OCD patients who met DSM-III-R criteria for a co-morbid diagnosis of major depressive disorder were more overgeneral than both the OCD patients who did not fulfill such criteria and the normal controls. Thus concluding that it was the depressive element which differentiated the group who responded in a more overgeneral style.

Goddard, Dritschel & Burton (1997) found that an overgeneral response bias, previously associated with clinical depression, was demonstrated by a non-clinically depressed group, as rated by the self administered BDI.

More recently **Wessel *et al* (2001)** identified a clear association between a current diagnosis of major depressive disorder and overgenerality in their sample of patients drawn from local anxiety and mood disorder clinics. They reported no association between remitted depression and overgenerality, concluding that this casts doubt on the argument that overgeneral recall reflects a stable trait.

Trait: The findings from three main studies assessing autobiographical recall in parasuicide patients suggest that overgenerality may reflect a stable trait in patients perhaps more vulnerable to emotional disturbances such as depression (**Williams, 1996**). **Sidley *et al* (1997)** found that parasuicide patients were more overgeneral in their recall, similar to other clinical groups, yet this was not seen to be associated with current depressed mood as indexed by a self report measure of depression. **Williams & Dritschel (1988)** also found no association between the observed overgenerality in their group and transient mood levels in an earlier study of parasuicide patients. **Brittlebank *et al* (1993)** assessed 13 parasuicide patients across 3 different time periods found that despite a gradual reduction in self-reported depressed mood (indexed by scores from the Hamilton Rating Scale for Depression) this group were consistently seen to display significant difficulties in retrieving specific memories across time.

Merckelbach *et al* (1996) found no association between overgenerality and current self report levels of depression in a group of 194 university students. **Kuyken & Brewin (1995)** reported that the severity of current depression, as indexed by self report BDI scores, was unrelated to any aspect of memory performance.

Overgenerality in Relation To Past Trauma

The potential association between overgenerality, functioning as some kind of avoidant coping strategy, and trauma began to feature in the literature.

McNally *et al* (1995) reported that a group of Vietnam veterans suffering from PTSD demonstrated an overgenerality in their recall, however, depression was not controlled for in this study. **Harvey *et al* (1997)** found a group of acute stress disordered patients to be more overgeneral in their responses, particularly in response to positive cue words, even when the effects of depression, as indexed by a self-report measure of depression (BDI), were controlled for.

Kuyken & Brewin (1995) found that, in their sample of patients who met DSM-III-R criteria for a major depressive episode, overgeneral memories were seen to be over represented in patients who had reported childhood sexual abuse, in comparison to a group of depressed individuals who did not report such experiences. This was said to be true even after the effects of mood had been accounted for. However, whereas the association between overgenerality and depression was previously based upon clinical diagnoses, this evaluation was conducted with the self-rating measure. According to the literature, the use of self-rating measures of depression have not widely been associated with overgeneral autobiographical memory. Their findings may cast doubt on the conviction of such an association between past trauma and overgenerality, when depression is inadequately accounted for.

In the study conducted by **Wilhelm *et al* (1997)**, the occurrence of past trauma in the lives of these OCD patients was assessed in terms of its association with overgenerality. These authors report no association between overgenerality and past trauma. Similar results were reported by **Wessel *et al* (2001)**, they too conclude that a lack of association between childhood traumatic experiences and overgenerality casts doubt on the suggestions emphasizing the role of childhood trauma in overgeneral autobiographical memory.

MAJOR RESEARCH PROJECT PROPOSAL

Autobiographical Memory, Dissociative Symptoms and Emotionally Traumatic Past Experiences in Adults with Borderline Personality Disorder (BPD)

Joy Airlie, Trainee Clinical Psychologist

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Address for correspondence: Joy Airlie

Department of Psychological Medicine,

Faculty of Medicine

University of Glasgow,

Gartnavel Royal Hospital,

1055 Great Western Road,

Glasgow G12 0XH

Prepared in accordance with *The D. Clin. Psych. Trainee Handbook*

(Appendix 3.1 for course guidelines)

APPLICANTS:

Ms Joy Airlie — Trainee Clinical Psychologist

Dr Kate M. Davidson — Research Tutor

Department of Clinical Psychological Medicine

Academic Centre

Gartnavel Royal Hospital

1055 Great Western Road

Glasgow, G12 0XH

Title

Autobiographical Memory, Dissociative Symptoms and Past Traumatic Events in Borderline Personality Disorder (BPD).

Summary

This study aims to investigate whether patients with borderline personality traits have autobiographical recall deficits and, if present, are they similar or different in nature to those deficits reported in other psychologically disordered groups, according to the relevant literature. There is evidence to suggest that autobiographical memory deficits are displayed in people who have, or have had depression (Williams & Dritschel, 1992) and those who have experienced past traumatic life-events (McNally, Litz, Prassas, Shin & Weathers, 1994; McNally, Lasko, Macklin & Pitman, 1995). Such individuals have demonstrated a tendency to be 'over-general' in their recall of autobiographical memories and this response style has been associated with poorer problem-solving skills (Goddard, Dritschel & Burton, 1997), implying that identification of over-general recall may have clinical implications for designing interventions for groups displaying such a deficit. Given that both depression and past traumatic events are common in BPD it could be considered important to investigate this phenomenon within this group.

Until now, only one study has looked at autobiographical memory in BPD (Jones, Heard, Startup, Swales, Williams & Jones, 1999). The results from this study suggest that BPD subjects experience similar autobiographical memory deficits, as reported amongst patients suffering from a variety of psychological disorders, and their 'over-general' response style relates to their tendency to dissociate.

The aim of this study will be to broadly replicate existing findings in a sample of BPD patients compared with normal control subjects. This study also aims to elucidate the contributions depression and past traumatic experiences make to autobiographical memory.

Experimental groups will be recruited from Community Mental Health Teams (CMHT) within Greater Glasgow Primary Care, NHS Trust and Ayrshire and Arran Primary Care, NHS Trust. Each participant will be assessed using a range of standard clinical measures.

Introduction

Evidence suggests that patients suffering from a variety of psychological disorders have difficulties retrieving 'specific' autobiographical memories (McNally *et al*, 1994; Harvey, Bryant & Dang, 1998; Wilhelm, McNally, Baer & Florin, 1997; Kuyken & Dalgleish, 1995; Williams & Broadbent, 1986), instead they tend to respond with more 'over-general' memories when compared with control groups (Williams, 1996). 'Over-general' memory has been explained as a problem-solving activity and the main consequence of over-general recall is said to be compromised problem-solving abilities (Williams & Broadbent, 1986; Williams & Dritschel, 1988; Evans, Williams, O'Loughlin & Howells, 1992, Williams & Hollan, 1981).

Autobiographical memory disturbance has been displayed in individuals with depression (Moore, Watts & Williams, 1988; Williams & Scott, 1988). However the research reflects a certain degree of ambiguity with regards to the specific contribution depression makes to over-general memories. Where some studies support the role of current depressed mood (Williams & Scott, 1988) others suggest that when the effects of depression were controlled for, a group of acute stress disordered subjects continued to display recall

deficits, suggesting that depressed mood is not solely responsible for the reported deficits (Harvey, Bryant & Dang, 1998; Williams & Broadbent, 1986). The existing literature highlights the fact that the relationship between autobiographical memory and depression is not yet fully understood and therefore implicates the need for further investigation.

Williams & Dritschel (1992) propose that 'over-general' memories are the product of a certain cognitive style. According to this view, negative life events lead to a cognitive style that focuses on the affective dimensions of experiences (Merckelbach, Muris & Horselenberg, 1996), the peripheral details of those experiences are not memorised, resulting in 'over-general' recall. An inability to retrieve 'specific' memories would then permit avoidance of affectively charged, unwanted memories (Harvey, Bryant & Dang, 1998), similar to what might be expected of dissociative symptomatology. It has been proposed that individuals may fear certain emotions and may strive to avoid thoughts, memories or situations that they expect to elicit their emotion. Williams, Watts, MacLeod & Mathews (1997) suggest that avoidance of 'specific' memories following adverse life experiences leads to an over-elaboration of 'categorical' (referring to a generic) summary of past events (Kaney, Bowen-Jones, & Bentall, 1999). It has been argued that individuals who suffer negative events in childhood continue to retrieve in 'generic' form as a means of controlling their affect (Williams, 1996). Several studies have highlighted the relationship between difficulties in recalling 'specific' personal memories and a history of past trauma (McNally *et al*, 1994; McNally *et al*, 1995; Kuyken & Brewin, 1995; Kaney, Bowen-Jones & Bentall, 1999). Such studies support the possibility that 'over-general' retrieval style might represent a stable trait in patients who have experienced severe life events (Merckelbach, Muris & Horselenberg, 1996). However further research is required in order to investigate this association further.

Dissociation is said to be a response to psychologically overwhelming experiences (inducing fear and helplessness), especially in childhood (Draijer & Langeland, 1999). The propensity to dissociate has been related to a self-reported history of emotional traumatization (DiTomaso, & Roth, 1993). A study by van den Hout, Merckelbach & Pool (1996) investigated the relationship between past emotionally traumatic experiences, dissociative symptomatology and thought suppression. They found a relationship between

self-reports of traumatization and a tendency to dissociate and suggested that memory problems relating to trauma may be due to 'wilful forgetting', lending support to the suggestion that such a phenomenon may be a strategy for averting trauma related distressing emotions (Jones *et al*, 1999).

It is argued that memory problems are inherent to dissociation (van den Hout, Merckelbach & Pool, 1996), therefore, it is expected that autobiographical recall deficits and dissociation might be related. Also, as self-reported traumatization is associated with dissociative tendencies (van den Hout, Merckelbach & Pool, 1996) it is expected that evidence of past emotionally traumatic experiences may be related to dissociative symptomatology and recall deficits. Given the complex psychopathology of borderline personality disorder and its association with early traumatic experiences it is expected that such phenomena might be evident within this group.

A recent study by Jones et al (1999) has attempted to investigate such phenomena in borderline personality disordered (BPD) subjects. It was hypothesized that similar recall deficits, as reported amongst patients suffering from a variety of psychological disorders, would be found among individuals diagnosed with BPD. The possible relationship between autobiographical recall deficits and dissociation was also investigated. The results from this study suggest that BPD subjects do experience difficulties in recalling 'specific' autobiographical memories, responding with a more 'overgeneral' recall style when compared with a normal control group. Additionally, the BPD subjects provided a disproportionate number of over-general responses to negative cues, a finding that is qualitatively different in the pattern to other clinical samples. The overgeneral recall style was seen to relate to the subjects' tendency to dissociate. The authors concluded that the relationship between 'overgeneral' recall and a tendency to dissociate might be, at least partly, a result of past traumatic experiences or adverse early environments. Jones *et al* suggested that this recall style might be facilitating avoidance of highly emotional information as a means of controlling their affect. However, despite the evidence that an inability to recall 'specific' memories (McNally *et al*, 1994; McNally *et al*, 1995; Kuyken & Brewin, 1995; Kaney, Bowen-Jones & Bentall, 1999) and dissociation are related to self-reported histories of emotional traumatization (DiTomaso & Roth, 1993), Jones et al **[5]** did not assess the prevalence of early traumatic experiences, within this group

of individuals where histories of early traumatic experiences are common. Importantly, Jones *et al* did not control for the effects of depression, therefore future research should aim to address this point.

This current study will therefore attempt to replicate the results of Jones *et al* (1999) in order to investigate the autobiographical recall style of patients with BPD traits, and whether, if these deficits are present, they are associated with a particular cognitive style (e.g. dissociation) (Williams & Dritschel, 1992). In addition, the relationship between autobiographical recall style and past traumatic experience (Merckelbach, Muris & Horselenberg, 1996) and depression will be investigated.

AIMS:

1. Broadly replicate existing experimental work in relation to the specificity of autobiographical retrieval in a sample of BPD patients compared with a normal control group.

2. Assess cognitive style (in terms of dissociation) in order to evaluate the relationship between autobiographical memory and cognitive style.

3. Investigate whether autobiographical memory deficits are related to any past traumatic experiences.

Experimental hypotheses

- It is hypothesised that BPD subjects will show an over-generality in autobiographical recall when compared with a normal control group.

- It is hypothesised that BPD subjects will be more likely to dissociate when compared with a normal control group.

- It is hypothesised that BPD subjects will be more likely to report an early history of emotionally traumatic life events when compared with a normal control group.

- It is hypothesised that over-general recall, in BPD subjects, will be related to a specific cognitive style, namely dissociation.

- It is hypothesised that an early history of emotionally traumatic life events will be related to dissociation in BPD subjects.

- It is hypothesised that over-general recall will be related to an early history of emotionally traumatic life events in BPD subjects.

Methodology

Participants

In order for this study to have sufficient power ($\alpha = 0.05$ $p = 0.8$) to answer the questions that are being asked the number of participants required for this study was determined using a power analysis (Cohen, 1992). Based on a previous study, Jones *et al* (1999) recruited N=23 for the experimental group and N=23 for the control group, the power analysis indicated that at least 14 participants will be necessary for each group. Therefore, the aim of this study will be to recruit two groups, each with approximately 20 subjects, namely an experimental group and a matched control group.

The experimental group will consist of adults, aged 18-65 years, who meet criteria for a diagnosis of Borderline Personality Disorder as defined by the DSM-IV criteria for BPD. This will be ascertained using the BPD section of the SCID-II. This group will be drawn from local mental health services throughout Greater Glasgow and Ayrshire and Arran Primary Care, NHS Trusts. Clinical Psychologists, within CMHT departments throughout these areas, will be approached, whereby the researcher (JA) will explain the nature of the study. Clinicians will be asked to provide a summary of the study to individuals they consider to be appropriate for inclusion in the study. At this point clinicians will ask the individual for

permission to be contacted by the researcher (JA) who will explain the study in more detail. They will be assured that by agreeing to meet with JA, they will not be obliged to participate, as recruitment will be on a voluntary basis.

Subjects with a history of psychosis, schizophrenia, bipolar disorder, primary substance dependence, learning disabilities or any organic condition known to cause memory deficits will be excluded from the study. Due to the complex nature of borderline personality, it was expected that this group might display higher scores on measures of affect. Therefore measures for anxiety and depression will be controlled for across both groups.

The control group will be volunteers drawn from the general population, obtained throughout a hospital or university department. Such individuals will be matched for age, sex and level of qualification. They should not meet criteria for a diagnosis of Borderline Personality Disorder traits as defined by the DSM-IV criteria for BPD, ascertained using the BPD section of the SCID-II. Individuals with a current psychiatric disorder, any condition known to cause memory impairment or a history of psychiatric disorders, that required professional input, will be excluded from this study.

Following reading a study information sheet (Appendix 3.2), which will be retained by the individual, all participants will be asked to provide written consent (Appendix 3.3) before participating in this study, this will be documented in the experimental groups' clinical notes.

Measures

SCID-II (First, Spitzer, Gibbon & Williams, 1994)

The presence of BPD traits will be established using the Borderline Personality Disorder section of the Structured Clinical Interview for Personality Disorders. This is based on the diagnostic criteria in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994).

Beck Depression Inventory – (BDI) (Beck & Steer, 1993b)

A 21-item self-report questionnaire assessing cognitive, emotional and vegetative symptoms associated with depression.

Beck Anxiety Inventory – (BAI) (Beck & Steer, 1993a)

A 21-item self-report questionnaire that measures the severity of physiological and cognitive anxiety symptoms over the preceding week including the day of administration.

Autobiographical Memory Test – (AMT)

The study will adopt the AMT administration as described by Williams and Broadbent (1986) in which five positively valenced words (*happy, safe, interested, successful, surprised*) and five negatively valenced words (*sorry, angry, clumsy, hurt, lonely*) will be presented, on large printed cue cards (see Appendix 3.4), in a pseudo-random order. Positive and negative words will be alternately presented. Subjects will be asked to read each word and to try to think of a specific memory that comes to mind in relation to that word. The latency to the first word of each response made by the subjects will be recorded using a stopwatch. A time limit of 60 seconds will be allowed within which the subject will be required to provide a specific response before the next cue card is presented. If the first response is a general memory (e.g. to the cue word 'safe': 'At home') the subject will be prompted to be more specific ('Can you think of a specific time, one particular occasion?'). First responses will be categorized as 'specific', 'overgeneral' or 'omissions' (if subjects exceeded the time limit or could not provide a response). 'Overgeneral' memories will then be rated as either 'categorical' or 'extended' in accordance with the observation that only 'categorical' memories are over-represented in depressed individuals (Williams & Dritschel, 1992). Responses will be assessed in order to investigate the nature of autobiographical recall in borderline personality disordered subjects and will be rated by the researcher (JA). A sample will be independently rated (e.g. by a fellow trainee), who will be unaware of the group status, in order to assess inter-rater reliability. Practice items will be given to ensure that subjects fully understand the experimental procedure, the trial will not commence until this has been demonstrated.

Dissociative Experiences Scale – (DES) (Bernstein & Putnam, 1986) (see Appendix 3.5)

The DES is a reliable and valid scale measuring dissociative symptomatology (Jones *et al*, 1999). This self-report questionnaire consists of 28 items, each relating to dissociative experiences. Subjects are asked to indicate how often such experiences happen to them throughout their daily life by making a mark on the 100mm VAS provided for each item. The mean of all the items ranges from 0 – 100%, with 0% representing that the experiences never happens and 100% indicating that it happens all the time. The scale score is determined by calculating the average score across all items.

The Childhood Trauma Questionnaire – (CTQ) (Bernstein *et al*, 1994) (see Appendix 3.6)

The CTQ is a 53-item, self-report, measure assessing the frequency of traumatic events throughout childhood, including experiences of abuse and neglect as well as related aspects of the child-rearing environment. The questionnaire assesses 4 main trauma related characteristics: physical and emotional abuse; emotional neglect; sexual abuse and physical neglect. Subjects are asked to indicate how often such experiences happen to them throughout their childhood by making a mark on the 5 point Likert-scale provided for each item. The responses range from "*never true*" to "*very often true*". The administration of the CTQ should take between 10 – 15 minutes and is intended for use with adults and adolescents in clinical settings.

Design

This experiment will use a 2 (Group : BPD, control) x 2 (Valence: positive, negative) mixed subjects design. The first factor will be measured between-groups (comparing borderline subjects against normal controls) whereas the second factor will be measured within-subjects (comparing participants' responses to positive and negative cue words).

Procedure

Upon obtaining consent, subjects will be screened, by interviewer (JA), for a clinical diagnosis of borderline personality disorder using the BPD section of the SCID-II. Levels of depressive and anxiety related symptomatology would then be assessed by completion of the BDI and BAI respectively. The

experimental task will then be administered. Responses from the AMT will be recorded on a tape recorder which only those involved in the study will have access to. These tapes will duly be erased once the information has been transcribed. Finally, all subjects will then be asked to complete the Dissociative Experiences Scale and the Childhood Trauma Questionnaire. On completion of the questionnaires, time will be allowed for debriefing any participants for whom this was felt to be necessary.

Settings and Equipment

The research protocol will be conducted either at the client's local health centre, at Gartnavel Royal Hospital, or at a venue convenient to the participants. Equipment will consist of the Autobiographical Memory Task (AMT), a stopwatch and measures of anxiety, depression, past traumatic events and dissociation.

Data Analysis

Data collected will be stored on a password-protected database compiled on SPSS for Windows. It is expected that the participants with borderline personality traits will differ from controls on the affect, dissociation and childhood trauma scales, therefore t-tests will be used to investigate the differences between the two groups. The main analysis will use mixed analysis of variances in order to investigate the differences between the two groups' performances on the Autobiographical Memory Task. This same analysis will enable an investigation of the differences within subjects performances according to positive versus negatively valenced cue words. Finally, correlational analyses may be used to investigate any associations between autobiographical recall style, depression, dissociation and childhood traumatic experiences.

Practical Applications

Over-general recall has been related to poorer problem solving skills (Evans, Williams, O'Loughlin & Howells, 1992). The propensity to retrieve over-general memories that were 'categoric', (referring to generic summary of events, e.g 'drinking in pubs') rather than 'extended' (referring to an extended period of time, e.g. 'my undergraduate days') (Kaney, Bowen-Jones & Bentall, 1999) has been significantly associated with poorer social problem solving skills (Goddard, Dritchel & Burton, 1996). Further research

has indicated that 'specificity' is important for successful social problem solving skills (Goddard, Dritchel & Burton, 1997).

Overgeneral memory has been seen to be a good predictor of which individuals will respond poorly to intervention (Brittlebank, Scott, Williams & Ferrier, 1993). Confirmation of an autobiographical memory deficit could therefore assist in the development of treatment interventions with certain psychologically disordered groups demonstrating an autobiographical recall deficit. Individuals who are more over-general may benefit from the use of cognitive techniques directed towards enhancing the specificity of information processing. This would provide them with a richer database that would offer more details for constructing adequate solutions.

Timescale

September 2000	Ethical clearance applied for.
October – May 2001	Data collection
June – August 2001	Data analysis & preparation of study for publication

Ethical approval

Ethical approval will be required from Greater Glasgow (see Appendix 3.7a,b) and Ayrshire & Arran Primary Care, NHS Trusts (see Appendix 3.8).

REFERENCES:

American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association. Washington DC.

Beck, A. T., & Steer, R. (1993a). Manual of the Beck Anxiety Inventory – (BDI). The Psychological Corporation: San Antonio.

Beck, A. T., & Steer, R. (1993b). Manual of the Beck Depression Inventory – (BDI). The Psychological Corporation: San Antonio.

Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E. & Ruggiero, J. (1994). Initial Reliability and Validity of a New Retrospective Measure of Child Abuse and Neglect. *American Journal of Psychiatry, 151,(8); 1132-1136.*

Bernstein, E. M., & Putnam, F.W. (1986). Development, Reliability, and Validity of a Dissociation Scale. *The Journal of Mental and Nervous Disease, 174, 727-735.*

Brittlebank, A.D., Scott, G., Williams, J.M.G., & Ferrier, I.N. (1993). Autobiographical memory in depression: state or trait marker? *British Journal of Psychiatry,* 162, 118 – 121.

Cohen, J. (1992). A power primer. *Psychological Bulletin,* 112, 155 – 159.

DiTomaso, M. J., & Roth, D. K. (1993). Recall of abuse in childhood and three measures of dissociation. *Child Abuse and Neglect.* 17, 477 - 485.

Draijer, N., & Langeland, W. (1999). Childhood Trauma and Perceived Parental Dysfunction in the Etiology of Dissociative Symptoms in Psychiatric Inpatients. *American Journal of Psychiatry, 156, 3: 379 – 385.*

Evans, J., Williams, J.M.G., O'Loughlin, S., & Howells, K. (1992). Autobiographical memory and problem solving strategies of parasuicide patients. *Psychological Medicine,* 22, 399 – 405.

First, N.B., Spitzer, R.L., Gibbon, M. & Williams, M.B.W. (1994). Structured Clinical Interview for Axis II DSM-IV Disorders. New York State Psychiatric Institute, Biometrics Research Department: New York.

Goddard, L., Dritschel, B., & Burton, A. (1996). The role of autobiographical memory in social problem-solving and depression. *Journal of Abnormal Psychology,* 105, 609 – 616.

Goddard, L., Dritschel, B., & Burton, A. (1997). Social problem solving and autobiographical memory in non-clinical depression. *British Journal of Clinical Psychology,* 36, 449 – 451.

Harvey, A.G., Bryant, R.A., & Dang, S.T. (1998). Autobiographical memory in acute stress disorder. *Journal of Consulting and Clinical Psychology,* 3, 500 – 506.

Jones, B., Heard, H., Startup, M., Swales, M., Williams, J. M. G., & Jones, R. S. P. (1999). Autobiographical memory and dissociation in borderline personality disorder. *Psychological Medicine,* 29, 1397 – 1404.

Kaney, S., Bowen-Jones, K., & Bentall, R.P. (1999). Persecutory delusions and autobiographical memory. *British Journal of Clinical Psychology,* 38, 97 – 102.

Kuyken, W., & Brewin, C.R. (1995). Autobiographical memory functioning in depression and reports of early abuse. *Journal of Abnormal Psychology,* 104, 585 – 591.

Kuyken, W., & Dalgleish, T. (1995). Autobiographical memory and depression. *British Journal of Clinical Psychology,* 34, 89 – 92.

McNally, R. J., Litz, B.T., Prassas, A., Shin, L.M., & Weathers, F.W. (1994). Emotional priming of autobiographical memory in post-traumatic stress disorder. *Cognition and Emotion,* 8, 351 – 367.

McNally, R.J., Lasko, N.B., Macklin, M.L., & Pitman, R.K. (1995). Autobiographical memory disturbance in combat-related post-traumatic stress disorder. *Behaviour Research and Therapy,* 33, 619 – 630.

Merckelbach, H., Muris, P., & Horselenberg, R. (1996). Correlates of overgeneral memories in normal subjects. *Behavioural and Cognitive Psycholtherapy,* 24, 109 – 115.

Moore, R.G., Watts, F.N., & Williams, J.M.G. (1988). The specificity of personal memories in depression. *British Journal of Clinical Psychology,* 27, 275-275.

van den Hout, M., Merckelbach, H. & Pool, K. (1996). Dissociation, Reality Monitoring, Trauma, and Thought Suppression. *Behavioural and Cognitive Psychotherapy.* 24, 97 – 108.

Wilhelm, S., McNally, R.J., Baer, L., & Florin, I. (1997). Autobiographical memory in obsessive-compulsive disorder. *British Journal of Clinical Psychology,* 36, 21 – 31.

Williams, J. M. G., & Dritchel, B. H. (1992). Categorical and extended autobiographical memories. In M.A. Conway, D. C. Rubin, H. Spinnler & W. A. Wagenaar (Eds), Theoretical Perspectives on autobiographical Memory, *pp. 391-410.*

Williams, J.M.G. (1996). Depression and specificity of autobiographical memory. In D. Rubin (ed.), *Remembering Our Past: studies in autobiographical memory,* pp. 244 – 267. Cambridge: Cambridge University Press.

Williams, J.M.G., & Broadbent, K. (1986). Autobiographical memory in suicide attempters. *Journal of Abnormal Psychology,* 95, 144 –149.

Williams, J.M.G., & Dritschel, B.H. (1988). Emotional disturbance and the specificity of autobiographical memory. *Cognition and Emotion,* 2, 221 –224.

Williams, J.M.G., & Dritschel, B.H. (1992). Categoric and extended autobiographical memories. In M.A. Conway, D.C. Rubin, H. Spinnler, & W.A. Wagenaar (eds.), Perspectives on autobiographical memory. London: Kluwer.

Williams, J.M.G., & Scott, J. (1988). Autobiographical memory in depression. *Psychological Medicine,* 18, 689 – 695.

Williams, J.M.G., Watts, F.N., MacLeod, C. & Mathews, A. (1997). Cognitive psychology and emotional disorders, 2nd ed. London: Routledge.

Williams, M.D. & Hollan, J.D. (1981). The process of retrieval from very long-term memory. *Cognitive Science,* 5, 87-119.

MAJOR RESEARCH PROJECT PAPER

Autobiographical Memory, Dissociative Symptoms and Emotionally Traumatic Past Experiences in Adults with Borderline Personality Disorder (BPD)

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Prepared for submission to the *British Journal of Clinical Psychology*

(Appendix 4.1 for contributors' notes)

Author:	Joy Airlie, Trainee Clinical Psychologist*
Running Title:	Autobiographical Memory, a review of the literature
Address for correspondence:	The University of Glasgow Department of Psychological Medicine
	Gartnavel Royal Hospital
	1055 Great Western Road,
	Glasgow G12 0XH
Telephone number:	0141 211 3920
Fax Number:	0141 357 4899.
E-mail address:	joyairlie@yahoo.co.uk

* author for correspondence

Objective

The purpose of this study was to investigate autobiographical recall in a group of patients (N=19) diagnosed with Borderline Personality Disorder (BPD), and to compare their performances with a normal control group (N=19). In addition, this present study sought to elucidate the contributions that depressed mood and a past history of trauma made to autobiographical recall style.

Method

Employing a 2 (Group: BPD, Normal Control) x 2 (Valence: Positive, Negative) mixed factorial design, the participants performances on the Autobiographical Memory Task were assessed. The differences between the two groups were investigated using a Mixed ANOVA, this also enables the authors to investigate whether there was any effect for the valence of the cue word presented.

Results

As expected the two groups differed on measures of affect, with the BPD group reporting higher levels of affect than the normal control group. Consistent with an earlier study (Jones *et al,* 1999), the BPD patients in this present study provided significantly more over-general responses, to both positively and negatively valenced cue words, than the normal control group. However, when the effects of depression were accounted for, the main effect for group was lost. In addition, this present study does not lend support to the theory that childhood trauma plays a role in over-general autobiographical recall.

Conclusions

The results from this present study support the argument that autobiographical recall is associated with depression, as the differences observed between the two groups was lost when depression was accounted for, thus suggesting that it is indeed depression that plays a significant role. However, the exact nature of this association is not clear, therefore future research implications are discussed.

Running title: Autobiographical Memory in Borderline Personality Disorder (BPD)

Introduction

Over recent years, knowledge about autobiographical memory in emotional disorders has steadily accumulated (Wessel, Meeren, Peeters, Arntz & Merckelbach, 2001) and evidence suggests that patients suffering from a variety of psychological disorders experience difficulty in retrieving 'specific' autobiographical memories (*e.g.* Wilhelm, McNally, Baer & Florin, 1997; Williams & Dritschel, 1992; Williams, Williams & Ghadiali, 1998). Such individuals are reported to respond with a more 'over-general' recall style when compared to control groups (Williams, 1996) and recent evidence suggests that patients diagnosed with Borderline Personality Disorder (BPD) also demonstrate an over-general autobiographical recall bias when compared with a non-clinical comparison group (Jones *et al*, 1999).

BPD has more recently become the subject of intense theoretical and clinical investigation (Herman, Perry & van der Kolk, 1989). These patients have been found to be high users of mental health services (Swartz, Blazer, George & Winfield, 1990) yet it is generally agreed that they are particularly difficult to treat (Herman *et al*, 1989). This may be somewhat associated with their often complex presentation, such as depression (Pope, Jonas, Husdson, Cohen & Gunderson, 1993), dissociative symptomatology (APA, 1994), recurrent parasuicidal behaviours (Keherer & Linehan, 1996), and the frequent occurrence of trauma and neglect in the childhood experience of adult patients diagnosed with BPD (Sabo, 1997), which often accompany such a diagnosis. Further research is required in order to understand more about this complex group, particularly due to their frequent reliance on self-harmful behaviours as a means of coping, thus highlighting their often considered non-adaptive choice of problem solving strategies.

It has been argued that over-general recall appears to be a phenomenon of general clinical importance and may possibly underpin the problem solving deficits, similar to those found in parasuicide and perhaps other clinical groups (Sidley & Calam, 1997). Over-general autobiographical memory has therefore been explained as a problem-solving activity and some

authors have argued that the main consequence of over-general recall is compromised problem-solving abilities (*e.g.* Williams & Dritschel, 1988). An association between low effectiveness of problem solving strategies and over-general recall has been demonstrated throughout the existing autobiographical memory literature (Evans, Williams, O'Laughlin & Howells, 1992).

The autobiographical memory literature inconclusively highlights potential causes and implications of over-general recall, and clearly awaits further research in order to provide additional clarification. However, much of the existing literature implicates depressive phenomenology in relation to over-general recall style (for a review, see Airlie, 2001). Substantial evidence now exists suggesting that autobiographical recall disturbance is associated with depression (Moore, Watts & Williams, 1988) with some authors suggesting that recall deficits may be a symptomatic feature of depressive phenomenology (Wessel *et al*, 2001). In support of this Wilhelm *et al,* (1997) recently reported that the most robust manifestations of over-general memories were found in those Obsessive Compulsive Disorder (OCD) patients who had a co-morbid diagnosis of major depression. However, the evidence to suggest whether over-generality is indicative of current mood state or reflective of a more stable trait effect remains inconclusive as other authors have reported the persistence of recall deficits across time, despite a reduction in depressive symptomatology (Brittlebank, Scott, Williams & Ferrier, 1993). Such evidence provides support for Williams & Dritschel's (1988) earlier findings, that a group of overdose patients were comparable to current overdose patients in terms of their autobiographical memory performance (Wessel *et al*, 2001).

Existing literature also indicates that difficulties in recalling 'specific' personal memories may be related to a history of past trauma (McNally, Prassas, Shin & Weathers, 1994; McNally, Lasko, Macklin & Pitman, 1995; Kuyken & Brewin, 1995), suggesting that over-general retrieval style might represent a specific response to traumatic events. Kuyken & Brewin (1995) reported an association between trauma, as indexed by reports of childhood sexual abuse, and over-general recall in a group of women who met diagnostic criteria for major depression, claiming this to be true even after the effects of depression were controlled for. However these authors used two different means of assessing current depressed mood, the self-report measure and the clinical diagnostic assessment.

Their subsequent analyses used these measures interchangeably. There is reason to believe that the two different forms of assessment may represent slightly different phenomenon, due to inconsistencies in results from studies making use of and comparing both methods (see Wessel *et al*, 2001). Therefore it is not possible to conclude that depressive phenomenology was reliably accounted for in this study (see Airlie, 2001).

Jones *et al* (1999) would argue that the association they observed between their BPD groups' tendency to dissociate and over-generality lends support to the idea that over-generality may reflect a specific response to traumatic events. Indeed dissociation has been conceptualized as being an initially adaptive response to traumatic events (Putnam, 1989). Therefore this may seem a reasonable suggestion, given the fact that dissociative experiences are a common feature of BPD symptomatology (APA, 1994). However, in Jones *et al*'s study no formal assessment of past traumatic experiences was conducted. Future studies need to formally assess the existence of past trauma in BPD in order to investigate this hypothesis further. In addition, given the reported association between depression and over-generality, future studies assessing autobiographical recall in patients with BPD would need to control for the effects of depression. Jones *et al* (1999) did not report controlling for the effects of depression, despite recognising that their BPD group had significantly higher levels of self reported depression than their normal control group. Thus preventing any firm conclusions from being drawn from this study, as the possibility that the effects of depression may have affected the response style cannot be ignored.

In summary, the existing literature demonstrates an incongruity between conclusions drawn across studies. The relationships between depression, trauma and over-general recall require further clarification. Therefore the aims of this study were twofold. This present study endeavoured to replicate the previous findings reported by Jones *et al* (1999) in order to ascertain whether over-generality is indeed a characteristic feature of BPD patients' response styles. This study sought to elucidate the precise contributions depression and/or childhood trauma make to autobiographical recall style in a group of subjects diagnosed with BPD.

Methodology

Design

A 2 (Group: BPD, control) × 2 (Valence: positive, negative) mixed design was used. The first factor was measured between-subjects, whereas the second factor was measured within-subjects.

Participants

Twenty-nine patients were approached for participation in this study. However, after consenting to meet with the researcher, 10 patients were withdrawn from the study on the basis of literacy skills (n=2), repeated cancellations (n=4), DNA's (n=2), and refusal to complete the childhood trauma questionnaire. The clinical group therefore comprised 19 participants (16 females, 3 males; mean age 32.6, S.D. 8.7), who were in contact with local mental health services. These participants were referred having previously received a formal diagnosis of borderline personality disorder or whose care-managers believed may fulfil DSM-IV criteria for Borderline Personality Disorder (APA, 1994). Clinical diagnosis was confirmed through the administration of the BPD section of the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Spitzer & Gibbon, 1994). Any participants with a history of psychotic illness, bipolar disorder, learning disabilities or any organic condition known to cause memory deficits and individuals currently diagnosed with substance dependence were excluded from the study.

Nineteen non-clinical participants (16 females, 3 males; mean age 32.0, S.D. 9.6) were recruited, from a university hospital department, as a comparison group. The two groups did not differ significantly with respect to gender, age ($t=.20$, $df=36$, $p>0.05$, one-tailed), and years of full-time education ($t=.21$, $df=36$, $p>0.05$, one-tailed). They too were administered the SCID-II, this time to ensure the absence of a clinical diagnosis of BPD. Individuals with a current psychiatric disorder, any condition known to cause memory impairment or a history of psychiatric disorders, that required professional input, were excluded from this study.

Measures

Beck Depression Inventory (BDI) (Beck & Steer, 1993b).

This consists of a 21-item self-report questionnaire assessing the cognitive, emotional and vegetative symptoms associated with depression over the preceding fortnight including the day of administration.

Beck Anxiety Inventory (BAI) (Beck & Steer, 1993a).

This consists of a 21-item self-report questionnaire measuring the severity of physiological and cognitive symptoms associated with anxiety over the preceding week including the day of administration. This was simply used as an initial screening tool in order to assess each participant's level of anxiety.

The Autobiographical Memory Test (AMT) (Williams & Broadbent, 1986).

The administration of the AMT as described by Williams & Broadbent (1986) was employed. Participants were presented with ten large printed cue cards, bearing five positively valenced words (*happy, safe, interested, successful & surprised*) and five negatively valenced words (*sorry, angry, clumsy, hurt & lonely*). The cards were delivered in a pseudo-random order alternating the presentation of positive and negative words. Participants were asked to read each word aloud and to try to think of a specific personal memory in relation to that word. This task was tape-recorded and the latency from reading the word aloud to the first word of the first responses made by the subjects was recorded. The participants were allowed 60 seconds within which to provide a specific response before the subsequent cue card was presented. Previous research indicates that specific and general memories can be reliably distinguished with an inter-rater reliability of between 0.87 and 0.93 (Williams & Dritschel, 1988). If the participant provided a 'general' response (e.g. to the cue word 'safe': 'At home') the participant was then prompted to be more specific.

First responses were categorized as 'specific', 'over-general', or omission' (if the subject exceeded the time limit or could not provide a response). Over-general memories were subsequently rated as either 'categoric' or 'extended' in accordance with the observation that only 'categoric' memories

are over-represented in depressed individuals (Williams & Dritschel, 1992). The researcher rated responses in order to evaluate the individual's autobiographical recall response style. A sample of the participants' responses were independently rated by a colleague, who was blind to the group status, in order to assess inter-rater reliability. Reliability scores were calculated using the standard percentage agreement index (Suen & Ary, 1989) – Agreements ÷ (agreements + disagreements) × 100. In terms of the specificity of the responses, (*i.e.* specific vs. general) agreement between raters was 91%. In terms of classifying the nature of the over-general responses (*i.e.* categorical vs. extended), both raters agreed on 89% of responses. Any disagreements were resolved by discussion.

Prior to commencing, practice items were provided in order to ensure that the participants fully understood the experimental procedure. The trial was not commenced until this had been demonstrated.

Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986).

This self-report questionnaire consists of 28 items, each relating to dissociative experiences. The participants were asked to indicate how much of their daily life is affected by such experiences through the use of a visual analogue scale ranging from 0% (none of the time) to 100% (all of the time). The scale score is determined by calculating the average score across all the items.

The Childhood Trauma Questionnaire (CTQ) (Bernstein, Ahluvalia, Pogge & Handelsman, 1994).

This self-report questionnaire consists of 53 items and is a retrospective measure of various aspects of abuse and neglect experienced during the individual's childhood. The CTQ yields a global score (5-25) and can be subdivided to yield five subscales: physical abuse (seven items; range 7-35), emotional abuse (12 items; range 12-60), sexual abuse (seven items; range 7-35), physical neglect (eight items: range 8-40) and emotional neglect (16 items; range 16-80). The items are scored on a 5-point scale ranging from 1 (*never true*) to 5 (*very often true*). Favourable analyses of the scale's psychometric properties have been published by Fink, Bernstein, Handelsman, Foote, & Loverjoy (1995) and Bernstein, Ahluvalia, Pogge, & Handelsman (1997) and this scale has been devised for the use with adolescent and adult psychiatric populations.

Procedure

Upon obtaining consent, each participant was screened for the presence of borderline personality disorder using the SCID-II. The measures were then administered in the order that has been described above. The duration of the assessments varied between one to two hours. On completing the administration of the measures, time was allowed to debrief any participants for whom this was felt to be necessary. Any disclosures revealed within the assessment session were fed back to the referring body with the participant's written consent. Provision was made for the control group should they become distressed by the assessment by providing the contact numbers for local mental health services.

Data Analysis

Following initial tests of normality of distribution and homogeneity of variance, the data were analysed. The mean numbers of over-general responses were analysed using a 2 (Group: BPD, control) × 2 (Valence: positive, negative) mixed analysis of variance. Participant group was used as the between-groups factor and the valence was used as the within-subjects factor. Correlational analyses were then employed to look at the relationships between the participants' performance on the AMT and additional measures.

Results

Box and whisker plots, which show the median, spread and inter-quartile range of scores can be employed to show the spread of scores and these plots can be used to identify any unusual cases (outliers) which are displayed by a dot outside of the main range of scores. Prior to any analyses being conducted, outliers were identified on the DES scores using box and whisker plots and these were specified as DES scores that were greater than 1.5 times the interquartile range of DES scores. In total only 13% of DES scores were outliers. Homogeneity of variance was subsequently met following square-root transformation for all of the DES scores in order to minimize the impact of outliers.

Affect and Childhood Trauma Scores

Means and standard deviations for the BPD and the control groups on the BAI, BDI, DES and CTQ are included in Table 4.1. Due to the complex nature of BPD, it was expected that the two groups would differ on scores across these measures.

(Insert Table 4.1 here)

Levene's test of homogeneity of variances indicated that equal variance could only be assumed for two of the affect and trauma variables, namely DES and emotional neglect. Where the variances of the two groups differed significantly on any of the variables, *t*-tests for unequal variances were employed and significant differences were found in the expected directions on each of the variables.

As expected, the BPD group scored significantly higher than control subjects did on the BAI (t=4.89, df=20.24, $p<0.001$, one-tailed), BDI (t=10.24, df=25.54, $p<0.001$, one-tailed), DES (t=4.30, df=36, $p<0.001$, one-tailed), and CTQ Global (t=7.30, df=22.29, $p<0.001$, one-tailed). The distribution of the participants' BDI scores indicates a range of moderate to severe depression.

Investigation of the CTQ sub-tests indicate that the BPD group attained significantly higher scores across each of the scale's domains: emotional abuse (t=7.1, df=21.18, $p<0.001$, one-tailed); physical abuse (t=4.57, df=18.20, $p<0.001$, one-tailed); sexual abuse (U=92.50, N_1=19, N_2=19, $p<0.01$, one-tailed); emotional neglect (t=4.97, df=36, $p<0.001$, one-tailed) and physical neglect (t=6.11, df=18.81, $p<0.001$, one-tailed).

Autobiographical Recall Style in BPD

- *Recall Specificity*

All respondents offered memories to the majority of cues and a summary of the participants' responses can be seen in Table 4.2. In order to test whether the BPD patients recalled more over-general memories than the controls, the mean numbers of over-general responses were analysed using a 2 (Group: BPD, control) × 2 (Valence: positive, negative) mixed analysis of variance. The

analysis revealed a main effect of participant group ($F_{(1,36)}$=23.74, $p<0.05$) with the BPD group retrieving significantly more over-general responses than the control participants. A main effect of valence was revealed ($F_{(1,36)}$=6.13, $p<0.05$), with significantly more over-general responses being retrieved by the whole sample in response to negatively valenced cue words, however there was no significant interaction between group and valence ($F_{(1,36)}$=1.53, $p>0.05$).

(Insert Table 4.2 here)

Previous research has indicated that depressed patients typically recall more 'categoric' rather than 'extended' over-general responses (Williams & Dritschel, 1992). This was considered due to the fact that the clinical group had significantly higher scores than the control subjects on the BDI. However, in this present study, the mean number of autobiographical responses (see Table 4.2) indicate that the BPD patients recalled almost equal number of categoric and extended responses (M=2.5 and M=3, respectively). Thus unlike William's studies, but consistent with Wilhelm *et al*'s (1997) study, over-generality was not confined to categoric memories.

- *Recall Latency*

Mean response times for generating autobiographical memories were analysed using a 2 (group) × 2 (valence) mixed ANOVA. The results indicated that there were no main effects for group ($F_{(1,36)}$=3.73, $p>0.05$) nor valance ($F_{(1,36)}$=0.01, $p>0.05$) nor group by valence interactions ($F_{(1,36)}$=3.18, $p>0.05$). Thus, indicating that both groups took approximately the same length of time to retrieve an autobiographical memory regardless of the valence of the cue word.

Investigating the effects of depression on autobiographical recall

In order to index the contribution of depression on autobiographical recall, the previous analyses were repeated with BDI scores entered as a covariate.

- *Recall Specificity*

When the effects of depression were controlled for, the main effect of group was lost ($F_{(1,35)}$=0.02, p>0.05) indicating that when the effect of depression is removed, the main effect of group becomes non-significant. The results of the between-subjects simple effects indicate that depression significantly predicts the number of over-general responses ($F_{(1,36)}$=11.59, p<0.05). There were no changes in the significance of the main effects of valence and the interaction effects of group by valence as both remained non-significant ($F_{(1,35)}$= 0.06, p>0.05 & $F_{(1,36)}$=0.01, p>0.05, respectively).

Correlational Analyses

- *Investigating associations between variables*

Correlation analyses were conducted between the mean number of over-general responses and the various measures, the results of which can be seen in Table 4.3. Unlike Jones' findings, significant positive correlations can be found between all of the variables, indicating that the higher the scores on measures of affect and reported trauma the higher the number of over-general responses.

(Insert Table 4.3 here)

A significant positive correlation was found between BDI scores and a propensity to provide over-general responses (r=0.81, p<0.01). A significant positive correlation was found between dissociation and number of over-general responses (r =0.52, p<0.01), replicating the findings of Jones *et al.* A positive correlation indicated an association between dissociation and a previous history of childhood trauma (r=0.66, p<0.01). Such results suggest that the higher a participants' childhood trauma score was, the more likely they were to score highly on the dissociative experiences scale. In order to investigate recent hypotheses suggesting an association between over-generality in autobiographical recall and past traumatic experiences, these two measures were assessed. Indeed, a positive correlation was found between childhood trauma scores and over-generality on the AMT (r=0.57, p<0.01).

- *Controlling for the effects of mood.*

In order to explore whether the significant correlation between childhood trauma and the propensity to retrieve over-general memories could largely be explained by mood, a partial correlation coefficient between these two parameters was calculated while controlling for the scores on the BDI. The correlation was subsequently found to be low (-0.07) and non-significant ($p>0.05$) suggesting that the relationship between over-general recall and a previous history of traumatic childhood experiences was largely mood dependent.

Discussion

The present study was primarily concerned with replicating the findings of the only existing study to assess autobiographical recall in patients diagnosed with Borderline Personality Disorder (BPD) (Jones *et al,* 1999). An examination of autobiographical memories in a group of BPD patients was therefore conducted. As was expected, and consistent with Jones *et al*'s (1999) findings, compared to normal controls this present BPD group obtained significantly higher scores on measures of affect and childhood trauma. The initial analyses confirmed that patients diagnosed with BPD did exhibit a greater tendency to provide over-general responses on an autobiographical memory task, when compared to a normal control group. This result concurs with those reported throughout studies assessing patients suffering from a variety of psychological disorders (for a review, see Airlie, 2001), and are consistent with the autobiographical response style exhibited by the BPD subjects participating in Jones *et al*'s (1999) study.

Previous studies indicate a tendency for clinical groups to produce significantly more over-general responses than control groups particularly in relation to positive cue words (Williams, 1996), and support for this can be found in Jones *et al*'s (1999) study. This present study indicated that over-generality was characteristic of BPD individuals' responses, regardless of the valence of the cue word. Similar findings have been reported in a group of patients diagnosed with OCD who were observed to have exhibited greater difficulty retrieving specific personal memories than did healthy controls, regardless of cue word valence (Wilhelm *et al*, 1997).

The available literature also suggests that depressed patients typically recall more categoric, rather than extended over-general memories (Williams & Dritschel, 1992). In order to examine whether this style was characteristic of borderline personality disordered patients, this present study examined the styles of responses provided by the BPD group. The results indicated that over-generality was not confined to categoric memories in this group. This finding again concurs with Wilhelm *et al* (1997) who reported that the OCD group recalled almost equal numbers of categoric and extended memories. In this present study, the BPD and control group did not differ in their latencies to provide a response to the cues. Furthermore, the present study found no evidence to suggest that there is a differential latency in retrieving negative memories over positive memories in either the BPD or the control group, unlike those reported in other studies, for example, (Williams & Scott, 1988).

Jones *et al* (1999) were the first authors to demonstrate autobiographical memory deficits in BPD patients and the present study lends support to the suggestion that these individuals possess an over-general response bias. However a notable concern, when drawing conclusions from *Jones et* al's study, was that they appeared to overlook any investigation into the effects of depression on autobiographical recall. Despite highlighting that the BPD group were significantly more depressed than the control group, as indicated by BDI scores, no controls for the effects of depression on the subjects' performance on the autobiographical memory task were undertaken. Yet the association between autobiographical recall and depression has featured significantly in the existing autobiographical memory literature, and this would suggest that attention to the effects of depression ought to be a fundamental consideration in the study of autobiographical memory. The present study sought to elucidate the contribution depression makes to over-general retrieval style, as indexed by participants' BDI scores. Interestingly, when the effects of depression were controlled for, secondary analyses indicated that the main effects of the group were lost. This would suggest that the presence of a diagnosis of BPD alone is insufficient to cause autobiographical memory disturbance, rather these findings strongly suggest that over-generality was attributable to the presence of depressed mood in the patient group, and not to the diagnosis of BPD *per se.* Such a finding raises doubts over the validity of the conclusions drawn by Jones *et al* (1999). Further research, assessing the effects of depression on recall, will be needed in order to clarify the discrepancy between these two studies,

whilst several methodological inconsistencies, implicated throughout the existing autobiographical memory literature, warrant further consideration. The existing literature would appear to suggest that over-generality is related to depression, yet the exact nature of this relationship remains inconclusive. Some authors have suggested that over-generality reflects a current mood state. This is inclined to be the case when objective clinical diagnoses have been used to index depression. Relatively fewer studies have reported such an association when self-report measures of depression have been used (*e.g.* Goddard *et al*,1997).

Contrary to previous research (e.g. Wessel *et al*, 2001; Williams *et al*, 1998), the present study demonstrates a clear association between over-generality and the patient's subjective assessment of the severity of his/her depressive symptomatology. Wessel *et al* (2001) argues that self-report depression severity does not predict autobiographical memory specificity. The incongruity between such a report and this present study highlights the apparent lack of consistency in the methods used to assess current mood state. Despite this methodological inconsistency, an apparent assumption that these different measures of depression reflect the same phenomenon seems to exist across the available literature. A recent review by Airlie (2001) indicates that further research is necessary in order to clarify the relationship between autobiographical recall and depression. Whether over-generality is associated with the individual's subjective assessment of the severity of their current mood state, as indexed by a self-report measure of depression, or a more objective assessment of the presence of a depressive disorder, as indexed by a structured clinical diagnosis, is not yet clear. Overall conclusions cannot be drawn until further studies have been conducted comparing both objective and subjective means of assessing depression.

Jones *et al* (1999) suggested that the relationship they observed between patients' dissociative experiences scores and over-generality implicated a role for past trauma. Indeed there is a respectable body of literature associating dissociation with past traumatic experiences, but the conclusions drawn from Jones *et al*'s study were not substantiated with any formal means of assessing past experiences. The present study investigated this relationship and found that patient scores on measures of dissociative and childhood traumatic experiences were associated. When the effects of depression

were accounted for these associations no longer remained significant, lending further support to the hypothesis that depression plays a significant role in over-general response style. Therefore, in accordance with the findings reported by Wessel *et al* (2001), the present study does not support the idea that childhood trauma is a necessary antecedent of over-general memories.

These present findings would appear to challenge those reported in previous studies, for example associations between childhood trauma and over-generality were indicated by Kuyken & Brewen (1995). They reported that over-general memories were found to be especially over represented in depressed patients who had reported childhood sexual abuse compared to the group of depressed patients with no such reports. This was said to be true even after the effects of depressed mood, as indexed by the BDI scores, were controlled for. The authors concluded that this suggested that the impact of trauma played a significant role in over-general recall. However, it may not be possible to accept that the effects of depression were reliably controlled for in this study. The authors' initial conclusions regarding the association between depression and over-generality were based on objective clinical diagnoses. They proceeded to explain that the effects of depression were controlled for by means of a self-report measure of depression. The reliability of BDI scores being used to reflect the patients' current mood state may be questioned. It is unclear from the autobiographical memory literature whether both measures, intended to reflect current mood state, do in fact represent the same phenomenon, thus raising questions about the reliability of the conclusions drawn from their study. Further studies will be necessary to clarify the relationship between over-generality and past histories of trauma. This present study would suggest that trauma may not necessarily play a significant role in over-general recall style, but rather that this style may be accounted for by current depressed mood.

Conclusions

Existing studies would suggest that self-report measures of depressed mood are not associated with over-general recall style (Wessel *et al*, 2001). The present study clearly demonstrates that self-reported depressed mood is related to over-generality in recall style. The equivocal findings, according to the use of self-reports of depressed mood versus clinical diagnoses, indicate the need for

further clarification in order to promote more consistent measures being used within autobiographical memory studies. A potential limitation of this current study may have been the use of a self-report measure of depression as such measures reflect a 'subjective' evaluation of the individual's perception of his/her current mood state. The accuracy of the self-report assessment of current mood state may be questioned as completion of this assessment relies wholly upon the individual's account. The individual may be influenced by certain response biases, such as attempts to rate according to what they think the researcher is trying to discover, producing inflated ratings. Alternatively, under-rating may occur due to poor motivation associated with depressed mood. Such considerations may therefore imply the need for more objective means of assessing current levels of depression, such as the clinical diagnosis. No formal co-morbid diagnoses were made in this study, and, given the implications of the current literature, future studies ought to consider assessing both in order to contribute to the understanding of the precise contribution depression makes to recall style. Further studies need to evaluate both clinical diagnosis and self-report measures to help answer these remaining questions. In order to investigate to what extent over-general memories reflect a depressive trait-like phenomenon, it may have been useful if the sample contained patients with remitted depression, or to conduct more longitudinal studies. Therefore at this time no firm conclusions regarding the 'state' 'trait' debate can be drawn from this present study. The current results do not support the idea that childhood trauma is a necessary antecedent of over-general memories, and therefore further studies are needed to confirm such reports.

Future research comparing BPD individuals with clinical control subjects from different diagnostic populations (e.g. depressed group with no formal BPD diagnosis) may be a more valuable comparison to make as it is thought that such a comparison may help to extend our understanding of the processes believed to be underlying autobiographical memory deficits. In addition, comparing BPD subjects with clinical control groups, rather than normal healthy controls, may help to prevent confounding the results, which may be caused by the naturally expected differences between a group of individuals engaged with services against a group of independent individuals with no professional contact.

The correlations found between the participant's depression scores, past trauma and overgeneral recall style may partly be due to shared variance among these measures, indicating that these assessments may essentially be tapping into related or similar constructs. One way in which confounding variables could have been controlled for would have been to use a more definitively somatic rating scale for depression as the BDI is known to assess both cognitive aspects as well as biological aspects of depression. This would potentially prevent the measure of depression from tapping into questions potentially being asked by the other measures.

Another difficulty with this current study was that the drop out rate may have reduced the statistical power of the study. As ten subjects either withdrew or were deemed unsuitable for participation in this study it is possible that they may have reflected a different cohort of borderline personality disordered patients. Therefore, future studies are needed with larger numbers of participants in order to verify whether the results demonstrated in this current study are representative of the borderline personality disordered population as a whole.

Notwithstanding these limitations, the current findings suggest that a lack of specificity in the recall of personal memories appears to characterize patients with BPD, and rather than relating directly to a history of past trauma this appears to be associated with the presence of current depression, as indicated by self-report measures of mood.

References

Airlie, J. (2001) Autobiographical Memory, Dissociative Symptoms and Emotionally Traumatic Experiences in Adults with Borderline Personality Disorder (BPD): A Review of the Literature. Unpublished article submitted as partial fulfilment for the degree of Doctorate in Clinical Psychology.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders,* DSM-IV, 4th edn. American Psychiatric Association: Washington, DC.

Beck, A.T. & Steer,R. A. (1993a). *Manual of the Beck Anxiety Inventory.* The Psychological Coorporation: San Antonio.

Beck, A.T. & Steer, . (1993b). *Manual of the Beck Depression Inventory.* The Psychological Coorporation: San Antonio.

Bernstein, D. P., Ahluvalia, T. B. A., Pogge, D., Handelsman, L. (1997). Validity of the Childhood Trauma Questionnaire in an Adolescent Psychiatric Population. *American Academy of Child and Adolescent Psychiatry,* 36 (3), pp. 340 –348.

Bernstein, E. M., & Putnam, F. (1986). Development, Reliability, and Validity of a Dissociation Scale. *The Journal of Nervous and Mental Disease*, 174 (12), pp. 727 – 735.

Brittlebank, A. D., Scott, G., Williams, J. M. G., & Ferrier, I. N. (1993). Autobiographical memory in depression: state or trait marker? *British Journal of Psychiatry,* 162, pp.118–121.

Evans, J., Williams, J. M. G., O'Loughlin, S., & Howells, K. (1992). Autobiographical memory and problem solving strategies of parasuicide patients. *Psychological Medicine,* 22, pp.399–405.

First, N. B., Spitzer, R. L., Gibbon, M. & Williams, M. B. W. (1994). *Structured Clinical Interview for Axis II DSM-IV Disorders.* New York State Psychiatric Institute, Biometrics Research Department: New York.

Fink, L. A., Bernstein, D., Handelsman, L., Foote, J. & Lovejoy, M. (1995). Initial Reliability and Validity of the Childhood Trauma Interview: A New Multidimensional Measure of Childhood Interpersonal Trauma. *American Journal of Psychiatry,* 152 (9), pp. 1329 – 1335.

Goddard, L., Dritschel, B., & Burton, A. (1996). The role of autobiographical memory in social problem-solving and depression. *Journal of Abnormal Psychology,* 105, pp.609–616.

Herman, J.L., Perry, C., & van der Kolk, B.A. (1989). Childhood Trauma in Borderline Personality Disorder. *American Journal of Psychiatry,* 146: pp.490-495.

Jones, B., Heard, H., Startup, M., Swales, M., Williams, J. M. G., & Jones, R. S. P. (1999). Autobiographical memory and dissociation in borderline personality disorder. *Psychological Medicine,* 29, pp.1397–1404.

Keherer, C. A., & Linehan, M. M. (1996). Interpersonal and Emotional Problem Solving Skills and Parasuicide among Women with Borderline Personality Disorder. *Journal of Personality Disorders,* 10(2), pp.153-163.

Kuyken, W., Brewin, C. R. (1995). Autobiographical Memory Functioning in Depression and Reports of Early Abuse. *Journal of Abnormal Psychology,* 104, pp.585–591.

McNally, R. J., Litz, B. T., Prassas, A., Shin, L. M., & Weathers, F. W. (1994). Emotional Priming of Autobiographical Memory in Post-Traumatic Stress Disorder. *Cognition and Emotion,* 8, pp.351–367.

McNally, R. J., Lasko, N. B., Macklin, M. L., & Pitman, R. K. (1995). Autobiographical Memory Disturbance in Combat-Related Post-Traumatic Stress Disorder. *Behaviour Research and Therapy,* 33, pp.619–630.

Moore, R. G., Watts, F. N., & Williams, J. M. G. (1988). The Specificity of Personal Memories in Depression. *British Journal of Clinical Psychology,* 27, pp.275-275.

Pope, H. G., Jonas, J. M., Hudson, J. L., Cohen, B. M., & Gunderson, J. G. (1993). The Validity of DSM-III Borderline Personality Disorder. *Archives of General Psychiatry,* 40, pp.23–30.

Putnam, F. W. (1989), Pierre Janet and Modern Views of Dissociation. *Journal of Traumatic Stress,* 2, pp.413–429.

Sabo, A. N. (1997). Etiological Significance of Associations between Childhood Trauma & Borderline Personality Disorder: conceptual and clinical implications. *Journal of Personality Disorders,* 11(1), pp.50-70.

Sidley, G. L., Whitaker, K., Calam, R. M. & Wells, A. (1997). The Relationship between Problem Solving and Autobiographical Memory in Parasuicude Patients. *Behaviour and cognitive Psychotherapy,* 25, pp.195–202.

Suen, H. K., & Ary, D. (1989). Analyzing Quantitative Behavioural Observation Data. Lawrence Erlbaum Association Inc.

Swartz, M., Blazer, D., George, L., & Winfield, I. (1990). Estimating the Prevalence of Borderline Personality Disorder in the Community. *Journal of Personality Disorders,* 4, pp.257-272.

Wessel, I., Meeren, M., Peeters, F., Antz, A., Merckelbach, H. (2001). Correlates of Autobiographical Memory Specificity: the role of depression, anxiety and childhood trauma. *Behaviour Research Therapy,* 39, pp.409-421.

Wilhelm, S., McNally, R.J., Baer, L., & Florin, I. (1997). Autobiographical memory in obsessive-compulsive disorder. *British Journal of Clinical Psychology,* 36, pp.21 – 31.

Williams, J. M. G. (1996). Depression and Specificity of Autobiographical Memory. In D. Rubin (ed.), *Remembering Our Past: studies in autobiographical memory,* pp.244 – 267. Cambridge University Press: Cambridge.

Williams, J. M. G. (1997). Cry of Pain: Understanding Suicide and Self-Harm. London: Penguin Books.

Williams, J. M. G., & Broadbent, K. (1986). Autobiographical Memory in Suicide Attempters. *Journal of Abnormal Psychology,* 95, pp.144 –149.

Williams, J. M. G., & Dritschel, B. H. (1988). Emotional disturbance and the specificity of autobiographical memory. *Cognition and Emotion,* 2, pp.221–224.

Williams, J. M. G., & Dritschel, B. H. (1992). Categoric and Extended Autobiographical Memories. In M. A. Conway, D. C. Rubin, H. Spinnler, & W. A. Wagenaar (eds.), Perspectives on Autobiographical Memory. London: Kluwer.

Williams, J. M. G., & Scott, J. (1988). Autobiographical Memory in Depression. *Psychological Medicine,* 18, pp.689–695.

Williams, H. W., Williams, M. D. & Ghadiali, E. J (1981). Autobiographical Memory in Traumatic Brain Injury: Neuropsychological and Mood Predictors of Recall. *Neuropsychological Rehabilitation*, 8, pp. 43 – 60.

Tables

Table 4.1 Mean scores (*standard deviations*) across the various affect measures

Measure	BPD Group		Control Group	
	Mean	(S.D)	Mean	(S.D)
BAI	22.0	(14.6)	5.2	(3.6)
BDI	37.7	(11.1)	8.8	(5.2)
DES	36.0	(20.9)	14.3	(12.7)
CTQ Scores:				
Global	12.6	(3.4)	6.5	(1.2)
Emotional Abuse	36.5	(12.0)	16.2	(3.6)
Physical Abuse	15.5	(7.8)	7.3	(0.6)
Sexual Abuse	13.5	(8.5)	7.4	(1.2)
Emotional Neglect	55.0	(15.3)	31.2	(14.2)
Physical Neglect	15.7	(6.0)	8.63	(0.9)

Table 4.2 Mean number (*standard deviation*) of responses generated by borderline personality disordered and normal participants.

	Recall Style				
	Over-general	Categorical	Extended	Specific	Omissions
BPD Group					
All cues:	5.5 (1.5)	2.5 (1.5)	3.0 (1.4)	3.5 (2.0)	1.0 (1.0)
Positive cues:	2.3 (1.1)	1.4 (0.9)	0.9 (0.7)	2.2 (1.0)	0.6 (0.8)
Negative cues:	3.2 (1.2)	1.1 (1.0)	2.1 (1.4)	1.4 (1.3)	0.3 (0.5)
Control Group					
All cues:	3.2 (1.5)	1.8 (1.2)	1.4 (1.0)	6.3 (1.5)	0.5 (0.7)
Positive cues:	1.4 (1.0)	1.0 (0.9)	0.4 (0.6)	3.5 (1.0)	0.1 (0.2)
Negative cues:	1.7 (1.1)	0.8 (0.9)	1.0 (0.8)	2.84 (1.2)	0.5 (0.7)

Table 4.3. Intercorrelations between the mean number of over-general responses and scores on the BAI, BDI, DES, CTQ-Global.

	AMT	BDI	BAI	DES	CTQ
AMT	–	0.74	0.58	0.52	0.57
BDI		–	0.84	0.73	0.81
BAI			–	0.75	0.76
DES				–	0.66
CTQ					–

($p < 0.01$, one tailed)

Feeding Problems in Cystic Fibrosis (CF):
A Single Case Experimental Investigation of the Effects of
Differential attention of mealtime behaviours

Joy Airlie, Trainee Clinical Psychologist

Submitted in partial fulfillment of the requirements
for the Degree of Doctorate in Clinical Psychology

(Separately bound)

Address for correspondence: Department of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Fax number: 0141 357 4899
E-mail address: joyairlie@yahoo.co.uk

Prepared for submission to the Journal of *Behaviour Research and Therapy incorporating Behavioural Assessment.*
(See Appendix 1.2, in Portfolio Part II, for contributors' notes)

A Single Case Experimental Investigation of the Effects of Differential Attention of Mealtime Behaviours

Abstract

Diet is now considered a crucial component in the management of Cystic Fibrosis (CF) (Stark, 1999). As the importance of nutritional intake has assumed an increasingly important role in the treatment of CF, the apparent challenges being faced by families, attempting to meet these dietary requirements, are becoming increasingly evident. Mealtime behaviours have become the subject of clinical evaluation, with particular attention now being paid to the parent-child interactions. There is some evidence to suggest that behavioural techniques, employed to increase the child's nutritional intake and weight, result in positive outcomes. However, relatively fewer studies have specifically addressed the parent-child interaction.

The purpose of this study was therefore to investigate the efficacy of a particular behavioural approach on the parent-child mealtime interactions, between a 6 year-old female, diagnosed with CF, and her mother. The results suggest that the use of differential attention, as a single intervention, may prove efficacious in improving the adaptive behaviours of a child during mealtimes. This was believed to be the result of positive attention that the child's adaptive behaviours received and the absence of reinforcement received by the maladaptive behaviours. Future research implications and the clinical significance of the current findings are disclosed.

Key Words

Cystic Fibrosis, Differential Attention, Mealtime Behaviours, Feeding Problems

APPENDICES – PORTFOLIO PART I

Notes for Contributors

Journal of Mental Health welcomes original communications and articles which have relevance to the field of mental health. Papers are accepted on the understanding that they are subject to editorial revision and that their contents have not been published elsewhere.

Manuscripts should be sent to the Executive Editor, Professor Ray J Hodgson, Centre for Applied Public Health Medicine, Lansdowne Hospital, University of Wales College of Medicine, Cardiff CF1 8UL, United Kingdom.

To expedite assessment, 3 complete copies of each manuscript should be submitted. All submissions should be in the style of the American Psychological Association (*Publication Manual*, Fourth edition, 1994). Papers should be typed on one side of the paper, double spaced (including the references), with margins of at least 2.5 cm (1 inch). The first sheet should include the full title of the paper, a short title not exceeding 45 characters (for a running title at the head of each page), names of authors and the address where the work was carried out. All pages must be numbered. Significant delays may occur to manuscripts that do not conform to journal style. Each article should be accompanied by an abstract of not more than 150 words. Manuscripts should not exceed 6000 words in total, unless previously agreed by the Editor. The full postal address of the author who will check proofs and receive correspondence and offprints should also be included. Footnotes should be avoided where possible.

In order to improve accuracy and expedite publication, authors are requested to submit the ***final*** and ***revised*** version of their manuscript on disk. The disk should contain the paper saved in its original application software (e.g. WordPerfect or Microsoft Word), and as either Word for Macintosh, rich text format (RTF) if available, or as a text or ASCII (plain) text file. The disk should be clearly labelled with the author(s) name, paper title, file names and the software used. A good quality copy of the manuscript is ***always*** required.

References should follow the style of the American Psychological Association. All publications cited in the text should be listed following the text; similarly, all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Folkman, 1992) or (Sartory & Stern, 1979), or if there are more than two authors (Gallico *et al.*, 1985). Where several references are quoted consecutively, or within a single year, within the text the order should be alphabetical, e.g. (Mawson, 1992; Parry & Watts, 1989) and (Grey, 1992; Kelly, 1992; Smith, 1992). If more than one paper from the same author(s) and year are listed, the date should be followed by (a), (b), etc., e.g. (Cobb, 1992a).

References should be listed alphabetically by author on a separate sheet(s) (double spaced) in the following standard form, capitalisation and punctuation:

a) For periodical articles (titles of journals should *not* be abbreviated):

Rachman, S., Cobb, J., Grey, S.J., McDonald, B., Mawson, D., Sartory, G. & Stern, R. (1979). The behavioural treatment of obsessive-compulsive disorders, with and without clomipramine. *Behaviour Research and Therapy*, **17**, 467-478.

b) For books:

Powell, T.J. & Enright, S.J. (1990). *Anxiety and stress management.* London: Routledge.

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989). More fun, less stress: How to survive in research. In G. Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75-89). London: Lawrence Erlbaum.

Journal titles should not be abbreviated and unnecessary references should be avoided.

Clear, grammatical and tabular presentation is strongly encouraged.

Illustrations should not be inserted in the text. Each should be provided separately, and numbered on the back with the figure number, title of the paper, and names of the author(s). Three copies of all figures must be submitted. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Fig 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate sheet and should make interpretation possible without reference to the text. Captions should include keys to symbols. Where possible it would help to ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate sheets and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should *not* be used.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within 3 days of receipt.

The *Journal* does not provide free offprints; although the corresponding author will receive a complimentary copy of the relevant issue of the journal approximately 3 weeks after publication. Authors may order offprints on the form that accompanies the proofs at the time proofs are returned.

Printed and Bound in Great Britain by
Wace Journals, Abingdon, Oxfordshire, England

PSYCHOLOGICAL ASSESSMENT OUTCOME PROFORMA

ologist - Clinic – Assessment Date -

NDED / DNA / CANCEL? (If Cancel, does patient require further appointment? YES/NO)

ENT DETAILS :

Name	Address	D.O.B./CHI	G.P.

RRER : GP/GPFH/PSYCHIATRIST/CMHT Member/OTHER (please specify) –

.....
.....
.....
.....
.....

rral Date -

SENTING PROBLEMS/REASON FOR CARE (Use EPPIC categories) :

.....
.....
.....
.....

NTRIBUTORY FACTORS (Use EPPIC categories) :

.....
.....
.....

OVISIONAL FORMULATION : (*Briefly*)

.....
.....
.....

AGNOSIS (per DSM-IV, if applicable)

(Primary).....
(Secondary).....
(Secondary).....

OBLEM CATEGORY :

1 ☐ Life transitions, life events

2 ☐ Psychological Disorder - simple – complex – moderate – severe

3 ☐ Severe and enduring mental illness; major psychosocial disorder; requires multidisciplinary management

SITIVE RISK ASSESSMENT? YES/NO

Yes – Risk Assessment Form Completed? .....

TERVENTION REQUIRED :

oblem Solving ☐ Behavioural Therapy ☐

itive Behavioural Therapy ☐
oanalytic Therapy ☐
y System Therapy ☐

Counselling ☐
Psychometric Assessment ☐

r (specify).....

Contd.....

EPTABLE CONTEXT : ☐ Individual ☐ Group ☐ Family

L OF PSYCHOLOGICAL INTERVENTION REQUIRED :

☐ No further intervention required
☐ Counselling
☐ Circumscribed psychological activities, protocol driven, eg. behaviour modification, anxiety management
☐ Specialist, flexible, psychological intervention, tailored using multiple theoretical base.

ails of Self-help Material to be/or has been forwarded to Patient :

.....
.....
.....

TCOMES :

FERRAL ON: Urgent – refer on now ☐ To whom .....
Non-urgent – refer on ☐ To whom .....

SCHARGE: Single session sufficient ☐
Problem resolved prior to assessment ☐
Other reason (specify) ☐ .....

TURN TO WAITING LIST AS PRIORITY OF:

High ☐ Medium ☐ On what basis? .....

AS REFERRAL APPROPRIATE FOR PSYCHOLOGY? YES/NO

NO, appropriate destination .....

For Assistant Psychologist/admin use only :

HECK LIST :

rgent referral made to .....

otocol Logged on Database ☐ Self-help material forwarded ☐ Letter sent G.P. ☐
I Scores Logged on Database ☐

itials : ..... Date .....

EPPIC FORMULATORY CATEGORIES (PRESNTING PROBLEMS)

1 Agoraphobia
2 Anger
3 Anorexia
4 Anti-Social
5 Anxiety (NOS)
6 Attention Deficit
7 Bulimia
8 Carer Management
9 Communication
10 Depressed Mood
11 Developmental Delay
12 Encopresis
13 Enuresis
14 Epileptic Behaviour
15 Family Problems (NOS)
16 Gambling
17 GAD
18 Grief Reaction
19 Hyperactivity
20 Hypersomnia
21 Illness Behaviour
22 Immature
23 Insomnia
24 Intellectual/Memory Impairment
25 Interpersonal Skills Deficit
26 Irritability
27 Marital Problems
28 Mono-Symptomatic Phobia
29 Mood Disorder (NOS)
30 Motivation
31 Not otherwise specified
32 Obsessional
33 Obsessive Compulsive Dsorder
34 Over-eating
35 Pain
36 Panic
37 Parental Management
38 Peer Relationships
39 Perceptual Deficit
40 Phobic Avoidance
41 Post Traumatic Stress
42 Psychopathic
43 Psychosexual Dysfunction
44 Ruminations
45 Schizoid
46 School Refusal
47 Self-care
48 Self Injury
49 Separation Anxiety
50 Sexual Identity
51 Sexual Offending – Exhibitionism
52 Sexual Offending – Voyeurism
53 Sexual Variation
54 Social Adjustment
55 Social Phobia
56 Social Relationships (NOS)
57 Social Withdrawal
58 Specific Learning Difficulty
59 Speech/Language Disorder
60 Stereotopy
61 Stress Adjustment
62 Substance Use – Alcohol
63 Substance Use – Drugs
64 Substance Use – Solvents
65 Substance Use – Tobacco
66 Temper Tantrums
67 Tics
68 Torticollis
69 Treatment Compliance
70 Tremors
71 Work Stress

EPPIC FORMULATORY CATEGORIES (CONTRIBUTORY FACTORS)

1 Life events or Transitions

2 Abuse or Trauma

3 Social Adversity

4 Psychosomatic / Physical Illness

5 Sensory / Physical Handicap

6 Developmental Delay

7 Psychiatric Illness

8 Acquired CNS Impairment

9 More than one of the above

10 Other

11 Unknown

16th February, 1999

Private & Confidential

Ayrshire.

Dear ,

I am sorry that you may have been waiting for some time to see a member of our Department. Unfortunately, the high demand for our service continues and we have had to review how we can best help people referred to us. Our current system of taking people on for therapy immediately after their initial assessment means that our staff can only take on a few new patients at any given time. This results in people waiting, often for months, for their first appointments.

We recognise that long waiting times for a first appointment are unacceptable and that we need to offer at least a one-off assessment appointment to all the people waiting to see us. We are therefore writing to offer you an appointment:

Appointment Date/Time		Location	Therapist

This appointment will be in the form of a clinical assessment to see whether psychological intervention can help you. Where possible, you will be given immediate advice regarding your problem. If follow-up intervention is needed, either by our Psychologists/Therapists or by another service, such as Counselling or group-work, referral will be made for this, although unfortunately, this may necessitate a further wait. **Unfortunately, we will be unable to offer an alternative date, time or location for the above appointment. However, if you are required to be seen again, we will try to ensure that any future appointments are at a date, time and location convenient to you**

In order to make the most of your assessment appointment, it is important for you to complete and return the attached questionnaire. This will mean that the person you see will already have some information about you.

Please also return the attached slip indicating whether or not you will be accepting the appointment offered. Because of the high numbers of people waiting to be seen, if we do not hear from you within seven working days of the date on this letter, we will automatically cancel your appointment and offer it to someone else.

I look forward to hearing from you and once again apologise for your long wait.

Yours sincerely,

Consultant Clinical Psychologist

Name:	
Address:	
Appointment Date:	
Location:	
Therapist:	

Please tick the appropriate box(es):

- I will be attending the above appointment: ☐
- I will not be attending the above appointment and wish no further appointments: ☐
- I will not be attending the above appointment but wish to remain on the waiting list: ☐
- **I have enclosed my completed questionnaire:** ☐

Signed: ..... Date: .....

March 1999

RICTLY CONFIDENTIAL

ear Dr

E: (d.o.b.)

e above named patient has been seen as part of our Waiting List Initiative on at the Clinic,

hope the enclosed summary information is sufficient. If you wish to discuss this se further, please do not hesitate to contact me.

ours sincerely

onsultant Clinical Psychologist

nc.

PRESENTING PROBLEM CATEGORIES WITH LESS THAN A 4% INCIDENCE WHICH WERE GROUPED INTO THE 'OTHER' CLASSIFICATION

The 'other' category included:

Substance Abuse, Social Withdrawal, Relationship Problems, Work Stress, Marital Problems, Insomnia, Family Problems, Illness Behaviour, Stress Adjustment, Irritability, Epileptic Behaviour, Intellectual & Memory Impairment, Eating Disorders, Sexual Identity Problems, Psychosexual Disorders and Ruminations.

RETROSPECTIVE ACCOUNT FOR CLINICIAN'S PRIORITISATION

High Priority:

Moderate/severe impairment of quality of life by the disorder.

Good motivation to work psychologically.

Need to act quickly to prevent deteriorating / disorder just developing.

Complexity of disorder.

Direct risk to physical Health

Time Urgency (e.g. *exam phobic with exam in x weeks time*)

Problem will require very brief input

Other (*e.g. other supports available, organic problem, first – disclosure of problem*)

Medium Priority:

Long-standing, chronic problem

Another service/ other supports involved

Lack of severity or risk

Patient not well motivated to work psychologically

Other (*e.g. need for long-term therapy, relationship problem, unlikely to respond to psychotherapy, need to access another service first, patients unable to take early appointment)*

NOTES FOR CONTRIBUTORS

1. The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour, e.g. neuropsychology, age associated CNS changes and pharmacological (in the later case an explicit psychological analysis is also required), through studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis. The general focus of studies in an abnormal behaviour such as that described and classified by current diagnostic systems (ICD-10, DSM-IV) but it is not bound by the exclusive use of such diagnostic systems. The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

2. The following types of paper are invited:

(*a*) Papers reporting original empirical investigations.

(*b*) Theoretical papers, provided that these are sufficiently related to empirical data.

(*c*) Review articles which need not be exhaustive, but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications.

(*d*) Brief Reports and Comments (see paragraph 6).

Case studies are normally published only as Brief Reports. Papers are evaluated in terms of their theoretical importance, contributions to knowledge, relevance to the concerns of practising clinical psychologists, and readability. Papers generally appear in order of acceptance, except for the priority given to Brief Reports and Comments.

3. The circulation of the Journal is worldwide, and papers are reviewed by colleagues in many countries. There is no restriction to British authors, and papers are invited from authors throughout the world.

4. The editors will reject papers which evidence discriminatory, unethical or unprofessional practices.

5. Papers should be prepared in accordance with The British Psychological Society's *Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, England. Contributions should be kept as concise as clarity permits, and illustrations kept as few as possible. Papers should not normally exceed 5000 words. A structured abstract of up to 250 words should be provided (see Volume 35(2), pp. 323–1996, for details). The title should indicate exactly but as briefly as possible the subject of the article, bearing in mind its use in abstracting and indexing systems.

(*a*) Contributions should be typed in double spacing with wide margins and only on one side of each sheet. Sheets should be numbered. The top copy and at least three good duplicates should be submitted and a copy should be retained by the author.

(*b*) This journal operates a policy of blind peer review. Papers will normally be scrutinized and commented on by at least two independent expert referees as well as by the editor or by an associate editor. The referees will not be made aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to a removeable front page and the text should be free of such clues as identifiable self citations ("In our earlier work ..."). The paper's title should be repeated on the first page of the text.

(*c*) Tables should be typed in double spacing on separate sheets. Each should have a self explanatory title and should be comprehensible without reference to the text. They should be referred to in the text by arabic numerals. Data given should be checked for accuracy and must agree with mentions in the text.

(*d*) Figures, i.e. diagrams, graphs or other illustrations, should be on separate sheets numbered sequentially (Fig. 1, etc., and each identified on the back with the title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reduced in size. Special care is needed with symbols: correction at proof stage may not be possible. Lettering must not be put on the original drawing but upon a copy to guide the printer. Captions should be listed on a separate sheet.

(*e*) Bibliographical references in the text should quote the author's name and the date of the publication thus; Hunt (1993). They should be listed alphabetically by author at the end of the article according to the following format:

Moore, R. G., & Blackburn, I.-M. (1993). Sociotrophy, autonomy and personal memories in depression. *British Journal of Clinical Psychology*, *32*, 460–462.

Steptoe, A., & Wardle, J. (1992). Cognitive predictors of health behaviour in contrasting regions of Europe. In C. R. Brewin, A. Steptoe, & J. Wardle (Eds.), *European perspectives in clinical and health psychology* (pp. 101–118). Leicester: The British Psychological Society.

Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

(*f*) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see BPS *Style Guide*).

(*g*) Authors are requested to avoid the use of sexist language.

(*h*) Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The materials should be submitted to the Editor together with the article, for simultaneous refereeing.

6. Brief Reports and Comments are limited to two printed pages. These are subject to an accelerated review process to afford rapid publication of research studies, and theoretical, critical or review comments whose essential contribution can be made within a small space. They also include research studies whose importance or breadth of interest is insufficient to warrant publication as full articles, and case reports making a distinctive contribution to theory or method. Authors are encouraged to append an extended report to assist in the evaluation of the submission and to be made available to interested readers on request to the author. To ensure that the two-page limit is not exceeded, set typewriter margins to 66 characters maximum per line and limit the text, including references and a 100 word abstract, to 150 lines. Figures and tables should be avoided. Title, author and name and address for reprints and data of receipt are not included in the allowance. However deduct three lines from the text each and every time any of the following occur:

(*a*) title longer than 70 characters,

(*b*) author names longer than 70 characters,

(*c*) each address after the first address,

(*d*) each text heading (these should normally be avoided).

A character is a letter or space. A punctuation mark counts as two characters (character plus space) and a space must be allowed on each side of a mathematical operator.

7. Proofs are sent to authors for correction of print, but not for introduction of new or different material. They should be returned to the Journals Manager as soon as possible. Fifty complimentary copies of each paper are supplied to the senior author on request; further copies may be ordered on a form supplied with the proofs.

8. Authors should consult the Journal editor concerning prior publication in any form or in any language of all or part of their article.

9. Authors are responsible for getting written permission to publish lengthy quotations, illustrations, etc., of which they do not own copyright.

10. To protect authors and journals against unauthorized reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to The Journal, authors will be requested to sign an appropriate assignment of copyright form.

West of Scotland Doctorate in Clinical Psychology

Course Guidelines for Major Research Project Proposal

The Research Proposal should be laid out according to the format described below. This format is based upon the application for a mini-project grant in Health Services Research (SOHHD 0 Chief Scientist Office). Trainees may find that forms provided by ethical committees are substantially similar to this and this may be an acceptable alternative format.

1.1 Applicants – names and addresses including the names of co-workers and supervisor(s) if known.

1.2 Title – no more than 15 words.

1.3 Summary – No more than 300 words, including a reference to where the study will be carried out.

1.4 Introduction – of less than 600 words summarising previous work in the field, drawing attention to gaps in the present knowledge and stating how the project will add to knowledge and understanding.

1.5 Aims and hypotheses to be tested – these should wherever possible be stated as a list of questions to which answers will be sought.

1.6 Plan of investigation – consisting of a statement of the practical details of how it is proposed to obtain answers to the questions posed. The proposal should contain information on Research Methods and Design *i.e.*

1.6.1 Subjects – a brief statement of inclusion and exclusion criteria and anticipated number of participants.

1.6.2 Measures – a brief explanation of interviews/observations/rating scales etc. to be employed, including references where appropriate.

1.6.3 Design and Procedure – a brief explanation of the overall experimental design with reference to comparisons to be made, control populations, timing of measurements, etc. A summary chart may be helpful to explain the research process.

1.6.4 Setting and equipment – a statement on the location(s) to be used and resources or equipment which will be employed (if any).

1.6.5 Data analysis – a brief explanation of how data will be collated, stored and analysed.

1.7 Practical applications – the applicants should state the practical use to which the research findings could be put.

1.8 Timescales – the proposed starting date and duration of the project.

1.9 Ethical approval – stating whether this is necessary and, if so, whether it has been obtained.

Division of Clinical Psychology

Direct Line: 0141-211
Fax: 0141-357 4899
E-mail:

Joy Airlie

Trainee Clinical Psychologist: Third Year
University of Glasgow

Supervised by: Dr Kate M. Davidson

UNIVERSITY
of
GLASGOW

PARTICIPANT INFORMATION SHEET

Is there a relationship between your personality, your past experiences and the way in which you remember personal memories?

Thank you for taking the time to consider my research. I am a Trainee Clinical Psychologist, studying at the University of Glasgow and am currently in my final year.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully. If there is anything that you are unsure about and you have any questions, or if you would like more information, please feel free to ask me.

What is the purpose of the study?

This study aims to investigate whether a person's personality plays a role in the way in which they remember personal memories, also we aim to investigate whether this may be related to your early experiences. Recruitment for this study aims to be completed by April/May 2001.

Why have you been chosen?

I am looking for 40 volunteers to help me with this study. I am asking people who make use of the Community Mental Health Teams or Clinical Psychology departments throughout Glasgow, Ayrshire and Lanarkshire and people who work in a hospital or education departments if they would like to take part in this study.

Do you have to take part?

You are free to decide whether you would like to take part in this study or not. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you do decide to take part you will still be free to withdraw at any time and without having to give a reason. This will not affect the standard of care you receive now or at any time in the future.

What will happen if you take part?

If you do decide to take part in this study, you will be asked to meet with myself on one occasion only. I will arrange an appropriate place to meet at a convenient venue and I will gladly reimburse your travelling expenses. The appointment will last approximately 1 - 1½ hours (maximum) of your time.

What do you have to do if you decide to take part in this study?

Well, if you decide that you would like to take part in this study, you will be asked to complete the participation consent form. The study will then involve an initial set of questions telling me a little more about yourself. You will then be asked to do a short memory task, this is then followed by 3 multiple-choice questionnaires. As mentioned earlier, this should take *no longer* than an hour and a half.
If you are in contact with a Clinical Psychologist or CMHT member, taking part in this study will not affect or alter the input you already receive, you will simply be helping us to gain further information by taking part in this study.

What are the possible advantages of taking part?

This study does not involve any therapeutic intervention, which simply means that we are looking for volunteers to help us to gain further information. We hope that the information we get from this study may help us to understand aspects of our personalities a little better in the future.

Will my taking part in this study be kept confidential?

If you consent to take part in this study, any information collected about you will be kept strictly confidential and you name and address will be removed from the information so that you cannot be recognised from it. A tape recorder will be used for the memory task **only**, however as soon as your responses have been transcribed, these tapes will be erased.

If you are in contact with a Clinical Psychologist or CMHT member, a letter will be sent to that person to let them know that you have agreed to take part in the study. They will be aware of the study and might be interested to hear how you have got on with it.

What will happen to the results of the study?

Everyone who participates in this study will have their results anonymously entered onto a computer database, the results will then be looked at to investigate whether a person's personality plays a role in the way in which they remember personal memories and whether this may be related to early experiences.

If you are in contact with a Clinical Psychologist or CMHT member, with your consent a summary of how you get on with the study can be provided to that person who is already involved in your care.

This study will be completed by August 2001 and the results will be written up as part of the requirements for completing the Doctorate in Clinical Psychology training course. Any individuals who are interested in the overall outcome of this study can be forwarded a summary of the results of this study, on completion.

.....

I am aware that there are a number of research studies being conducted at the moment and you are in no way obliged to participate in this study, therefore I am looking for **volunteers** who would like to participate in this study. Please feel free to ask any questions and take your time to decide whether or not you wish to participate.

Thankyou for taking the time to read this information.

Joy Airlie
Trainee Clinical Psychologist

Division of Clinical Psychology

Direct Line: 0141-211
Fax: 0141-357 4899
E-mail:

UNIVERSITY *of* GLASGOW

Centre Number:
Study Number:
Participant Identification Number:

CONSENT FORM

IS THERE A RELATIONSHIP BETWEEN YOUR PERSONALITY, YOUR PAST EXPERIENCES AND YOUR ABILITY TO REMEMBER PERSONAL MEMORIES?

NAME OF RESEARCHER: Joy Airlie

(Please initial box)

1. I confirm that I have read and understand the information sheet dated June 2000 (version 1) for the above study and have had the opportunity to ask questions. ☐

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

3. I understand that sections of my medical notes may be looked at by responsible individuals involved in this study or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐

4. I agree to take part in the above study. ☐

Name of participant:	_____	Researcher:	_____
Date:	_____	Date:	_____
Signature:	_____	Signature:	_____

HAPPY

SAFE

INTERESTED

SUCESSFUL

SURPRISED

CLUMSY

HURT

LONELY

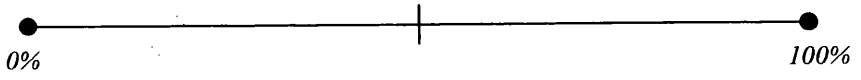
SORRY

ANGRY

THE DISSOCIATIVE EXPERIENCES SCALE – (DES)[1]

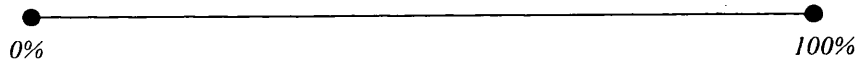
This questionnaire consists of twenty-eight questions about experiences you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and mark the line with a vertical slash at the appropriate place, as shown in the example below.

Example:



Some people have the experience of driving a car and suddenly realising that they don't remember what has happened during all or part of the trip.

Mark this line to show what percentage of the time this happens to you.

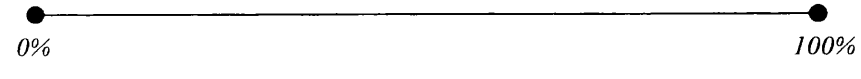


Some people find that sometimes they are listening to someone talk and they suddenly realise that they did not hear part or all of what was just said.

Mark this line to show what percentage of the time this happens to you.

Some people have the experience of finding themselves in a place and having no idea how they got there.

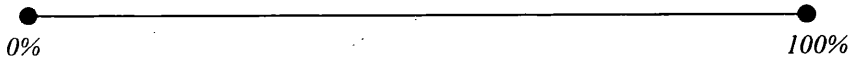
Mark this line to show what percentage of the time this happens to you.



[1] THE DISSOCIATIVE EXPERIENCES SCALE. Bernstein, Frank & Putnam (1986)

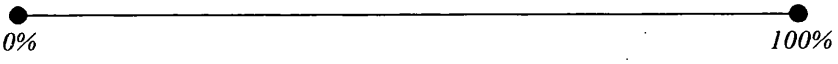
Some people have the experience of finding themselves dressed in clothes they don't remember putting on.

Mark this line to show what percentage of the time this happens to you.



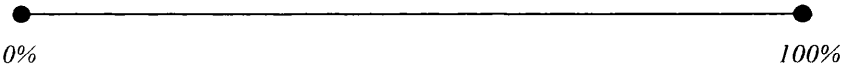
Some people have the experience of finding new things among their belongings that they do not remember buying.

Mark this line to show what percentage of the time this happens to you.



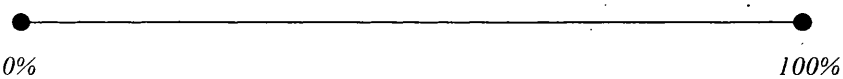
Some people find that they are approached by people that they do not know who call them by another name or insist that they have met them before.

Mark this line to show what percentage of the time this happens to you.



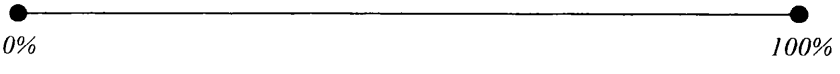
Some people have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person.

Mark this line to show what percentage of the time this happens to you.



Some people are told that they sometimes do not recognise friends or family members.

Mark this line to show what percentage of the time this happens to you.

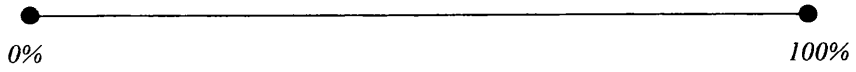


---

[1] THE DISSOCIATIVE EXPERIENCES SCALE. Bernstein, Frank & Putnam (1986)

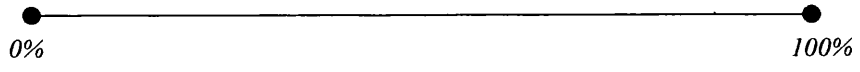
Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation).

Mark this line to show what percentage of the time this happens to you.



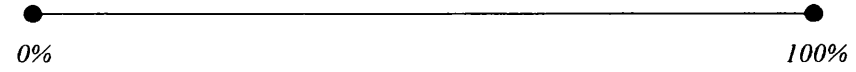
Some people have the experience of being accused of lying when they do not think that they have lied.

Mark this line to show what percentage of the time this happens to you.



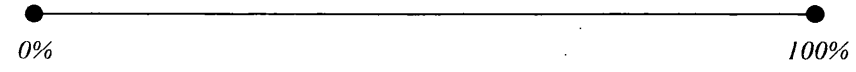
Some people have the experience of looking in the mirror and not recognising themselves.

Mark this line to show what percentage of the time this happens to you.



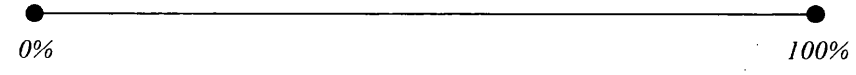
Some people have the experience of feeling that other people, objects, and the world around them are not real.

Mark this line to show what percentage of the time this happens to you.



Some people have the experience of feeling that their body does not seem to belong to them.

Mark this line to show what percentage of the time this happens to you.



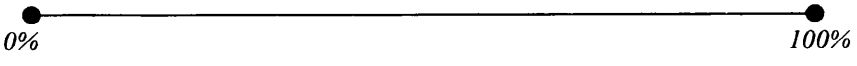
[1] THE DISSOCIATIVE EXPERIENCES SCALE. Bernstein, Frank & Putnam (1986)

Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving the event.

Mark this line to show what percentage of the time this happens to you.

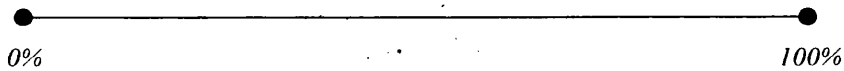
Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them.

Mark this line to show what percentage of the time this happens to you.



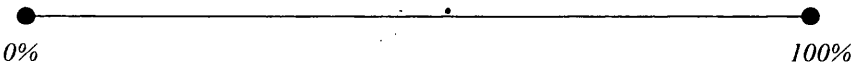
Some people have the experience of being in a familiar place but finding it strange and unfamiliar.

Mark this line to show what percentage of the time this happens to you.



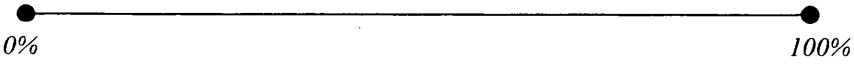
Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them.

Mark this line to show what percentage of the time this happens to you.



Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them.

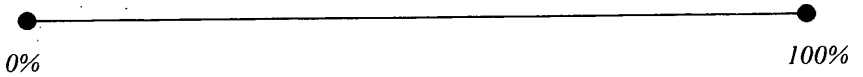
Mark this line to show what percentage of the time this happens to you.



[1] THE DISSOCIATIVE EXPERIENCES SCALE. Bernstein, Frank & Putnam (1986)

Some people find that they sometimes are able to ignore pain.

Mark this line to show what percentage of the time this happens to you.

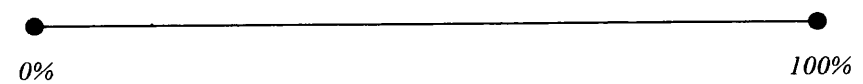


Some people find that they sometimes sit staring off into space, thinking about nothing, and are not aware of the pass of time.

Mark this line to show what percentage of the time this happens to you.

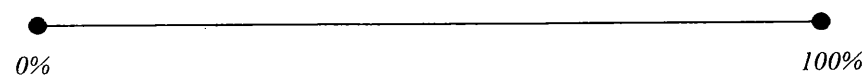
Some people find that when they alone they talk aloud to themselves.

Mark this line to show what percentage of the time this happens to you.



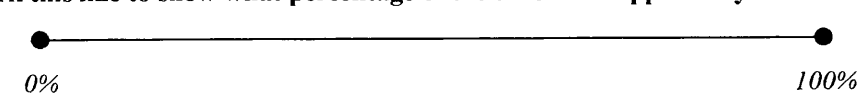
Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people.

Mark this line to show what percentage of the time this happens to you.



Some people find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.).

Mark this line to show what percentage of the time this happens to you.

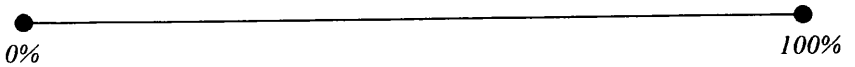


---

[1] THE DISSOCIATIVE EXPERIENCES SCALE. Bernstein, Frank & Putnam (1986)

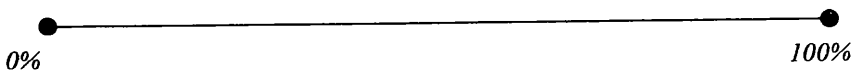
Some people have the experience of finding themselves in a place and having no idea how they got there

Mark this line to show what percentage of the time this happens to you.



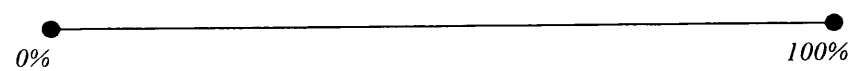
Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it).

Mark this line to show what percentage of the time this happens to you.



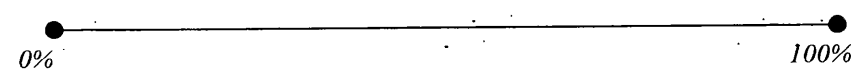
Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.

Mark this line to show what percentage of the time this happens to you.



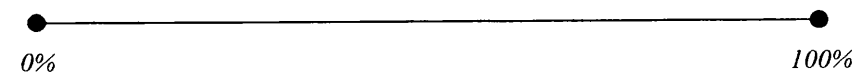
Some people sometimes find that they hear voices inside their head that tells them to do things or comment on things they are doing.

Mark this line to show what percentage of the time this happens to you.



Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear.

Mark this line to show what percentage of the time this happens to you.



[1] THE DISSOCIATIVE EXPERIENCES SCALE. Bernstein, Frank & Putnam (1986)

THE CHILDHOOD TRAUMA QUESTIONNAIRE – (CTQ)[1]

Instructions: These questions ask about some of your experiences growing up as a child and a teenager. For each question, circle the number that best describes how you feel. Although some of these questions are of a personal nature, please try to answer as honestly as you can. Your answers will be kept confidential.

When I was growing up. ...

		never true	rarely true	sometimes true	often true	very often true
1.	There was someone in my family whom I could talk to about my problems.	1	2	3	4	5
2.	People in my family criticized me.	1	2	3	4	5
3.	I didn't have much to eat.	1	2	3	4	5
4.	People in my family showed confidence in me and encouraged me to succeed	1	2	3	4	5
5.	Someone in my family hit me or beat me.	1	2	3	4	5

When I was growing up.

		never true	rarely true	sometimes true	often true	very often true
6.	I lived in a group home or foster home	1	2	3	4	5
7.	I knew that there was someone to take care of me and protect me	1	2	3	4	5
8.	Someone in my family yelled and screamed at me	1	2	3	4	5
9	I saw my mother or one of my brothers or sisters get hit or beaten.	1	2	3	4	5
10.	People in my family called me things like "stupid", "lazy", or "ugly"	1	2	3	4	5

[1] THE CHILDHOOD TRAUMA QUESTIONNAIRE © 1995 David P. Bernstein, Ph.D

When I was growing up. ...

		never true	rarely true	sometimes true	often true	very often true
11.	I was living in the streets by the time I was a teenager or even younger.	1	2	3	4	5
12.	There was someone in my family whom I admired and wanted to be like.	1	2	3	4	5
13	My parents were too drunk or high to take care of the family.	1	2	3	4	5
14.	People in my family got into trouble with the police.	1	2	3	4	5
15.	There was someone in my family who made me feel that I was important or special.	1	2	3	4	5

When I was growing up. ...

		never true	rarely true	sometimes true	often true	very often true
16	I had to protect myself from someone in my family by fighting, hiding or running away.	1	2	3	4	5
17	There was someone in my family who wanted me to be a success.	1	2	3	4	5
18	I had to wear dirty clothes.	1	2	3	4	5
19	I lived with different people at different times (like different relatives or foster families)	1	2	3	4	5
20.	I believe that one of my brothers or sisters might have been molested.	1	2	3	4	5

When I was growing up. ...

		never true	rarely true	sometimes true	often true	very often true
21	I felt loved.	1	2	3	4	5
22	My parents tried to treat all of us children the same.	1	2	3	4	5

[1] THE CHILDHOOD TRAUMA QUESTIONNAIRE. © 1995 David P. Bernstein, Ph.D.

23.	I thought that my parent wished that I'd never been born.	1	2	3	4	5
24.	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1	2	3	4	5
25.	There was someone in my family who made sure that I stayed out of trouble.	1	2	3	4	5

When I was growing up. . . .

		never true	rarely true	sometimes true	often true	very often true
26.	People in my family hit me so hard that it left me with bruises or marks.	1	2	3	4	5
27.	I had sex with an adult or with someone who was a lot older than me (someone at least 5 years older than me)	1	2	3	4	5
28	There was someone older than myself (like a teacher or a parent) who was a positive role model for me	1	2	3	4	5
29.	I was punished with a belt, a board, a cord, or some other hard object.	1	2	3	4	5
30	There was nothing I wanted to change about my family.	1	2	3	4	5

When I was growing up. . .

		never true	rarely true	sometimes true	often true	very often true
31	People in my family looked out for each other.	1	2	3	4	5
32	People in my family said hurtful or insulting things to me.	1	2	3	4	5
33.	I believe that I was physically abused.	1	2	3	4	5
34.	People in my family tried to keep me away from bad influences	1	2	3	4	5

[1] THE CHILDHOOD TRAUMA QUESTIONNAIRE. © 1995 David P. Bernstein, Ph.D.

35.	I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour, or doctor.	1	2	3	4	5

When I was growing up. . .

		never true	rarely true	sometimes true	often true	very often true
36.	People in my family seemed out of control.	1	2	3	4	5
37.	People in my family encouraged me to stay in school and get an education.	1	2	3	4	5
38.	I spent time out of the house and no one knew where I was	1	2	3	4	5
39.	The punishments I received seemed cruel.	1	2	3	4	5
40.	Someone in my family hated me.	1	2	3	4	5

When I was growing up. . .

		never true	rarely true	sometimes true	often true	very often true
41.	People in my family felt close to each other.	1	2	3	4	5
42.	Someone tried to touch me in a sexual way or tried to make me touch them.	1	2	3	4	5
43.	People in my family pushed or shoved me.	1	2	3	4	5
44.	Someone threatened to hurt me or tell lies about me unless I did something sexual with them	1	2	3	4	5
45.	I had a perfect childhood.	1	2	3	4	5

[1] THE CHILDHOOD TRAUMA QUESTIONNAIRE. © 1995 David P. Bernstein, Ph.D.

When I was growing up. …	never true	rarely true	sometimes true	often true	very often true
46. I was frightened of being hurt by someone in my family.	1	2	3	4	5
47. Someone tried to make me do sexual things or watch sexual things.	1	2	3	4	5
48. Someone in my family believed in me.	1	2	3	4	5
49. Someone molested me.	1	2	3	4	5
50. I believe that I was emotionally abused.	1	2	3	4	5
51. I had the best family in the world.	1	2	3	4	5
52. I believe that I was sexually abused.	1	2	3	4	5
53. My family was a source of strength and support.					

THE CHILDHOOD TRAUMA QUESTIONNAIRE – (CTQ)

Instructions. To compute maltreatment factor scores, fill in the blanks with item raw scores, then sum the item scores for each factor. All emotional neglect items must be reverse coded before summing:
1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1.

Maltreatment has the following ranges..

Emotional Abuse	*12 - 60*	*Emotional Neglect*	*16 - 80*
Physical Abuse	*7 - 35*	*Physical Neglect*	*8 - 40*
Sexual Abuse	*7 - 35*		

A formula for computing the weighted total score (with each factor given equal wight) is given below. To calculate the Minimization Denial score, assign one point for each item endorsed with a score of "5" ("very often true"). Scores on the Minimization Denial scale have a range of 0 - 3.

EMOTIONAL ABUSE	PHYSICAL ABUSE	SEXUAL ABUSE	EMOTIONAL NEGLECT	PHYSICAL NEGLECT	MINIMIZATION /DENIAL
2.	5. ____	20. ____	1. ____	3. ____	30. ____
8.	9. ____	27. ____	4. ____	6. ____	45. ____
10.	24. ____	42. ____	7. ____	11. ____	51. ____
16.	26. ____	44. ____	12. ____	13. ____	
23.	29. ____	47. ____	15. ____	14. ____	
32.	33. ____	49. ____	17. ____	18. ____	
36.	35. ____	52. ____	21. ____	19. ____	
39.			22. ____	38. ____	
40.			25. ____		
43.			28. ____		
46.			31. ____		
50.			34. ____		
			37. ____		
			41. ____		
			48.		
			53. ____		
SUM = ____	SUM = ____	SUM = ____	SUM = ____	SUM = ____	SUM = ____

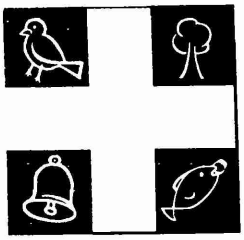
Weighted total score = sum EA/12 + sum PA/7 + sum SA/7 + sum EN/16 + sum PN/8

(____ = ____ /12 + ____ /7 + ____ /7 + ____ /16 + ____ /8)

Weighted total score, range: 1 - 25.

[n.b. Reverse all emotional neglect items before summing.]

Our Ref: BR/AW/APP



GREATER GLASGOW PRIMARY CARE NHS TRUST

14 August 2000

Ms J Airlie
Trainee Clinical Psychologist
Dept of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Dear Ms Airlie

Project Reference Number: **00CP12**
Project Title: **Is there a relationship between your personality, your past experiences and your ability to recall personal memories?**

The above research project has now received the approval of the Research and Development Directorate. Therefore when you receive the approval of the Ethics Committee, your research may commence.

The enclosed computer print-out shows your project details which have been entered on the Trust's R & D database. The information we collect follows Chief Scientist Office guidelines and will be entered on the National Research Register in due course. You should therefore check the information entered, correct any errors and return to the Research & Development Directorate as soon as possible.

Information on the database will be up-dated from time to time and I would appreciate if you would inform the R & D office of any change of details, including the ethics committee decision. A final report should also be submitted when the project is complete.

Do not hesitate to contact the R & D office if you need any assistance in submitting the necessary information.

Your help is much appreciated.

Yours sincerely

BRIAN RAE
Research Manager

Enc.

Research & Development Directorate, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
Tel 0141 211 3661 Fax 0141 211 3814 e.mail annette.watt@gartnavel.glacomen.scot.nhs.uk

Ref: AmcM/0030

GREATER GLASGOW
PRIMARY CARE
NHS TRUST

27 September, 2000

Ms Joy Airlie
42F Sharon Street
Dalry
Ayrshire
KA24 5DT

Dear Ms Airlie

PROJECT: Is there a relationship between your personality, your past experiences and your ability to recall personal memories?

Many thanks for sending the amendments to the above named submission to the Research Ethics Committee - it was formally discussed at our meeting on 21 September 2000. I am pleased to be able to tell you that the Committee has no objections from an ethical point of view, to this project proceeding and ethical approval is formally granted.

Before your project commences you will also require to obtain management approval via the Research & Development Directorate, Gartnavel Royal Hospital.

I would also like to take this opportunity to remind you that you should notify the Committee if there are any changes, or untoward developments, connected with the study – the Committee would then require to further reconsider your application for approval. The Committee expect to receive a brief regular update every 6 months, and then a brief final report on your project when the study reaches its conclusion. (Failure to keep the Committee abreast of the status of the project can eventually lead to ethical approval being withdrawn)

May I wish you every success with your study.

Yours sincerely

A W McMAHON
Administrator – Research Ethics Committee

cc B Rae

AYRSHIRE AND ARRAN
HEALTH BOARD

HEAD OFFICE
Boswell House
10 Arthur Street
Ayr KA7 1QJ

Tel: (01292) 611040
Fax: (01292) 885890

r Ref. AC-403/Sept2000C/MC Your Ref. DDI: 01292 885859

14 December 2000

Ms J Airlie
Trainee Clinical Psychologist
42F Sharon Street
DALRY
Ayrshire
KA24 5DT

Dear Ms Airlie

Autobiographical memory, dissociative symptoms and emotionally traumatic past events in borderline personality disorder. (Is there a relationship between your personality, your past experiences and your ability to recall personal memories?)

I am in receipt of your letter of 1 December 2000 and documentation associated with amendments to your protocol.

I can confirm that the protocol, as amended, may proceed locally.

Yours sincerely

Dr Adrian Carr
Secretary – Local Research Ethics Committee